

AMERICAN
PSYCHIATRIC
ASSOCIATION

ANNUAL MEETING

May 21-25, 2022 • New Orleans

June 7-10, 2022 • Online



2022
Theme

**Social Determinants of
Mental Health**

Syllabus and Proceedings

Focus Live

Tuesday, May 24, 2022

Focus Live! Novel Neurotherapeutics

Moderator: Mark Hyman Rapaport, M.D.

Presenter: Alexander Bystritsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine the distinctions between recent transcranial electrical stimulation approaches for the treatment of psychiatric illness.; 2) Examine the mechanisms of transcutaneous auricular vagus nerve stimulation on neuropsychiatric disorders.; 3) Describe photobiomodulation and optogenetics techniques in psychopharmacology.; 4) Demonstrate an understanding of the application of biological therapy on neuropsychiatric illness.; and 5) Explain treatment strategies for intractable psychiatric illness..

SUMMARY:

For years, biological psychiatry stagnated as a whole. This has changed ever since the end of the first decade of the millennium, when genetics, neuroimaging, psychedelics, and neuromodulation became the new leading areas of research. As a result, we hold a broad spectrum of new tools to treat and study mental health. This 90-minute interactive session will allow participants to test their knowledge of the current literature on the use of neurotherapeutics to treat mental illness. Presenters will examine improvements in our understanding of mental illness through advancements in brain stimulation, or *circuit-based*, rather than *synaptic-based*, treatments, as well as discuss promising new techniques and technologies to further develop the treatment of psychiatric disorders.

Focus Live! Obsessive-Compulsive and Related Disorders

Moderator: Mark Hyman Rapaport, M.D.

Chair: Michele Pato, M.D.

Presenters: Barbara Van Noppen, Katharine Phillips, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe what OCD-related disorders—including body dysmorphic disorder, hoarding, trichotillomania, and skin picking—share with OCD and how they differ from OCD diagnostically.; 2) Explain the differences in efficacious treatments for hoarding disorder from OCD.; 3) Determine treatment options for trichotillomania and skin-picking disorder.; 4) Appreciate the differences required for cognitive-behavioral therapy (CBT) for body dysmorphic disorder (BDD) versus OCD.; and 5) Understand the current knowledge on genetic underpinnings of OCD and Related Disorders and what future genomics research needs to focus on..

SUMMARY:

Despite the ever-growing literature on Obsessive-Compulsive and Related Disorders, which finally received their own diagnostic classification separate from anxiety disorders within DSM-5 in 2013, there is still much to learn with future research. This 90-minute interactive session will allow participants to test their knowledge of the current literature on genetics, diagnosis (including comorbid psychiatric conditions), neurobiology, and treatments (both pharmacologic and psychotherapeutic). Discussants will also field questions and provide up-to-date findings as reflected in the Fall 2021 Issue of FOCUS.

Forum

Sunday, May 22, 2022

Special Forum With APA Board of Trustees Members: Antiracism and APA's Future

Chairs: Rebecca W. Brendel, M.D., J.D., Vivian Pender, M.D., Altha J. Stewart, M.D.

Moderator: Natalie Gillard

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide culturally competent

care for diverse populations; 2) Integrate knowledge of current psychiatry into discussions with patients; and 3) Identify barriers to care, including health service delivery issues.

SUMMARY:

Presented by the APA Board of Trustees, this session will provide a forum to discuss antiracism efforts at APA to develop tangible solutions and effect positive change within the organization and beyond. Using collaborative working groups/breakouts with a professional facilitator, members are invited to share their ideas for promoting diversity, equity, and inclusion within the APA and other professional organizations in an interactive town hall format. Attendees are encouraged to bring their smartphones or other mobile device to fully engage in the participatory opportunities this session will offer. Natalie Gillard will moderate the session.

General Sessions

Saturday, May 21, 2022

A Circuits-First Approach to Mental Illness: Development of Precision Medicines for the Brain (Not Available for CME)

Introduction: Eric R. Williams, M.D.

Presenter: Amit Etkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand tools and findings relevant to brain-based subtyping of psychiatric disorders; 2) Explain the utility of supervised and unsupervised machine learning; and 3) Delineate pathways for development of precision medicines for psychiatric disorders.

SUMMARY:

Over the past two decades, brain imaging studies have defined a set of distributed brain systems that contribute to cognition, emotion, sleep, mood and other mental processes. Perturbations in these circuits have been identified in different ways across psychiatric disorders. Yet, these insights have not translated to the development and deployment of

novel precision treatments in psychiatry. I will discuss work on neural circuit signatures that either define specific biologically-discrete forms of psychopathology, or predict treatment outcome, doing so at the individual patient level through a range of new machine learning-based analyses. Together, these data suggest that we are now on the brink of scalable and clinically-applied innovations in circuit-based diagnostics and treatments for mental illness, thereby taking us beyond dependence on symptom checklists for diagnosis, and having only one-size-fits-all treatments.

A Revolutionary in Psychiatry: Dr. Roger Peele

Chair: Robbie Shinder

Presenters: Roger Peele, M.D., Saul Levin, M.D., M.P.A., Jack Drescher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide culturally competent care for diverse populations; 2) Integrate knowledge of current psychiatry into discussions with patients; and 3) Identify barriers to care, including health service delivery issues.

SUMMARY:

For many years, the LGBTQ community was deemed mentally ill, and homosexuality was considered a psychosexual disorder. A new documentary titled 'A Revolutionary in Psychiatry' examines Dr. Roger Peele's life and his work to ensure LGBTQ patients are properly treated for their mental illness regardless of their sexuality, as well as countless other transformative psychiatric treatments. While working at Saint Elizabeths Hospital, Dr. Peele argued for the declassification of homosexuality as a mental illness from the DSM, citing the lack of data in support of this diagnosis. Dr. Peele started a revolution in psychiatry that has changed the world today. A part of this movement is the APA's own Dr. John Fryer, who is well known for drawing attention to how the LGBTQ community was mistreated in psychiatry. This session will begin with a viewing of the documentary, followed by a panel discussion of the changes Dr. Peele made within the field of psychiatry, including his support of the LGBTQ community.

Addressing Mental Health Disparities: Challenges and Innovative Opportunities

Chair: Dawn Tyus, Ph.D., L.P.C.

Presenters: Rachel Talley, M.D., Madhuri Jha, L.C.S.W., M.P.H., Sosunmalu Shoyinka, M.D., Mary Roary, Ph.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the historical context of current mental health disparities in the U.S.; 2) Describe the data that demonstrates the severity of current existing mental health disparities; 3) Examine how wide the treatment gaps are for African Americans, Hispanics, and others vs US population for mental health (MH), substance use (SU), and co-occurring MH and SU; 4) Understand the experience of addressing mental health disparity on the front lines through the lens of a clinical case example and implementation of the Health Equity Tracker to bridge data gaps; and 5) Apply the SMART tool in an organizational setting to address mental health disparity, and consider its potential as one of many innovative tools to address disparities on a system level.

SUMMARY:

To gain an understanding of the origins of the current mental health disparities in the United States, it is important to understand the historical context and how data demonstrates the severity of these disparities. This helps to reveal the cultural disparities, reform efforts, and the wide variation in the way services have developed and evolved over time (Williams et al, 2016). In this presentation, priority will be given to understanding the importance of data access and equitable representation in data sources to ensure visibility of marginalized groups most affected by Behavioral Health concerns. We will highlight some examples of policies that have created this restricted access (i.e. Snyder Act, Civil Rights Act and distinctions in the development of the diagnostic manual), and provide a framework for thinking about burden through a lens that looks at political determinants of health (Dawes, 2020). Innovations will be explored through work being conducted at the Satcher Health

Leadership Institute that aim to bridge these data gaps like the Health Equity Tracker, utilization of intersectionality based policy analysis and research (Hankivsky et al, 2014), and facilitation of unique dialogue spaces where lesser represented voices can convene with leading policy makers. We will then consider other innovative system-level solutions to address mental health disparity, with a focus on the Self-Assessment for Modification of Anti-Racism Tool (SMART) (Talley et al, 2021). We will describe the SMART's development process including its grounding in existing health disparity organizational change frameworks (Spitzer-Shohat & Chin, 2019). We will highlight the key domains of SMART and process for using SMART in the organizational setting. Lastly, we will discuss SMART's potential as one of many innovative tools to address system-level disparity, including lessons learned from SMART's development and use on general system-level approaches to address health disparity.

Advances in the Treatment of Mood Disorders: Problems and Promises

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

Presenters: Alan F. Schatzberg, M.D., Natalia L. Rasgon, M.D., Ph.D., Stephen M. Strakowski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe our current understanding of the pathophysiology of mood disorders; 2) Describe the current evidence-based treatments of mood disorders; 3) Understand the available data concerning the efficacy and safety of novel antidepressant treatments including ketamine and psychedelics; 4) Describe novel treatments for mood disorders in women; and 5) Describe current evidence-based treatments of bipolar disorder and the need for novel approaches.

SUMMARY:

The four editors of the Second Edition of the APA Textbook of Mood Disorders, Charles B. Nemeroff, Alan F. Schatzberg, Natalie Rasgon and Stephen Strakowski will present state of the art summaries on treatment of mood disorders. After a lull of several years, exciting new development in the treatment of depression have emerged and the

pipeline for novel agents is exponentially growing. Dr. Nemeroff will review the current understanding of treatment response of Major Depression with a focus on antidepressant medication, somatic non-pharmacological interventions such as transcranial magnetic stimulation (TMS) and evidence-based psychotherapies. He will review the many unmet needs including predictors of treatment response with a focus on the failure of pharmacogenomic testing to fulfill early promises. In addition the management of treatment resistant depression will briefly be reviewed with a focus on unmet needs. Finally the role of child abuse and neglect as a major factor in treatment resistance will be discussed. Alan Schatzberg will discuss the current literature concerning the efficacy and safety of ketamine and esketamine, the latter recently approved by the FDA for treatment resistant depression. In this context he will discuss what is known on the mechanism of action of these compounds, as well as their safety profile. He will also review the burgeoning area of psychedelic drug therapy for treatment resistant depression with an emphasis on psilocybin. If time permits, he will discuss other novel treatments in the pipeline. Natalie Rasgon will describe the development of brexanolone, a positive allosteric modulator of the GABA A receptor, which is now FDA approved for the treatment of post-partum depression. Moreover, an oral form of the drug, zuranolone now has also shown efficacy in this very serious mood disorder. If time permits, she will also discuss other agents targeting depression in women. Finally Stephen Strakowski will discuss the current state of treating bipolar disorder, both mania and depression, including recent studies of cariprazine, lurasidone and lumateperone. He will also describe the current efficacy and safety data with mood stabilizers and the need for the development of novel treatments.

Alcohol Use Disorder: Hyperkatifeia, COVID-19, and Deaths of Despair

Introduction: Nancy Diazgranados, M.D.

Presenter: George F. Koob, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the 3 stages,

domains and neurocircuits that form a heuristic framework for AUD; 2) Understand the term hyperkatifeia and its relationship to AUD; and 3) Understand the interface and impact of AUD in the U.S with the effects of the Covid-19 pandemic and deaths of despair.

SUMMARY:

Alcohol use disorder (AUD) causes an enormous amount of human suffering, loss of productivity and cost to our medical care system and the nation's economy. Recent developments, including an increase in "deaths of despair" in the United States, increases in alcohol use by some individuals as a result of the 2019 coronavirus disease (COVID-19) pandemic, and limited availability of in-person treatment and recovery support, raise concerns about the use of alcohol and other drugs in an effort to cope with distress. A heuristic framework for studying addiction, characterized by a three-stage cycle—binge/intoxication, withdrawal/ negative affect, and preoccupation/anticipation—provides a starting point for exploring the intersection between alcohol addiction, deaths of despair, and social isolation that are caused by the COVID-19 pandemic. As such, advances in the science of alcohol use disorders can lead the way to better diagnosis, treatment and prevention of this significant public health problem. Using these heuristic frameworks, current challenges include addressing the intersection of pain, hyperkatifeia and negative reinforcement with deaths of despair impacts, and addressing the continuing challenges of women and alcohol, older adults and alcohol, pain and alcohol, and sleep and alcohol. In addition, using telehealth for prevention and treatment may help address continuing challenges in closing the treatment gap. Addressing such challenges will facilitate the implementation of evidence-based treatment for AUD in primary care, mental health, and other health care settings.

Amplifying Mental Health Value: Integration and Preference-Aware Care Navigation

Chair: Nora Marion Wilson Dennis, M.D.

Presenters: Ish Bhalla, M.D., M.S., Amy Helwig, M.D., Susan Foosness, M.P.P., M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the current challenges in behavioral health access and coordination, and the impact on overall health and wellbeing; 2) Discuss the impact of behavioral health care integration and preference-aware care navigation on total cost of care and key health care utilization metrics; and 3) Describe how a rigorous outcomes study can be implemented to help innovators and healthcare leaders understand the quality of digital health tools and advance value-based contracting.

SUMMARY:

In order to provide holistic care for all of patients' needs, high quality health care must include high quality behavioral health services. Those services are often not as widely available as physical health due to challenges with access and cost, identification of a high-quality behavioral health provider, and establishing therapeutic alliance. To address these challenges, Blue Cross North Carolina and Quartet Health implemented a new platform to better integrate behavioral health into primary care and improve access to mental health care. The platform helps identify patients with underlying mental health conditions and navigate them to the right care at the right time, accounting for their preferences. The platform provides multiple channels to engage patients, utilizes patient and provider preferences to facilitate effective matches, and improves member experience and speed to care. Quartet's network development work includes building an adequate and diverse provider network to meet all types of expected patient demand. For patients that are harder to match, Quartet leverages a hands on engagement strategy where a hybrid clinical team engages with the patient to support them while a provider engagement team looks to find additional providers to add to the network. During this time Quartet supports patients by connecting them with online digital and other community based resources. Additionally, Quartet partners with the primary care providers and offers curbside consultations to enable care in the primary care setting. Blue Cross NC and Quartet Health entered into an at-risk contract for the solution and used an independent third party, RTI Health Advance, to evaluate the total

cost of care savings. In the evaluation, RTI Health Advance studied the effect on total cost of care as well as cost and utilization measures by category of care: primary care, emergency department, inpatient care, pharmacy, and behavioral health services (outpatient medication management, outpatient therapy, and residential treatment centers). The evaluation studied the overall effect of the platform implementation as well as the effects of various mechanisms through which the 9,715 members interacted with the platform during the study period. In this presentation, the three parties describe the improvements in member experience vs the status quo, share the studied effects of the behavioral health integration and navigation platform and discuss how this third-party evaluation can serve as a blueprint for digital health innovators and technology solutions in the move towards value-based health care.

PRESENTER UPDATE: Amy Helwig, M.D. will replace Denise Clayton, Ph.D.

An Overview of Bipolar Mixed States and Managing Medication Side Effects in the Treatment of Mood Disorders

Presenters: Carrie L. Ernst, M.D., Joseph F. Goldberg, M.D.

Moderator: Ron M. Winchel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will learn how to recognize when somatic or psychiatric symptoms are likely the result of adverse effects from psychotropic drugs in mood disorder patients.; 2) Participants will be able to describe side effects that are common versus rare, dose-related or dose-independent, transient vs. enduring, and serious versus benign; 3) Attendees will be able to identify patient-specific risk factors that increase the likelihood for developing adverse drug reactions during pharmacotherapy for mood disorders; 4) Recognize the differential diagnosis of mixed features as a course specifier for mood episodes in bipolar and unipolar disorders; and 5) Identify the cross-sectional and longitudinal clinical and prognostic implications of mixed states in mood disorder patients.

SUMMARY:

An Overview of Bipolar Mixed States: Mixed states have been recognized as heterogeneous, common presentations ever since Kraepelin's early descriptions of manic-depressive illness. Nosologic systems have evolved to embrace a more dimensional than categorical approach for understanding mixed features - now regarded as a course specifier for both bipolar and unipolar mood episodes - falling along a continuum of symptoms involving both depression and psychomotor acceleration. This presentation will briefly review the qualitative elements and frequency of co-occurring manic and depressive symptoms across mood disorder subtypes, including bipolar I and II disorder as well as unipolar depression. We will then describe clinical features related to phenomenology, comorbidity, suicide risk, and short and long-term prognosis and outcome. Practical consideration will be given to differential diagnostic considerations regarding mixed states, including other course specifiers, comorbid anxiety disorders, psychotic features, and iatrogenic factors. The potential hazards of antidepressant use for major depressive episodes in the setting of mixed features will be reviewed. The evidence base for specific mood stabilizing drugs, second generation antipsychotics, and novel therapeutics will be described in mixed versus pure-manic or pure-depressed phases of illness, as well as the rationale for specific combination pharmacotherapies **Managing Medication Side Effects:** Drug side effects are a leading cause of poor treatment adherence in mood disorder patients, accounting for premature discontinuation in a substantial subgroup of individuals who undergo medication trials. Clinicians often struggle to maintain an awareness and appreciation for balancing the risks and benefits of psychotropic medications, at times avoiding more efficacious pharmacotherapies for fear that potential adverse effects may be insurmountable or otherwise outweigh the value of a drug's efficacy. This presentation will provide an overview of basic core concepts in the assessment and management of adverse drug effects associated with pharmacotherapies for depression and bipolar disorder. We will initially discuss strategies for deducing plausible iatrogenic relationships between medication use and patients' physical and psychiatric

complaints. Patient-specific risk factors for "side effect proneness" will be reviewed alongside a delineation of common adverse effects, dose relationships, temporal associations, and manageability. Methods for devising risk-benefit analyses will be emphasized, particularly in the case of medication for which side effect risks may be considerable but efficacy may be substantial and unique. We will then provide a concise overview of specific management strategies for common adverse effects involving cardiovascular function, metabolic and weight-related issues, sexual dysfunction, and neurological adverse effects including extrapyramidal reactions and tardive dyskinesia.

An Update on the Treatment of Alzheimer's Disease
Chair: Art C. Walaszek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the epidemiology and presentation of Alzheimer's disease; 2) Describe the evidence supporting and contradicting the amyloid hypothesis of Alzheimer's disease; 3) Distinguish between mild cognitive impairment and dementia; 4) Develop a comprehensive treatment plan for patients with dementia; and 5) List the risks and benefits of aducanumab and other cognitive enhancers for the treatment of Alzheimer's disease.

SUMMARY:

Six million people in the U.S. have Alzheimer's disease (AD), a number that is expected to climb to 14 million by 2060. There are 55 million people worldwide with dementia, with 10 million new cases each year. AD and other causes of dementia have profound effects on the ability of people to live independently and on the lives of their family members and other caregivers. While we have made great strides in our understanding of the pathogenesis of Alzheimer's disease, this has generally not translated into clinical gains. In June 2021, the U.S. FDA granted accelerated approval of an anti-amyloid therapy, aducanumab - the first new FDA-approved treatment for AD in nearly 20 years. However, concerns have been raised about the clinical benefit of anti-amyloid therapies, about the cost, and about health equity. For example, despite

Black and Latinx older adults in the U.S. being at markedly increased risk of dementia compare with white older adult, very few Black and Latinx subjects were included in the aducanumab trials. Caring for persons living with dementia requires a comprehensive approach, including promoting their independence, addressing behavioral and psychological symptoms of dementia, addressing safety concerns (e.g., driving safety, gun safety, suicide risk), supporting family caregivers, and preparing for the future. Furthermore, public health approaches and public policy changes are needed to help prevent dementia and to address healthcare disparities in the care of persons living with dementia and their families.

Assessing the Proximal Warning Behaviors for Targeted Violence

Presenters: Reid Meloy, Ph.D., Jens Hoffmann, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the 8 proximal warning behaviors for targeted violence; 2) Explain the definition for each of the warning behaviors; 3) Be able to recognize these warning behaviors in their patients with sufficient information; 4) Know the risk of the most predictive warning behaviors based upon validation research; and 5) Learn how to think about interventions to mitigate such risks for targeted violence.

SUMMARY:

Over a decade ago a typology of proximal warning behaviors for targeted violence--acts that are planned and purposeful--was proposed by Drs. Meloy and Hoffmann and their colleagues. The eight warning behaviors--pathway, fixation, identification, leakage, novel aggression, energy burst, last resort, and directly communicated threat--have subsequently been researched in a number of targeted attackers in both North America and Europe. The findings of these studies which have focused upon both ideologically-motivated (terrorist) attackers and non-ideological (personal grievance) attackers have found the proximal warning behaviors to be both reliable and valid. Interrater reliability has been consistently in the

excellent range, and validity studies have shown that these warning behaviors correlate with, and in some studies predict, acts of targeted violence. Validation studies have ranged from early uncontrolled pilot studies to test the ecological validity of the warning behaviors, to retrospective comparative studies, to postdictive studies. Very recent research has begun to look at the time sequencing of these warning behaviors in large samples of lone actor terrorists in North America and Europe. Such a typology can serve a useful clinical purpose for all psychiatrists tasked with assessing risk of targeted or instrumental violence, a mode of violence distinctively different from the affective, reactive, and defensive violence often commonly seen in treatment settings. The past decade's worth of research has led to the incorporation of these proximal warning behaviors in violence risk protocols in colleges, universities, corporations, and various local, state, and federal agencies as an important element in their assessment of violence risk and mitigation of such violence. This presentation will teach the proximal warning behaviors and review the most relevant research for practicing psychiatrists.

Brainwashing: A Haunting Past and Troubling Future for Psychiatry and Society

Chair: Joel Edward Dimsdale, M.D.

Presenters: Joel Edward Dimsdale, M.D., Stephen Michael Stahl, M.D., Ph.D., Donatella Marazziti, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand how coercive persuasion research developed; 2) understand how social media can be utilized for coercive persuasion; and 3) understand how psychotropic drugs can induce neuroplasticity that can be modified by both positive and negative environmental input.

SUMMARY:

This session will examine the haunting past and troubling future of brainwashing or coercive persuasion. People think of brainwashing as a musty, Cold War topic, characterized by bad science (and scientists). That is part of the story, but the

phenomenon has deeper roots, and the people who studied it included leaders in 20th century psychiatry, psychology, and neurology—even Nobel laureates. We will review how such studies evolved in the last century, building on and contributing to the knowledge base on trauma, psychopharmacology, psychedelics, sensory isolation, and sleep deprivation. Because of the flamboyance of the term “brainwashing” and because of the ethical transgressions that characterized some of these studies, research in this area diminished after the 1960s. However, 21st century advances in neurosciences and social media are likely to extend the reach of coercive persuasion in troubling, new ways. Social media influence our choices, frequently in ways that are surreptitious and occasionally coercive. We will present findings from a series of studies exploring the prevalence of social media use in groups of different ages, while highlighting the distinct vulnerability of younger people. These lessons from our past should also serve as a cautionary tale for today's rush to use dissociative agents such as ketamine, hallucinogens such as psilocybin, LSD, DMT/ihauwaska, ibocaine, and empathogens such as MDMA-- drugs that could be effective in psychotherapy but could also go awry even in the hands of well-meaning practitioners. Psychiatrists have an important role in treating victims of coercive persuasion, ensuring that research is consonant with ethical principles, and helping society to develop appropriate regulations so that advances in neuroscience and social media will not be coercive.

Clinical Update on Working Alongside People Experiencing Psychosis

Presenters: David Kingdon, M.D., Doug Turkington, M.D.

Moderator: Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop a working relationship with a person experiencing psychosis, even where insight is lacking; 2) Collaborate in exploring delusional beliefs and hallucinatory experiences to enhance mutual understanding, alleviate distress, normalise and destigmatise where appropriate, and

assemble effective ways; and 3) Approach pervasive negative symptoms by developing shared understanding of their development and realistic phased strategies to move towards self-determined recovery.

SUMMARY:

Working alongside people experiencing psychotic symptoms can be enlightening and frustrating but is critical to promoting wellbeing and recovery. The therapeutic relationship is key but there is limited support for specific ways of enhancing it and securing collaboration across the range of psychiatric interventions available. However evidence for the use of cognitive therapy in psychosis continues to grow and the debate about its distinctive albeit small effect size for positive symptoms over and above treatment as usual does now seem to have been resolved (McKenna et al, 2019). Its value for use in clinical psychiatric practice has also been shown in terms of improving communication between patient and psychiatrist and the therapeutic relationship (McCabe et al, 2016). Theoretical conceptualisation of engagement, normalisation, assessment and formulation can enhance clinical practice and will be described and illustrated in this update. Relevant techniques will then be described and their application to enhance routine clinical practice outlined. Working alongside the individual, especially when they are apparently lacking insight, is developed through eliciting and developing shared understanding and goals. The latter can be derived from the psychiatric formulation, which elicits goals, challenges and strengths and examines possible precipitating events and circumstances in understanding current symptoms. Focused work in clinical settings is then possible, e.g. for collaboration with treatment and work on hallucinations, delusions, thought disorder and negative symptoms. Structured reasoning can assist in reattribution of voices, development of coping strategies and empowerment in managing critical content. Delusions may benefit from an exploratory narrative and understanding perpetuating factors, e.g. low self-esteem and isolation, focusing on worry, and systematically reorienting the patient towards dealing with these issues - ‘so what ..’ therapy. Negative symptoms seem to have benefited from attention to pacing, timing and, paradoxically,

reduction in perceived pressure. The audience will be encouraged to consider and discuss the applicability or enhancement of these techniques in their own practice in working with people with severe mental illness.

**COVID-19, Climate Change, and Politics, Oh My!
Disaster Psychiatry and Youth Mental Health**

Chair: Latoya Frolov, M.D., M.P.H.

Presenters: Linda Chokroverty, M.D., Lisa Fortuna, M.D., M.Div., M.P.H., Brandon Newsome, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the characteristics of disasters and the roles of psychiatrists; 2) Explore the impact of COVID-19 and other disasters on youth mental health and consider how to prepare for and intervene at different phases of disaster using evidence-informed and evidence-based practice; 3) Understand how to mitigate systems challenges encountered in post-disaster recovery, and to help populations become disaster-ready for future critical events; 4) Learn strategies of engaging community members to advocate for the needs of children after a disaster, especially among economically and politically disenfranchised groups; and 5) Discuss the roles of resilience vs. resistance and community centeredness in responding to climate change and related disasters.

SUMMARY:

Over the past year, COVID-19 has underscored pre-existing structural inequities, such as healthcare disparities, un- and underemployment, and poorly resourced schools in vulnerable populations, especially disenfranchised communities of color (Levinson et al, Kentor and Thompson). In the midst of the ongoing community crisis, recovery is occurring on a continuum, but toxic stress from systemic social determinants of health may impede recovery and necessitates community and cross-sector collaborations (Fortuna et al, SAMHSA). Healthcare responses to previous disasters, such as 9/11, provide a template for ways in which psychiatrists may intervene during this current pandemic, especially in evaluating factors that contribute to risk and resilience (DePierro et al).

However, vulnerable populations, such as children, deserve special consideration. In particular, children from minority groups are also thought to be at increased risk for experiencing adverse outcomes related to COVID-19, such as inadequate education, increased separation and loss in their families, decreased access to food and healthcare, and social deprivation (WHO-UNICEF). Globally, there has been an increase in the prevalence of anxiety and depression in children during the COVID-19 pandemic in systems which already had difficulty meeting the needs of children and families (Racine et al, Benton et al). In addition to the pandemic, youth are also experiencing the impact of other disasters, such as wildfires, hurricanes, earthquakes, and floods. Given the additive nature of trauma, children and their families are at increased risk for negative mental health outcomes. Psychiatrists can and should advocate for at-risk children and families after a disaster. The engagement of youth by psychiatrists and others in the work of disasters and community trauma is an important and meaningful experience for both young people and the adults involved (Berkowitz et al, Chokroverty et al, Chokroverty and Tompsett). It has great potential in facilitating resilience and recovery around disasters and traumatic events for these young people and their communities. This session aims to increase awareness of disaster systems and roles for psychiatrists; appreciation of threats to children's health created by destruction and loss; advocacy for vulnerable children; management of disruptions in infrastructure and resources; and awareness of challenges faced by schools and communities. Participants will also consider how we can support culture, religion, and spirituality for resilience. In addition, participants will discuss resources available for caring for children, families and vulnerable populations such as online resources available on American Academy of Child and Adolescent Psychiatry, the National Child Traumatic Stress Network, Center for Traumatic Stress Studies, and the CDC.

Current Trends in Suicide Research and Prevention

Chair: Christine Yu Moutier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Incorporate the top recent scientific findings from suicide research into clinical and community actions.; 2) Consider implementing brief suicide risk reducing interventions into clinical practice.; and 3) Contribute to addressing the public health crisis of suicide through health system leadership, opportunities in clinical practice, education of non-psychiatric colleagues, patients and famil.

SUMMARY:

Suicide is a critical public health concern that has persisted despite increased awareness and diminishing stigma. The twin pandemics of COVID-19 and systemic racism have further underscored the urgent need for national leadership to engage in suicide prevention. Suicide rates have been increasing for decades, and this trend could be exacerbated by challenges associated with social isolation, financial strain, grief, continued uncertainty, and racial trauma. Our culture is experiencing a sea change in national dialog, perceptions that embrace mental health as a valid component of human health and that understand suicide as a potentially preventable cause of death. These culture shifts are a key foundational step, however political will has only begun to ramp up the level of national investment required to address this complex problem. Just as investments in other leading causes of death have led to reductions in mortality, a more significant investment in suicide research, prevention programs and implementation to a broader scale can be mounted to address this complex health issue. The suicide research field has grown in momentum and sophistication, and while there are still many unanswered questions, new information and interventions are showing evidence for reducing suicide risk. A body of evidence has grown for particular community-based and clinical interventions demonstrating reductions in suicide risk. Many of these interventions were developed and studied in recent years; we cannot wait the average 17 years to translate from bench to bedside since lives are at stake. Scientists, clinicians, policy makers, and people with lived experience and suicide loss are speaking with one voice as a national movement to speed up translation and

dissemination. A national initiative called Project 2025 led by the American Foundation for Suicide Prevention (AFSP) aims to reduce the annual suicide burden 20% by 2025. Using the best available science, a data-driven implementation strategy is underway focused on healthcare, corrections, and the gun owning community. Numerous health systems are engaging in system change with policies and practice that prioritize suicide reduction as a quality issue and clinical target. Regulatory bodies including The Joint Commission have begun requiring screening and clinical care and the public's readiness to address mental health needs and suicide risk is at an all-time high. Key initiatives of Project 2025 include a partnership between the American Academy of Pediatrics (AAP), American Foundation for Suicide Prevention (AFSP), and National Institute of Mental Health (NIMH) to develop a Blueprint for Youth Suicide Prevention, which serves as a strategic plan to engage pediatricians, adolescent medicine specialists, and other care providers involved with youth in clinical and community settings.

Digital Psychiatry Part 1: Health Equity and Digital Divide in COVID Era

Chair: Shabana Khan, M.D.

Presenters: Brent Gregory Nelson, M.D., Darlene Rae King, M.D.

Discussants: James H. Shore, M.D., M.P.H., John Torous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess patients for access to technology and be able to refer them to programs to help ensure they can connect to reliable internet with modern devices; 2) Assess patients for digital literacy and know at least three resources to offer for those requiring further help; and 3) Formulate culturally competent treatment plans that account for patients' unique abilities and skills around technology.

SUMMARY:

Increasingly, mental health professionals are turning to telehealth solutions to deliver patient care. These trends, accelerated by COVID-19, are now becoming

standard of care and all mental health professionals must now become competent around the professional, clinical, legal, cultural, and safety considerations demanded by new modes of clinical care through technology. An important first consideration is if and how patients are able to connect to care through technology. This talk will present the latest data on digital inclusion and exclusion and explore factors related at a personal, community, and societal level. Learners will gain skills to assess digital literacy of patients as well as resources to refer to for helping patients gain these skills as well as low-cost access to internet and smartphones. Through hands on learning and case presentations, learners will be able to formulate a culturally competent care plan that considers digital equity and serves the needs of each patient.

Digital Psychiatry Part 2: Work Life Integration in Virtual World During Pandemic: Patient and Providers

Chair: James H. Shore, M.D., M.P.H.

Presenters: Steven Richard Chan, M.D., M.B.A., Smita Das, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess provider burnout and apply at least three strategies to minimize risk of burnout related to technology use; 2) Apply at least three strategies to better incorporate digital health into the clinical workflow and increase clinical efficiency as well as quality of care.; and 3) Minimize legal risks around telehealth usage through knowing the current regulations and how to check for ongoing changes at the local, state, and federal level.

SUMMARY:

Increasingly, mental health professionals are turning to telehealth solutions to deliver patient care. These trends, accelerated by COVID-19, are now becoming standard of care and all mental health professionals must now become competent around the professional, clinical, legal, cultural, and safety considerations demanded by new modes of clinical care through technology. One of the greatest barriers to use of telehealth in care, beyond digital equity, is clinical workflow considerations. This

session is designed to help learners use technology to improve their clinics and minimize their own burnout. Through interactive examples of successful practices, practical tips from experts in the field, and planning clinics around evolving regulations, learners will be able to better integrate technology into care whether delivered from a classical clinic to home office.

Digital Psychiatry Part 3: Integrating Patient Monitoring in Clinics

Chair: Brent Gregory Nelson, M.D.

Presenters: John Torous, M.D., Julia Tartaglia, M.D.

Discussant: Smita Das, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be able to choose from at least five different monitoring technologies to determine which is best suited for any patient case; 2) Formulate a safety plan around use of any remote monitoring technology and be able to communicate this with a patient; and 3) Integrate remote patient monitoring into routine clinic visits through creating updated treatment plans that reflect evidence-based use of this data.

SUMMARY:

Increasingly, mental health professionals are turning to telehealth solutions to deliver patient care. These trends, accelerated by COVID-19, are now becoming standard of care and all mental health professionals must now become competent around the professional, clinical, legal, cultural, and safety considerations demanded by new modes of clinical care through technology. Many of these technologies involve remote monitoring of patients and range from smart-homes to smartwatches. This talk will focus on smartphone apps and wearables as the most common monitoring tools and review use cases from diagnostic confirmation to relapse prevention. Attention will be focused on the safe, ethical, and professional use of this data so as to help APA members avoid risk and liability when using these technologies as part of care.

Digital Psychiatry Part 4: ABCs: Apps, Bots, and Clinical Interventions Offered by Technology

Chairs: John Torous, M.D., Steven Richard Chan, M.D., M.B.A.

Presenter: John Luo, M.D.

Discussant: Darlene Rae King, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List the five stages of the APA's app evaluation framework and be able to apply them to any technology so as to make an informed decision regarding its applicability to care; 2) Create a treatment plan that safely integrates remote interventions in effective and evidence-based manner; and 3) Recognize sources of bias in digital interventions and help patients better evaluate the actual utility of any technology for their care.

SUMMARY:

Increasingly, mental health professionals are turning to telehealth solutions to deliver patient care. These trends, accelerated by COVID-19, are now becoming standard of care and all mental health professionals must now become competent around the professional, clinical, legal, cultural, and safety considerations demanded by new modes of clinical care through technology. Many of these technologies now offer interventions and treatments ranging from CBT apps to virtual reality-based exposure therapies. This session is designed to allow mental health clinicians to assess the risks and benefits of these new interventions, understand their evolving evidence base, and make informed decisions regarding their use in care settings.

DSM-5-TR: What's New and Why Clinicians Should Care

Chair: Michael B. First, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the rationale and goals of the DSM-5-TR; 2) understand the most important changes to the DSM criteria and changes in terminology; 3) should be able to accurately make a diagnosis of Prolonged Grief Disorder, a disorder newly added to DSM-5-TR, and be able to

differentiate it from other disorders; and 4) correctly use the Suicidal behavior and Nonsuicidal self-injury codes.

SUMMARY:

The DSM-5 text revision (DSM-5-TR) is the first published revision of DSM-5 since its original publication in 2013. Like the previous text revision (DSM-IV-TR), the main goal of DSM-5-TR is to comprehensively update the descriptive text accompanying each DSM disorder based on reviews of the literature since the prior version of the DSM. In contrast to the prior text revision (DSM-IV-TR), in which the updates were confined almost exclusively to the text, there are a number of significant changes and improvements that are of interest to practicing clinicians, including the addition of diagnostic categories (prolonged grief disorder, stimulant-induced mild neurocognitive disorder, unspecified mood disorder) and symptom codes for reporting suicidal and nonsuicidal self-injurious behavior, modifications (mostly for clarity) of the diagnostic criteria for over 70 disorders, updates in terminology (e.g., replacing "neuroleptic medications" with "antipsychotic medications or other dopamine receptor blocking agents" and changing "desired gender" to "experienced gender" is Gender Dysphoria) and a review of the entire text to ensure appropriate attention to risk factors such as the experience of racism and discrimination, as well as to the use of non-stigmatizing language. This presentation will describe the revision process and summarize the changes, highlight those that are most clinically significant.

Early Life Risk for the Development of Pathological Anxiety: A Translational Neuroscience Approach

Chair: Ned Henry Kalin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand early life phenotypes such as anxious temperament that are associated with the later risk to develop anxiety and depressive disorders; 2) Understand how alterations in prefrontal-limbic circuitry contribute to the risk to develop stress-related psychopathology; 3) Understand the role of the amygdala in the

pathophysiology of maladaptive anxiety as well as alterations in gene expression in the amygdala that are related to the expression of pathological anxiety; and 4) Understand the value of translational studies to elucidate mechanisms and then conceptualize new treatment approaches.

SUMMARY:

Anxiety disorders are common, can be disabling and frequently begin during childhood. The work presented here is an overview of our studies in nonhuman primates and children aimed at characterizing the early-life factors that predispose to the development of anxiety disorders and other stress-related psychopathology. This translational neuroscience approach enables cross species studies that have the potential to uncover the influences of heritable and nonheritable factors on the circuits and molecules that mediate maladaptive childhood anxiety. In this regard, we have been studying anxiety from a dimensional perspective in preadolescent children and young rhesus monkeys; ranging from anxious temperament (AT), a trait like phenotype characterized by high levels of persistent subthreshold anxiety to anxiety disorders. Anxious temperament is of particular interest as it is an early life disposition that markedly increases the later in life risk to develop stress related psychopathology such as anxiety and depressive disorders. Data from our work and that of others implicates alterations in prefrontal-limbic circuitry as being critical in underlying the dysregulated fear and anxiety responses that are typically associated with anxiety disorders. Using viral vector methods to overexpress specific genes and lesioning and chemogenetic methods to alter circuit function, we demonstrated a causal role for the dorsal amygdala and a regulatory role for the posterior orbitofrontal cortex in mediating pathological anxiety. Based on this work, we are performing proof of concept studies in NHPs with the goal of establishing new circuit based, molecular targets for treating human anxiety disorders. Ultimately, a better understanding of the factors related to the childhood onset of pathological anxiety has the potential to facilitate the development of more effective, and life course changing, interventions in individuals at risk to develop anxiety disorders and other stress-related psychopathology.

Evaluation, Care, and Management of Adults With Intellectual and Developmental Disabilities

Chair: Elizabeth Wise, M.D.

Presenter: Robert Wisner-Carlson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) identify diagnostic criteria of autism spectrum disorder and intellectual disability; 2) adapt the psychiatric interview for adults with intellectual and developmental disabilities; 3) recognize typical and atypical signs and symptoms of depression and anxiety in adults with intellectual and developmental disabilities; and 4) describe the challenges of making a diagnosis of dementia in adults with intellectual and developmental disabilities.

SUMMARY:

Intellectual and developmental disabilities (IDD) are lifelong conditions that affect one's physical, intellectual, or emotional development. Examples include intellectual disability (ID) and autism spectrum disorder (ASD). Many individuals with IDD require support in terms of education, community services, and healthcare across the lifespan. Psychiatric disorders in people with IDD are common yet often undiagnosed and undertreated. Much of the research on phenomenology, outcomes, and interventions for individuals with IDD and co-occurring psychiatric illness is devoted to children and adolescents; however, with the aging of the population and improvement in lifespan for individuals with IDD, the population of adults with IDD continues to expand and has its own clinical and research needs. Many adults with IDD experience high rates of depression and anxiety, which correlate with impaired global functioning and increased risk of suicide, particularly in adults with ASD. This session will utilize a case-based approach to understanding the diagnosis of psychiatric conditions in individuals with IDD. Diagnosing psychiatric illness in IDD is challenging for several reasons, including individuals' variable premorbid baselines, language impairment, and difficulty reflecting on and expressing their internal mental experiences (phenomenal world). Psychiatric presentations of

illness can be atypical, and in addition to assessing the patient, the clinician must interview caregivers and other reliable informants. The diagnosis of dementia in older adults with IDD is also difficult due to varied cognitive baselines, communication challenges, and lack of a reliable informant in many cases. There are limited robust pharmacological treatment studies of psychopathology in adults with IDD, and no FDA-approved medications for the treatment of co-occurring psychopathology in adults with IDD. Research on psychotherapy for anxiety and depression in adults is also limited. Nonetheless, treatment of psychiatric illness in adults with IDD should be multimodal and collaborative, with medication, psychotherapy, psychosocial interventions, and caregiver involvement all playing a role.

Fitness to Evict: The Challenge of Housing Court for Persons With Serious Mental Illness

Chair: Merrill Richard Rotter, M.D.

Presenters: Faith Laurel, D.O., Ignacio Jaureguilorda, Sergio Jimenez

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the particular risks of eviction faced by individuals with serious mental illness; 2) Understand the challenges faced by individuals with mental illness at various stages of eviction; 3) Describe the Eviction Stage Model, a problem solving approach to preserving housing; and 4) Recognize the importance of housing as social determinant of mental health outcomes.

SUMMARY:

People with mental illness end up caught up in the housing court system for reasons that are often related to their disability. Eviction is a significant cause of stress and housing instability. that can lead to homelessness and/or institutionalization. Conversely, housing instability is a critical social determinant of mental illness. Housing Courts, therefore, are almost as high stakes a legal venue as criminal court, and may be particularly problematic settings for people with mental illness. However, housing courts have not received the same attention to procedural protections or problem-solving

solutions as their criminal counterparts. In this panel we will focus on the similar and the unique challenges facing individuals with serious mental illness in eviction proceedings and the housing court context. Dr. Rotter review housing instability as a social determinant and the risks of eviction for individuals with mental illness Dr. Laurel will describe housing court and the challenges individuals with mental illness and court personnel face therein (including a survey of court staff experience). The Hon. Sergio Jimenez will provide his perspective as a Housing Court Judge. Ignacio Jaureguilorda will describe a problem-solving court approach, and we will introduce the Eviction Intervention Stage Model, which identifies junctures at which supportive, problem-solving interventions can ensure the necessary community supports and legal representation.

Food for Mood: The “S.A.D.” Diet and the Social Determinants Affecting Mental Health

Chair: Bhagwan A. Bahroo, M.D.

Presenters: Jessica Nelson, M.D., Kristin Wahlberg-Painter, D.O., Taylor Tucker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of nutrition on mental health and cognition across the lifespan.; 2) Conceptualize the link between diet and inflammation and the effects of chronic inflammation on mental health; 3) Discuss the impact of food scarcity on mental health, accentuated by COVID-19’s impact and subsequently on mental health outcomes; 4) Address the paucity of clear guidelines for nutritional education regarding mental health from the FDA.; and 5) Demonstrate the difficulties that providers face in counseling patients on diet and nutrition.

SUMMARY:

Access to nutritious, low-cost food is considered one of the principal social determinants of health of an individual and thus, of a nation. “An army marches on its stomach” so it is said. We are taking it a step further to say that “A nation thrives on what it eats and drinks”. In ancient times, herbs, spices, plants and foods in general played a pivotal role in treating

mental health disorders, prior to the advent of psychotropics. This is documented in ancient texts of Chinese, Greek, Egyptian and Indian civilizations. In modern times, advice about nutrition has become the domain of the Nutritionists and Dietitians. Our colleagues in sister specialties emphasize the role of changes in diets in prevention of obesity, hypertension, diabetes, or kidney problems. Is it not about time that mental health providers did the same? In various stages of life and in different populations, nutrition changes can help or hinder mental health. As we age, chronic hyperinosemia and diets high in saturated fats increase our risk for Alzheimer's disease. Diet also has an undeniable effect on inflammation processes in the body. As a nation we are consuming almost 25% more calories a day than we were in 1970, and those calories are increasingly composed of more refined grains, fats, oils, and corn-based sweeteners and less essential nutrients. The Standard American Diet (SAD) has been linked to increased obesity, excess adiposity, and increased release of pro-inflammatory cytokines including tumor necrosis factor α (TNF- α), interleukin 1 (IL-1), and interleukin 6 (IL-6). Recently, research has demonstrated a link between these inflammatory cytokines and major depressive disorder, post-traumatic stress disorder, and schizophrenia. Unfortunately, access to healthy foods is not universal and for some it is cost prohibitive. Access to low-cost healthy foods is essential in improving both our physical and mental health, but there are numerous barriers to access adequate nutrition that have worsened in the setting of COVID-19. Food insecurity can have devastating effects on mental and physical health, the pandemic has highlighted the pre-existing holes in our social safety net that have kept millions of people from accessing quality nutrition. Addressing food insecurity in a sustainable way will help reduce the burden of mental health problems and reduce social inequality. What can we as mental health providers do to address these issues? Perhaps including diet and nutrition in every treatment discussion will help us gather more data and be better equipped to offer resources to help our patients optimize their diets. We are seeking a more holistic approach to patient care, but there are barriers to this as well. FDA dietary guidelines currently do not elaborate on the mental health impact of specific foods, but if this

were to change it would improve all healthcare workers' ability to counsel patients on the importance of diet and nutrition.

How Federal Legislation Can Improve Mental Health in America: Major Acts With Impacts on the Social Determinants of Mental Health

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

Presenters: Marc W. Manseau, M.D., M.P.H., Flavio Casoy, M.D., Benson S. Ku, M.D., Jacob Michael Izenberg, M.D., Kenneth Stewart Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify barriers to care, including health service delivery issues; 2) Provide culturally competent care for diverse populations; 3) Apply quality improvement strategies to improve clinical care; and 4) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:

The social determinants of mental health are underpinned by two types of larger societal factors: public policies and social norms. Public policies are the official laws, regulations, court decisions, executive orders, and other policy decisions that govern how a society functions and distributes resources. Both public policies and social norms are themselves influenced by broad historical trends (e.g., a history of slavery and racial segregation in the US), as well as overarching values (e.g., American values such as individualism, material comfort, and a belief in free market capitalism). This session offers highlights from the American Psychiatric Association Publishing book *The Social Determinants of Mental Health* (Compton & Shim, 2015) and previews to an upcoming American Psychiatric Association Publishing book that gives case studies of how major federal laws can have major impacts on mental health due to their impacts on the social determinants of mental health (Manseau & Compton, 2022). Specifically, four laws—two from the Franklin D. Roosevelt New Deal era and two from the Lyndon B. Johnson Great Society era—will be discussed: the Agricultural Adjustment Act of 1933 (the first Farm Bill), the National Labor Relations Act of 1935, the Clean Air Act of 1963, and

the Housing and Urban Development Act of 1965. Presenters will discuss how these landmark laws impacted one or more key social determinants of mental health, as well as how subsequent iterations of the law have or have not addressed equity.

Integrating Social Determinants of Health to Improve the Delivery of Mental Health Care

Chair: Regina S. James, M.D.

Presenters: Patrice A. Harris, M.D., Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop a baseline understanding of health disparities.; 2) Identify available strategies and opportunities to dismantle social structures and barriers experienced by underrepresented groups to equitable mental health care.; and 3) Explore the implications of social science research on mental health disparities..

SUMMARY:

The American Psychiatric Association (APA)'s Division of Diversity and Health Equity presents this session as part of their *Looking Beyond Series*. The APA Annual Meeting session will be a culmination of previous discussions focused the biological and clinical underpinnings of traditional frameworks and transition us to emerging multidisciplinary frameworks seeking to reduce mental health disparities. The panel of experts representing medical and non-medical sectors will share their interdisciplinary approaches to developing innovative frameworks and engage with APA members in the Q&A to collectively generate novel approaches to advancing our understanding of mental health care disparities.

Invisible Veterans: Mental Health Concerns for Women Veterans.

Chair: Elspeth Cameron Ritchie, M.D., M.P.H.

Presenters: Muniza A. Majoka, M.B.B.S., Maria Llorente, Lea Marin

EDUCATIONAL OBJECTIVES:

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

background and demographics of the women veteran population.; 2) Appreciate the unique and varied military exposures and risks faced by the women veterans.; 3) Learn about the various mental illnesses prevalent in the women veteran population including Depression, Anxiety, PTSD, and Neurocognitive Disorders.; 4) Discuss the increased morbidity and mortality associated with mental illness including suicidality and homelessness; and 5) Appreciate the mitigation strategies and interventions, as well as services available within the VA Healthcare System.

SUMMARY:

The session will elaborate on the unique mental health concerns of veterans who identify as female. Women veterans have a long and honorable history of involvement with the US military, and constitute increasing numbers of the veteran population. By 2030, 14% of the veteran population will be women[1]. As their numbers increase, there needs to be more focus on women veterans' physical and mental health. This session will review the unique military exposures and risk factors for mental illness facing women veterans. As more women serve in frontline active war duties than ever before, they have also experienced more combat-related trauma. Additionally, women veterans face high rates of Military Sexual Trauma (MST), with prevalence of up to 15-40% [2]. Women veterans are also at a higher risk for intimate partner violence(IPV) than non-veteran women[3]. High rates of IPV combined with combat related traumas increase women veterans' risk for Traumatic Brain Injury (TBI)[4]. While most TBI research focuses on men, with limited research into the different symptomatology women may experience after TBI [5]. Women veterans are reported to have more severe neurobehavioral and post concussive symptoms, with the presentation being more often comorbid with psychiatric conditions[6, 7]. We will provide an overview of the most salient features of mental health issues in the women veteran population. Women veterans are at a higher risk of having a mental health disorder than their male counterparts; with most common diagnoses being depression and anxiety disorders[8]. Up to a quarter of women veterans have been diagnosed with depression while another 12% reported symptoms but were undiagnosed[9]. Post-

Traumatic Stress Disorder (PTSD) prevalence in women may be equivalent or less than their male counterparts, with MST being the traumatic experience in 70% of women veterans with PTSD[10]. Other mental health issues will also arise longitudinally as this currently younger force, with multiple risk factors, ages over time. Given the risk factors described above, women veterans may be at higher risk of developing dementia in later life. According to new findings, women veterans older than 55 years of age with a history of TBI, depression or PTSD were at a higher risk of developing dementia than their female veteran counterparts[11]. We will also elaborate on the infertility and pregnancy related mental health concerns in women veterans[12]. Pregnancy is a significant period of concern for women veterans, as up to 30% of pregnant veterans have been shown to carry a mental health diagnosis; most common being depression, anxiety and PTSD [13]. Up to 10% of women veterans reported suicidal ideation in the perinatal period[14]. This highlights the importance of treatment of women veterans, particularly for depression and PTSD during the perinatal period. Last, we will discuss the increased morbidity and mortality concerns related to mental health of women veterans. Women veterans are nearly two times more likely than their civilian counterparts to die by suicide[15]. In women veterans, suicide is strongly linked with psychopathology, substance use disorders, intimate partner violence and emotional dysregulation. Interventions and mitigation strategies will be reviewed to assist psychiatrists in being able to offer needed resources to address housing, employment, and education and to provide gender-specific mental health care.

Late Life Depression and Ketamine and Esketamine for the Treatment of Adults With Treatment-Resistant Depression (Not Available for CME)

Presenters: Roger S. McIntyre, M.D., Martha Sajatovic, M.D.

Moderator: Ron M. Winchel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of the session the participant will be able to better understand the

growing problem of late-life depression; 2) At the conclusion of the session the participant will be better able to screen and assess the older adult who presents with depressive symptoms; 3) At the conclusion of the session the participant will be better able to initiate a treatment plan for the older adult who presents with depressive symptoms; 4) To identify treatment strategies to manage side effects and safety concerns associated with ketamine treatment; and 5) To be familiar with the evidence for both intravenous and intranasal ketamine formulations in depression.

SUMMARY:

Late-life Depression: It has been reported that over half of Major Depressive Disorder cases have their first onset after age 60. Some studies note a point prevalence for major depression of 4.6%–9.3% in some groups of patients over age 75, increasing to over 25% among those over age 85. The aging process itself may contribute to depression risk and there are credible mechanistic theories that posit vascular and/or inflammatory factors that may underpin and explain the unique clinical presentation of late-life depression (LLD) vs. depression in younger people. Depression in later-life is often under-recognized. Older adults may be less likely to verbally express their moods and depression symptoms, including anhedonia and cognitive problems. Some may attribute these symptoms to the normal aging process. Screening tools specific to geriatric patients, such as the Geriatric Depression Scale are helpful, especially in primary care settings. Key considerations in the evaluation of LLD include somatic comorbidity and cognitive testing that may indicate the presence of Alzheimer's disease or other dementia. Examination of anxiety is also warranted: prevalence estimates of anxiety disorders in LLD are as high as 50%. Antidepressant medication can have an important role in the treatment of LLD. But evidence suggests response among older adults may be limited. Relapse rates may be relatively high. Other biological therapies, such as ECT may also be effective, especially for psychotic depression or symptoms that affect nutrition and function. A variety of psychosocial therapies have positive evidence in LLD including problem-solving therapy, cognitive behavioral therapy, and interpersonal therapy.

Another consideration in the management of LLD is the need to coordinate treatment with primary care, specialty-care providers, and families for collaborative treatment. **Ketamine and Esketamine for Treatment-Resistant Depression Synthesizing Scientific Data and Clinical Application:** A significant percentage of individuals with major depressive disorder respond insufficiently to conventional monoamine-based antidepressants. Ketamine has been identified as a "breakthrough" by the US FDA and is used off-label for adults with treatment-resistant depression (TRD). Intranasal esketamine is FDA-approved for adults with TRD in combination with conventional antidepressants. Notwithstanding the need for innovation for adults with TRD as well as improving access to such treatments, there are significant concerns as it relates to patient selection, personnel and training requirements, implementation of ketamine/esketamine, as well as safety and tolerability. This program, will reflect the recent publication of the international synthesis of data as it relates to the science and implementation of ketamine/esketamine in TRD. The emphasis of this presentation will be on pragmatic aspects of implementation with attention given to real-world effectiveness, tolerability, and safety.

Life in ACES: An Innovative Training Strategy to Teach Social Determinants of Health and Adverse Childhood Experiences

Chair: Paul Rosenfield, M.D.

Presenters: Tomas Felipe Restrepo Palacio, M.D., Arifa Zaidi, M.D., Susan Kim

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Share an innovative training strategy to understand the impact of SDH and ACES; 2) Develop appreciation for how childhood trauma affects our patients' life trajectories; 3) Learn about a board game created to simulate some of the unique struggles that our patients may face; and 4) Greater appreciation of how trauma affects patients and their families.

SUMMARY:

Given the significance of eliciting a trauma history, it is important for psychiatrists, medical trainees and

providers from a wide range of specialties to feel comfortable discussing their patients' trauma history. In order to raise awareness of the importance of considering Adverse Childhood Experiences (ACEs), **we will utilize a board game in order to teach about how the presence of adverse childhood experiences can affect one's life trajectory. This interactive board game demonstrates what is it like to live a life with many ACEs by following the lives of four characters who come from different backgrounds. Attendees will be exposed to the characters' social determinants of mental health and learn first-hand how these characters' backgrounds may impact their ability to progress in life and achieve success and happiness.** During the session, the audience will be assigned to one of the four characters. Each character will have a different number and type of ACEs assigned to them. Our goal is to provide an opportunity for the audience members to learn and appreciate the various struggles and hurdles a character with many ACEs may have to overcome in life and how obtaining help or having a protective factor can alter the outcome. We also hope that this board game will motivate participants to consider how they would like to incorporate their patients' trauma history into their clinical practice in order to obtain a holistic understanding of their patients. The session will conclude with a discussion about the characters outcomes, the way in which ACEs and social determinants of health played a role in their lives, and the importance of incorporating trauma and structurally competent care to our practices. full objectives: -Share an innovative training strategy to engage and inspire residents to understand the impact of social determinants of health and adverse childhood experiences, and encourage participants to work on plans for enhancing their own training programs. - Develop a greater appreciation for how childhood trauma may affect our patients' life trajectories. - Learn about a board game created to simulate some of the unique struggles that our patients may face. Provide an interactive opportunity to understand how patients with significant trauma history face unique challenges and can have difficulty progressing through life. -Instill a greater appreciation and understanding of how trauma can affect patients and their families.

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

Chair: Brenna Rosenberg Emery, M.D.

Presenters: Joseph Truett, M.D., Ahmed Assar, Mariam Faris, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Promote greater awareness of the complicated overlap between medical and psychiatric comorbidities; 2) Provide a structural framework for differential diagnosis and work-up of psychiatric manifestations or sequelae of medical disorders, with evidence-based recommendations for practice; and 3) Discuss challenges and lessons learned through case examples in the work up and management of these patients at the crossroads of medical and psychiatric presentation.

SUMMARY:

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

residency training may result in lack of experience with conversion disorders, somatic symptom disorders, and factitious disorders. These are patient populations that are often responsible for excessive utilization of medical resources and healthcare dollars as well as being sources of mounting frustration and misunderstanding for medical colleagues. Requests for psychiatric involvement are not unusual, especially when medical work-ups are negative yet patients persist in their requests for medical/surgical intervention. The following workshop aims to provide residents, fellows, and general psychiatrists with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatic symptom and related disorders (medical mimics) in a case-based format with opportunities for questions and discussion with residents, fellows, and attending physicians with experience and/or expertise in consultation-liaison psychiatry patient populations.

Neurobiology and Treatment of Post-Traumatic Stress Disorder

Presenter: Charles B. Nemeroff, M.D., Ph.D.

Moderator: Edmond H. Pi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to describe the current understanding of how gene-environment interactions regulate vulnerability to develop PTSD.; 2) At the conclusion of this session, the participant will be able to describe all of the evidence-based treatments for PTSD, including psychotherapies and pharmacotherapies.; and 3) At the conclusion of this session, the participant will be able to describe novel neuromodulation, psychotherapy and pharmacological approaches to treatment of PTSD..

SUMMARY:

Post-traumatic stress disorder (PTSD) is a disabling serious psychiatric illness which has been increasing in prevalence in recent years. The diagnosis, epidemiology, pathophysiology and treatment of PTSD will be described with an emphasis on evidence based treatments. At the current time the vast majority of patients receive one of the two FDA

approved treatments, sertraline or paroxetine with some percentage of patients treated with either one of the evidence-based psychotherapies (trauma focused Cognitive-behavior therapy or Cognitive Processing Therapy) or a combination of the two. In spite of advances in the field, the majority of patients do not achieve remission, though they do exhibit reductions in symptom severity as measured by the CAPS or PCL-5, the two most common dimensional measures utilized in this population. Risk factors for the development of PTSD will be described including a history of child abuse or neglect, as well as the nature of the index traumatic event and genetic factors. Pathophysiology studies using PTSD as the prototype gene X environment interaction disease will be described with an emphasis on candidate genes that have proven to be predictive of development of PTSD such as FKBP5 and CRHR1. The role of epigenetic mechanisms in the pathogenesis of PTSD will also be described and how this effects expression of critical genes. Brain imaging studies will be described highlighting structural and functional CNS changes in patients with PTSD and how they change with effective treatment. Finally and most importantly, each of the various treatment modalities that have been studied in PTSD will be reviewed in detail including various psychotherapies, pharmacotherapies, and novel treatments (ketamine, MDMA, Stellate ganglion injection). If time permits, management of treatment resistant PTSD will be discussed as well in the context of a case presentation.

Person-Oriented Psychiatry: Changing the Way People With Mental Illness Are Viewed and Treated in West Africa and Around the World

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

Presenter: Grégoire Ahongbonon

Discussants: Benoît Des Roches, M.D., Jocelyn W. Bonner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the experience of the person with mental illness and brain disorders, in West Africa.; 2) Describe Association Saint-Camille-de-Lellis (ASC)'s birth, purpose, philosophy, evolution and structure.; 3) Review ASC's results, the

largest non-governmental Mental Health System in Africa, WHO-approved, offering affordable and adapted neuropsychiatric care to > 130,000 patients since 1990.; 4) Know ASC's strategies at changing mentalities - where to start, and how to go about it.; and 5) Understand: The bottom line - the dignity of the person..

SUMMARY:

Here is an ordinary uneducated married Beninese, a successful businessman who, upon going bankrupt in his mid-twenties, and close to committing suicide, underwent a profound change of heart and decided to dedicate his whole life to all those in distress. He founded in 1983 Association Saint-Camille-de-Lellis (ASC), tending the penniless, AIDS and leprosy patients, prisoners, and homeless children. In 1990, upon discovering the plight of African psychiatric patients, whose human rights were blatantly violated, went on to house them and treat them with dignity, enlisting the help of the local psychiatrist in Bouake, Ivory Coast, where he had settled since 1971. In the face of such a mental health care desert, ASC started setting up its own Mental Health Care facilities. Thirty years later, fueled by an unrelenting faith, a formidable energy, and unique qualities as an entrepreneur and as a therapist, and relying largely on charity from small NGOs across Europe and Canada, Grégoire founded an efficient universal Mental Health System, WHO-approved, spanning Ivory Coast, Benin, and Togo. Nearly 130,000 patients have now benefited from ASC's services. Ten 200-bed Inpatient Centers have been set up across those countries, headed by registered nurses and staffed mostly by remitted patients who regularly obtain qualified training from visiting and local psychiatrists. Furthermore, patients who need it, get trained in a trade at one of seven ASC Rehabilitation Centers. There are two general medicine Saint-Camille Hospitals, where ASC's patients and the poorer neighboring population get cared for their physical ailments. Nearly fifty Saint-Camille Outpatient Clinics are piggybacking on Catholic dispensaries across those countries where patients get followed up, obtaining their monthly neuropsychiatric medication, and where new cases are brought in from the surrounding villages to get screened and treated locally by nun nurses trained by ASC. Wherever ASC is based, chaining and

confining practices have significantly subsided, as people increasingly use ASC's neuropsychiatric services – a clear indication that stigmatization is declining with the provision of long-lasting affordable qualified psychiatric care and thanks to popular education ASC provides throughout those countries. Furthermore, ASC is soon to implement in Benin the first regional West African Addiction Clinic to face the ever-increasing problem of poly-drug addiction in Africa. Its pioneering use of peer helpers and practical clinical algorithmic screening and treatment tool, all have contributed to attracting the attention of medical schools in Canada and Europe as well as the USA's National Institute of Mental Health, Johns Hopkins Bloomberg School of Public Health, and the London School of Hygiene and Tropical Medicine. Numerous TV reports, films, articles, and books have been done underscoring Grégoire's and ASC's work, both crowned with many international awards over the years.

Promoting Neuroplasticity to Treat Psychiatric Disorders and Addiction

Chair: Kiran Vemuri, Ph.D.

Presenters: Alex Kwan, Ph.D., Lisa Monteggia, Ph.D., David E. Olson, Ph.D.

Discussant: Carlos A. Zarate, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the chemistry and underlying mechanism of psychedelics to promote neuroplasticity; 2) Understand the role of neuroplasticity in treating addiction and mental health disorders; 3) Review knowledge gaps in the translational aspects of psychedelics, including sex differences; and 4) Identify major challenges that need to be overcome for therapeutic use of psychedelics.

SUMMARY:

Recent clinical studies are demonstrating promising effects of ketamine, MDMA and classical psychedelics such as LSD, DMT, ibogaine, mescaline and psilocybin for treating psychiatric disorders and addiction. These agents have long been known to modulate the classical neurotransmitter systems. However, recent convergent evidence suggest that

their therapeutic potential results from their ability to promote structural and functional synaptic plasticity and that this is mediated through the regulation of expression of plasticity-related proteins, including BDNF. This panel will present data and discuss knowledge gaps on the molecular and cellular mechanisms underlying neuroplasticity and its translation to behaviorally relevant effects of psychedelics. Additionally, the panel will discuss the future of psychedelic research and the re-emerging therapeutic paradigms for treating mental health and addiction while reviewing on-going and future challenges for the approval of psychedelics for use in humans.

Psychodynamic Therapy With Self-Destructive Borderline Patients: An Alliance Based Intervention for Suicide

Chair: Eric Martin Plakun, M.D.

Presenter: Samar S. Habl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Utilize principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients; 2) Engage the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference; 3) List shared elements in treating self-destructive borderline patients derived by an expert consensus panel study of behavioral and dynamic psychotherapies; and 4) Improve outcomes in work with suicidal and self-destructive patients.

SUMMARY:

In the last 25 years suicide has increased by 30% increase in the US. Multiple social determinants have contributed to this increase. Broadening training of clinicians to treat suicidal patients is an appropriate response. Although several behavioral and psychodynamic therapies have been found to be efficacious in treatment of suicidal and self-destructive borderline patients, few clinicians achieve mastery of even one of these. This workshop presents 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive

borderline patients. The approach focuses on the therapeutic alliance, viewing suicide as an interpersonal event with meaning in the therapeutic relationship, and engages the patient's negative transference as underlying suicidal and some self-destructive behavior. The principles are: differentiate therapy from consultation, differentiate lethal from non-lethal self-destructive behavior, include the patient's responsibility to stay alive as part of the therapeutic alliance, contain and metabolize the countertransference, engage affect, non-punitively interpret the patient's aggression in considering ending the therapy through suicide, hold the patient responsible for preservation of the therapy, search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and provide an opportunity for repair. These principles are noted to be congruent with shared elements identified by an expert consensus panel review of behavioral and psychodynamic therapies for suicidal patients with borderline personality disorder. After the presentation the remaining time will be used for a highly interactive discussion of case material. Workshop participants will be encouraged to offer case examples from their own practices. The result will be a highly interactive opportunity to discuss this challenging and important clinical problem.

Social Factors in Proactive Consultation-Liaison Psychiatry: Experience in the US and UK

Chair: Rebecca W. Brendel, M.D., J.D.

Presenters: Sofia Elisa Matta, M.D., Michael Sharpe, M.D., Rusty Baik, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize barriers to identification and treatment of mental illness in underserved populations within medical and surgical units within the VA Healthcare Center and Oxford, UK.; 2) Identify the differences between Reactive and Proactive CL Psychiatry models.; 3) Recognize the effect of social factors including age, homelessness, race and ethnicity on psychiatric comorbidity and care within medical and surgical services.; and 4) Understand the range of

biopsychosocial patient needs identified by proactive C-L Psychiatry.

SUMMARY:

Proactive Consultation Liaison Psychiatry is a new way of providing C-L psychiatric care to general hospital medical and surgical inpatients. The proactive approach aims to proactively identify all patients who would benefit from psychiatric care and then to provide it in collaboration with the ward team. Unlike the standard reactive consult-based service, it is not limited to seeing only referrals and goes beyond merely providing consults. This service model was recommended by the ACLP and APA taskforce in a resource paper to address psychiatric comorbidity within medical and surgical services published in March 2021. (Oldham et al 2021) Mental illness accounts for 1/3 years lived with disability and is associated with twice the risk of all-cause mortality. One third of patients who are admitted to medical or surgical services have a psychiatric comorbidity, while more than half have psychological problems that will influence their care. The costs of mental illness in the general medical hospital are high and include longer length of stay, the need for constant companions and restraint, poorer health outcomes and early readmission. There is evidence from non-randomized studies that the systematic screening and active intervention of Proactive C-L psychiatry improves patient access to psychiatric care in the hospital, leads to better outcomes and decreases the costs of care. This presentation will focus on homelessness, age, culture, race, and the effect of social determinants of mental health within two Proactive CL models. In the Veterans Administration (VA), Proactive C-L psychiatry is being implemented on the medical and surgical wards where the number of patients with psychiatric diagnoses, including alcohol and substance use disorders has grown substantially in recent years. A large and growing number of veterans with mental illness have severe and complex comorbid medical problems. They account for a disproportionate amount of care utilization and costs for the VA. In the English National Health Service (NHS), medical inpatient beds are increasingly occupied by elderly patients with a mix of medical and psychiatric problems, especially dementia. Limited psychiatric care for these

inpatients is provided by a standard referral-based service. In order to better meet their needs a variation of the Proactive C-L model, called Proactive Integrated C-L Psychiatry has been designed especially for this patient group. (Sharpe et al 2020). In this service model all older inpatients are seen by a C-L psychiatrist to identify psychiatric, psychological and social needs that may complicate care and delay discharge. Assessment is followed by integrated psychiatric involvement in their care. A 3000 patient three hospital randomized trial of this model of care is nearing completion. Data will be presented on the needs identified, and interventions made, in more than 1000 patients during this trial.

Teaching Systems-Based Practice Through a Different Differential

Chair: Jessica Whitfield, M.D., M.P.H.

Presenter: Anna Ratzliff, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List at least three systems-based practice competencies and their value in psychiatry practice; 2) Explain why and how core psychiatric rotations can teach and assess team systems-based practice and thinking.; 3) Recognize that when a patient is not getting better there could be a clinical, team and/or systems challenge getting in the way.; 4) Apply the 'different differential' concept to determine possible causes of common challenges encountered by primary teams.; and 5) Construct a framework for adapting this approach to your specific clinical setting..

SUMMARY:

Shifts in medical knowledge and health care delivery have long demanded updates to medical education over time. The current crisis in access to quality care and rising need for services that outstrip system capacity increasingly demands that the next generation of psychiatrists have a broad range of skills that extend far beyond clinical care, including proficiency in systems factors that affect their patients and the health care they receive (Fried J et al 2014). Thus it becomes all the more critical for psychiatry residency programs to educate their graduates around systemic factors that impact

patient care and prepare psychiatrists with skills to identify and address to these issues. Recognizing this, the Accreditation Council of Graduate Medical Education (ACGME) developed competencies around systems-based practice (SBP) in 2009, as well as observable milestones (Graham 2009; Martinez J et al 2014; ACGME 2020). These competencies are a meaningful construct towards contributing to graduating a cohort of psychiatrists ready to assess and address systems-level impacts on individual patient care and have become increasingly valued by psychiatry residents in recent years (Ranz J et al 2014, Fried J et al 2014). However, the SBP competencies remain challenging to teach and practice, especially those outside patient safety and quality improvement; their broad nature and complexities in local health care delivery make large-scale SBP curricula elusive (Graham 2009; Martinez J et al 2014). Keeping this in mind, we have devised an expanded differential diagnosing technique called the "different differential", which is a systematic, algorithmic approach to identifying and addressing barriers to patients' clinical progress at the patient, provider, team and broader systems levels. Using an explicit framework for identifying, assessing and intervening on systems issues that impact a patient's progress can promote training in specific SBP areas. In this interactive workshop, we will teach the "different differential" framework, how to apply it in practice, how to teach this framework to trainees at various levels, and discuss strategies for building skills in navigating systems barriers with patients. We will start with an overview of the framework's structure, principles and an associated decision-making algorithm, and proceed to illustrate its application in clinical practice with 3 case examples. We plan to demonstrate how this framework could be used in integrated care, but feel it can be broadly applied to a wide range outpatient and inpatient settings. This workshop helps to address these challenges by providing a framework to incorporate critical thinking about systems-level factors that directly impact individual patient care that is adaptable to local contexts and a wide range of clinical settings. This workshop will be engaging for both a psychiatrist in practice and those involved in teaching psychiatry.

The Accelerating Medicines Partnership in Schizophrenia®: Big Data for Psychosis Prediction

Chair: Sarah E. Morris, Ph.D.

Presenters: Scott Woods, M.D., Rene Kahn, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) summarize the scientific rationale for the AMP SCZ project, its scope, and organizational structure.; 2) identify the elements of the AMP SCZ assessment protocol.; and 3) describe the scientific opportunities afforded by the planned availability of AMP SCZ data..

SUMMARY:

Progress in developing new treatments for individuals who are clinical high risk for psychosis (CHR) has been negatively impacted by the heterogeneity of clinical trajectories among CHR individuals. Studies with large numbers of participants are needed to dissect this heterogeneity and develop reliable predictors of diverse outcomes. The Accelerating Medicines Partnership® Schizophrenia initiative (AMP® SCZ) is a public-private partnership between the National Institutes of Health, the U.S. Food and Drug Administration, the European Medicines Agency, and multiple public and private organizations that supports a 42-site international research network focused on developing predictive biomarkers for psychosis. This session will include presentations by representatives of the three primary components of the AMP SCZ research network, including the Psychosis-Risk Outcomes Network (ProNET), the Prediction Scientific Global Consortium (PRESCIENT), and the Psychosis Risk Evaluation, Data Integration and Computational Technologies data processing, analysis, and coordination center (PREDICT DPACC). Speakers will provide an overview of the history of the AMP SCZ initiative, the study protocol and methods, and the data infrastructure, including procedures for making the data available to the scientific community. The large sample and inclusion of a wide range of data types will enable researchers to develop multivariate and dynamic algorithms to predict the course of illness for CHR individuals, allowing for early intervention and testing of

treatments that may prevent the development of schizophrenia and reduce the impact of CHR.

The IMG Journey: Snapshots Across the Professional Lifespan

Chair: Vishal Madaan, M.D.

Presenters: Muhammad Zeshan, M.D., Naziya Hassan, M.D., Consuelo C. Cagande, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the challenges faced by international medical graduates (IMGs) during both residency training and professional advancement in their practice of psychiatry.; 2) Identify successful strategies to overcome obstacles that may prevent IMGs from realizing their optimal potential in their careers in psychiatry.; and 3) Discuss various practical strategies for program to foster a culturally diverse and IMG friendly training and teaching environment.

SUMMARY:

International Medical Graduates (IMGs) constitute a significant proportion of both trainee residents and practicing faculty in Psychiatry across the United States. Recent data suggests that IMGs are 24.3% of practicing physicians, 30 % of practicing psychiatrists, and 33% of psychiatry residents in the U.S. Historically, IMGs constitute a substantial percentage of the practicing psychiatrists' workforce in various practice settings, which range from the private sector to practicing in underserved areas, public sector and academic settings. IMGs thus play a significant critical role in the delivery of psychiatric care to an increasingly diverse patient population. Despite being an indispensable aspect of the American healthcare system, IMGs commencing psychiatry residency training can struggle with overcoming cultural barriers, understanding aspects of the psychosocial framework, verbal and non-verbal communication skills and understanding psychotherapy from an American perspective. This is further complicated by their attempts at acculturation which may continue to hinder their academic progress even beyond the initial training years. The IMG Early Career Psychiatrists (ECPs) similarly face unique dilemmas in their career

trajectory which range from lack of federal research funding opportunities, to establishing a niche for themselves with the local population, if practicing in the community. As senior faculty, the IMG psychiatrists may similarly encounter challenges related to obtaining leadership positions. In this unique workshop, we will explore the challenges that IMGs face at various stages of their professional development, identify potential corrective strategies, and discuss innovative measures to consolidate strengths while addressing areas of growth. The speakers will also highlight successful strategies to facilitate supervision and mentorship of IMG trainees and early career psychiatrists, improve interviewing skills, approaching psychotherapy from an IMG perspective, and providing resources to access research and career opportunities. We will accomplish this by interacting with the audience, using real-life case scenarios and presentations by speakers ranging from a resident to a senior professor. The workshop will also be useful to colleagues and supervisors of IMGs. Conclusion: The career trajectory of an IMG has numerous challenges in addition to acculturation and professional stressors and it is important to address them to promote professional development and job satisfaction.

The Intersection of Arts, Humanities, and Psychiatry

Chair: Carlyle Hung-Lun Chan, M.D.

Presenters: Carlyle Hung-Lun Chan, M.D., Frank Clark, M.D.

Discussant: Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate the value of the arts and humanities in psychiatry; 2) Discuss their responses to various art forms; 3) Recognize various modalities of artistic and humanistic expression; and 4) Consider integrating more arts and humanities into their daily lives and practices.

SUMMARY:

There is an increased recognition that the arts and humanities play an important role in healthcare and healthcare delivery. Not only do arts and humanities provide insights into the human condition, but they

also shed light on the social determinants of health and healthcare. In addition, they provide an avenue for creativity, reflection, and expression essential to the wellbeing of healthcare providers. The National Academies of Sciences, Engineering, and Medicine (NASEM) believe, "The arts teach creative means of expression, understanding of different perspectives, an awareness of knowledge and emotions throughout the human experience, and the shaping and sharing of perceptions through artistic creation and practices in the expressive world." NASEM goes on to say, "The integration of the arts and humanities with medical training is associated with outcomes such as increased empathy, resilience, and teamwork; improved visual diagnostic skills; tolerance for ambiguity; and increased interest in communication skills." The Association of American Medical Colleges (AAMC) agrees that there is utility in educating clinicians and medical educators to better understand "the value of further integrating the arts and humanities into their teaching and learning practices." To facilitate this integration, they have recently published a monograph on "The Fundamental Role of Arts and Humanities in Medical Education" (FRAHME). There are multiple examples of art forms and humanities subjects which contribute to medical education and healthcare. These include but are not limited to creative writing and poetry, reflective writing, visual arts and visual thinking strategies, music, history, literature, narrative writing, film and television, comics and graphic novels, theater and drama, improvisation, and dance and movement. This workshop will provide an overview of these existing areas of arts and humanities as well as demonstrate examples from photography, poetry, and music and how these areas might complement and intersect with psychiatry. Participants will break into small groups and be asked to respond both in writing and in discussion to these stimuli. We will conclude by providing resources to enable participants to find the mode of engagement most suitable to their own individual preferences and interests.

The Psychopharmacology Algorithm Project at the Harvard South Shore Program: 2021 Update on Posttraumatic Stress Disorder

Chair: David Neal Osser, M.D.

Presenters: Laura A. Bajor, D.O., Charmi Balsara, M.D., Robert D. Patterson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the rationale for beginning treatment by addressing sleep challenges first.; 2) Be able to assess for comorbidities and make appropriate adjustments to treatment based on findings.; and 3) Be familiar with current evidence regarding prescribing choices for PTSD..

SUMMARY:

The Psychopharmacology Algorithm Project at the Harvard South Shore Program published algorithms for posttraumatic stress disorder (PTSD) in 1999 and 2011. Developments over the past ten years suggest need for another revision. A literature search was conducted using PubMed to locate new studies and review articles from January 2011 to April 2021 to see if evidence supported changes in the 2011 sequence of recommendations. Exceptions to the main algorithm for special patient populations were delineated. Consideration of treatment of sleep impairments remained the first step in the algorithm. Nightmares, disturbed awakenings (without nightmare recollection), and easily disrupted sleep are best treated with the anti-adrenergic agent prazosin, with doxazosin and clonidine as possible alternatives. Difficulty initiating sleep may be managed with hydroxyzine or trazodone as first-choices. If after treatment of sleep disturbance, significant general symptoms of PTSD continue, use of SSRIs is the next step. After this, another SSRI or venlafaxine could be a third step. Second generation antipsychotics (SGAs) are a consideration though positive evidence is limited and side effects are considerable. SGAs are particularly to be considered if there are PTSD-associated psychotic symptoms. Anti-adrenergic agents can be considered at this point for general PTSD symptoms if not already tried, though their evidence for daytime use is lower in quantity. While there are several other and, in some cases newer, pharmacologic and procedural options, e.g. transcranial magnetic stimulation, cannabinoids, ketamine, psychedelics, and stellate ganglion block,

evidence does not yet support inclusion in the main algorithm.

The Self-Assessment for Modification of Anti-Racism Tool (SMART): Practical Application of a Quality Improvement Tool to Address Structural Racism

Chair: Rachel Talley, M.D.

Presenters: Kenneth Minkoff, M.D., Sosunmolu Shoyinka, M.D.

Discussant: Hunter L. McQuiston, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the development of the SMART tool, including areas in which it builds on prior health inequity frameworks; 2) Describe the domains of the SMART tool and the key mental health equity issues addressed by each domain; and 3) Understand lessons learned from a case example of SMART tool implementation in an organizational setting (Gouverneur Health Center).

SUMMARY:

In response to a reinvigorated national dialogue around structural racism and the social determinants of mental health, the American Association for Community Psychiatry (AACCP) aimed to create a tool for community behavioral health providers that would (1) promote a stepwise, concrete quality improvement process that could be adapted for self-directed use in community behavioral health settings; (2) provide metrics specific to disparity and inequity issues in community behavioral health; and (3) extend beyond cultural competency and linguistic appropriateness to incorporate other issue relevant to structural inequity. Though numerous prior examples of organizing principles and frameworks to address inequity and racism in healthcare exist (Spitzer-Shohat & Chin, 2019; Metzl & Hansen, 2014; Gomez et al, 2016), none of these existing resources fully addressed the AACCP's three goals. The Self-Assessment for Modification of Anti-Racism Tool (SMART) is a quality improvement tool that aims to meet the AACCP's needs in facilitating organizational change in community behavioral health (Talley et al, 2021). In this presentation, we will describe the key domains of SMART, highlighting their connection to

previous literature on equity issues that are uniquely relevant to community behavioral health. We will describe the process for using SMART in the organizational setting. Lastly, we will describe a real-world example of SMART implementation in a community behavioral health organizational setting (NYC Health + Hospitals/Gouverneur) including key lessons learned.

Treatment Resistant Depression: Current and Future Pathways (Not Available for CME)

Presenter: Roger S. McIntyre, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define and operationalize treatment resistant depression; 2) Be familiar with most commonly encountered residual symptoms in persons with treatment resistant depression; and 3) Discuss multimodality treatments that can benefit persons affected by treatment resistant depression.

SUMMARY:

Major depressive disorder (MDD) is common, often severe, and chronic. Most individuals with MDD treated with conventional pharmacotherapeutic, psychosocial and/or neurostimulatory approaches do not achieve full recovery of illness. Treatment resistant depression (TRD) has been defined in more than half a dozen ways but is most frequently defined as insufficient outcome with at least two conventional pharmacotherapeutic treatments. Other definitions include non-response to multiple multimodality treatments as well as introduction of related but separate concepts referred to as difficult to treat depression. Cost analysis indicate that TRD is commonly encountered and is costly to individuals and healthcare systems. Relatively few treatments have received regulatory approval for TRD despite the fact that it is so commonly encountered in clinical practice. This session will endeavour to review concepts of TRD, discuss dimensions of psychopathology in depression most likely to be residual, and will review the latest treatments as to pharmacologic, psychosocial, neurostimulatory, and other approaches that have been shown to benefit people with MDD that is treatment resistant.

Xenophobia and the Mind: Facing a Growing Crisis

Chair: George Makari, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Present the previously unknown historical emergence of the term and concept of "xenophobia"; 2) Consider our "New Xenophobia" in this context.; 3) Explore four major psychosocial models for xenophobia.; and 4) Consider research goals that might further our understanding and enrich policy initiatives..

SUMMARY:

By 2016, it was impossible to ignore an international resurgence of xenophobia. Why now? Many brushed aside that question, arguing this was an eternal problem. Unconvinced, George Makari started out in search of this idea's origins. To his astonishment, he discovered an unfolding series of never-told stories. Coined by doctors and political commentators, popularized by an eccentric stenographer, xenophobia emerged alongside Western nationalism, colonialism, mass migration, and genocide. Stranger-hatred may indeed be ancient, Makari concludes, but the moral and political notion of a dangerous bias called xenophobia, emerged not long ago. After elucidating this forgotten history, Dr. Makari will move on to the 20th century thinkers who devoted themselves to understanding the causes of this menace. He will evaluate innovators like John Watson, Walter Lippmann, Sigmund Freud, Theodor Adorno, Jean-Paul Sartre, Simone de Beauvoir, Michel Foucault and Frantz Fanon, and crucial concepts such as stranger-anxiety, the stereotype, projection, the Other, and institutional bias. In the end, Dr. Makari will propose that we have been hindered by a lack of conceptual clarity in this "diagnosis," made worse by the Balkaziation of the psy sciences, in which schools and disciplinary boundaries obscure the way in which each framework has its logic and place. He will advocate for first differentiating Other anxiety from overt and covert xenophobia, and then demonstrate how these distinctions allow us to rationally apply behavioral, cognitive, psychoanalytic and structuralist remedies.

Youth Cyberbullying: Sticks and Stones May Break Bones, but Cyberbullying Can Shred Souls

Chair: Stephanie Alexis Garayalde, M.D.

Presenters: Anish Ranjan Dube, M.D., Rana

Elmaghraby, M.D., Gabrielle L. Shapiro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand key differences between bullying and cyberbullying and their impact on youth mental health;; 2) Feel comfortable prioritizing and addressing youths' social media use;; 3) Screen for victims and perpetrators of cyberbullying;; and 4) Counsel patients and their caretakers about risks of cyberbullying..

SUMMARY:

With a quick look into your waiting room, it's evident that most tweens and teens are glued to an electronic device. They are most likely using some form of social media as a way to reach out to others or as a platform of self expression while they wait for your appointment. You see the patients giggle, smile or maybe even frown. It's possible that the patients may tell you something about their social media use during your interview, but rarely do they freely volunteer this information. You call your patient and begin your interview. There is so much to cover from discussing mood and anxiety to screening for substance use and physical aggression. However, realistically, you will not have time to discuss your patient's social media use and screen for healthy cyber interactions. Social media is a great way to connect with others, share new ideas, find inspirations, and get informed about current events. However, it can have a dark side that we should all be aware of- it's the perfect place for bullying or cyberbullying. The lack of accountability, confusing laws (hate crime vs misdemeanor vs felony), biases about emotional pain not equating to physical pain, and so on, all enable these perpetrators. The 2019 National Youth Risk Behavior Survey identified that 20% of high school students were bullied on school property and that 16% were cyberbullied (CDC, 2019). However, data has indicated that most teens have been victims of some form of cyberbullying whether it be name calling, threats, rumor spreading, or sharing of explicit images (Anderson,

2018; Cook, 2021). Since the pandemic, socialization has relied heavily on cyber interactions which leads us to one important question: are we failing Gen Z-ers and future generations by not prioritizing this topic during interviews? It's well known that bullying can have detrimental impact on youth mental health. However, the pervasiveness of cyber interactions has some experts speculating that cyberbullying can be more damaging (Englander et al., 2017). Furthermore, 85% of those involved in cyberbullying are also involved in traditional bullying (as cited by Khan et al., 2020) and many victims of cyberbullying are at higher risk of becoming perpetrators later on (Yudes et al., 2020). Victims are also at higher risk of developing depression, self harm, suicide attempts, substance abuse, and anxiety (Englander et al., 2017; John et al., 2018; Zhu et al., 2021). In this presentation, we will discuss the impact of cyberbullying on youth mental health and explore barriers to prioritizing this topic during visits. We will use polls and breakout groups to explore our audiences' experience on this issue. We hope that by the end of the presentation, participants become more aware of the dangers youth face on social media and the importance of setting time aside to discuss cyber interactions. After all, sticks and stones may break bones, but cyberbullying can shred souls.

PRESENTER UPDATE: Anish Ranjan Dube, M.D. will replace Caitlin Rose Costello, M.D.

Sunday, May 22, 2022

A New Methodology for Implementing, and Sustaining Physical Health-Behavioral Health Integration: The Comprehensive Health Integration Framework

Chair: Joseph John Parks, M.D.

Presenter: Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify domains of integration applicable to both primary care and behavioral healthcare; 2) Participants will understand how to use the integration framework to assess the "integratedness" of a particular program; 3) Participants will be able to categorize which

integration construct is currently the closest fit for their organization; 4) Participants will be able to list at least 3 performance measures specific to integration operational and visible within their organization; and 5) Participants will be able to identify at least one new payment methodology to support integration within their organization.

SUMMARY:

There has been considerable progress on physical health behavioral health integration (PHBHI), including research defining different models of service delivery, tools and procedures/processes that support these models, evidence demonstrating improved outcomes and value for diverse populations and in multiple settings, and expanded understanding of both facilitators and barriers to implementation of PHBHI in different types of programs, practices, and organizations. But progress in implementing PHBHI more widely has been impeded by several barriers: • Lack of flexibility in implementation • Lack of appropriate bidirectional measures of progress in implementation • Lack of connection of implementation to value • Lack of financing to support integration, implementation and sustainability The National Council for Mental Wellbeing Center of Excellence for Integrated Health Solutions (SAMHSA funded) in partnership with the Medical Director Institute convened an expert consensus group to develop solutions to overcome these barriers. This presentation of the work of the expert panel includes: A new Comprehensive Health Integration (CHI) Framework for a broader and more sustainable methodology for the implementation of PHBHI that can be applied to integrated services provided in physical health and/or behavioral health settings. This approach is adaptable to diverse providers (large and small, rural and urban, varying levels of resource) and diverse populations (e.g., children and adults, populations at risk for disparity and inequity) The Framework also provides a measurement methodology for progress in “integratedness” The CHI Framework includes three Integration Constructs that each describe an approach that has several evidence based or expert consensus core integration concepts and implementation elements based on 8 core domains, that can be utilized depending on the mission, resources and capability of organizations seeking to

provide integrated services. Each Construct provides “more advanced” integratedness than historical “practice as usual” and is associated with evidence demonstrating that implementation of that Construct produces measurable value. Performance measures specific to integration applicable to each of the 3 integration Constructs. Recommendations on how to optimize current payment methodologies available to implement a support integration applicable to each of the 3 integration constructs. Better measurement of integratedness and performance related to integration paired with appropriate payment based on the value delivered by integration should improve implementation and sustainability of integration.

A Path to Mental Health Equity, Reconciliation and Resilience: Lessons from Early Career Psychiatrists and Trainees in Academic Leadership

Chair: Dwight E. Kemp, M.D., M.S.

Presenters: Matthew Edwards, M.D., Rachel Talley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain knowledge about the role of Diversity Equity and Inclusion in efforts toward mental health equity; 2) Gain knowledge about barriers to recruitment, advancement and retention of underrepresented minorities in academic psychiatry; and 3) Gain knowledge about interventions that may help promote more balanced, equitable, and welcoming environments for the recruitment, support, advancement and retention of underrepresented minorities in.

SUMMARY:

More than a moral or ethical concern, diversity and meaningful inclusion at all ranks of academic psychiatry is an imperative to diversifying the psychiatric physician workforce (Simonsen and Shim 2019; Stewart 2021), positive progress toward mental health equity and (Alsan et al 2019; Simonsen and Shim 2019), meeting the diverse needs of mental health care consumers in the United States (U.S.) (Sudak and Stewart 2021), yet the demographic landscape of academic leadership in psychiatry and academic medicine at large remains

nonrepresentative of the U.S. populous (Chaudhary et al 2020; Simonsen and Shim 2019). Historical and contemporary structural analysis of the Academy explicate the disadvantaged position in which Black Indigenous and People of Color find themselves compared to white colleagues as the product of historic systemic segregation, discrimination, and exclusion as well as enduring barriers including discriminatory traditions, culture, and elitism in academic medicine—some that are unintentional but well-institutionalized (Geller 2021; Shim 2020; Stewart 2021; Sudak and Stewart 2021). In this session, speakers will discuss existing literature, personal and anecdotal experience of underrepresented minority (URM) leaders in academic leadership to illuminate implicit frameworks that naturalize inequity for URM early career psychiatrists and trainees in academic psychiatry and identify leverage points for intervention implementation toward creating more balanced, equitable, and welcoming environments that promote recruitment, support, advancement and retention of URM in academic psychiatry (Jordan et al 2021; Stewart 2021; Sudak and Stewart 2021).

Addiction Research and Discrimination: The Need for a New Paradigm

Chair: John H. Halpern, M.D.

Presenter: Carl L. Hart

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain an overview of current research on the behavioral and neuropharmacological effects of psychoactive drugs in humans; 2) Understand the interrelationship among racial discrimination, group marginalization, preventable morbidity and mortality, and human rights; and 3) Learn why Social Psychiatry seeks debate and discussion on how medical research and practice can help reform public policies..

SUMMARY:

Social psychiatry recognizes the underlying social correlates of psychopathology. As such, physicians and especially psychiatrists are compelled to be heard: to share our expertise and trust within the

public space on social issues especially as advocates and champions for our patients and broader collective community health. The American Association for Social Psychiatry selects Dr. Carl Hart as the recipient of our 2022 Abraham L. Halpern Humanitarian Award. His position calling to recognize the discriminatory policies generated from research predetermined to only evaluate for harmful outcome has generated intense interest. As we enter the 51st year of the AASP, we seek close attention to how research may get misapplied by others when medicine excludes itself from active debate. Exaggerations of the detrimental impact of recreational drug use on the human health and functioning by addiction researchers have bolstered support for draconian drug policies. Such policies have led to racial discrimination, group marginalization, and countless preventable deaths. Dr. Hart's lecture will explain these links and how awareness and public resolve points to healthier solutions that may more fully remedy this age-old problem.

Addressing the Mental Health Needs of Human Trafficking Survivors

Chair: Lujain Alhajji, M.D.

Presenters: Vanessa Padilla, Maria Hadjikyriakou, M.D., Mitchell Rovner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participants will learn to recognize characteristics, risks factors, and barriers to care for victims of human trafficking, as well as the physical and mental health consequences of human traffick; 2) The participants will be able to apply trauma-informed screening and evaluation techniques when assessing the health needs of trafficked persons.; 3) The participants will be able to identify patient-centered needs of trafficked women including perinatal mental health and maternity services.; and 4) The participants will be able to improve knowledge and skills in collaborative care across related medical specialties to provide trauma-informed and culturally-humble care for trafficked persons..

SUMMARY:

Human trafficking is a public health issue which involves exploiting individuals for forced sex or labor, leading to long-term physical, mental, and social implications. These abuses can lead to mental health consequences including post-traumatic stress disorder, major depression, anxiety disorders, and substance use disorders. Physical complications of sex and labor trafficking include unintended pregnancies, HIV, traumatic injuries, and chronic pain. In addition to barriers in accessing healthcare services, the identification of human trafficking victims by health care professionals is often missed partly due to lack of providers education. Psychiatrists, especially those in consultation-liaison positions, are poised to connect victims and survivors to personalized multidisciplinary resources, as well as provide education on human trafficking and trauma-informed care to other healthcare providers. Mental health providers can address the mental health needs of trafficking survivors by providing comprehensive collaborative care that is patient-centered, culturally humble, and trauma-informed. The role of the mental health provider extends beyond clinical care through research, leadership, education, advocacy, and the promotion of partnerships with community resources. This workshop will provide education to healthcare providers in an effort to raise awareness on the public health issue of human trafficking, magnify mental health issues surrounding human trafficking, and to highlight the importance of collaboration in addressing the medical and psychosocial needs of trafficked individuals. PRESENTER UPDATE: Jessica Elizabeth Healey, M.D. will no longer present.

Am I Ready for My Patients to See Their Records? A Guide to Clinicians on Patient Centered Recovery-Oriented Documentation

Chair: Maria Mirabela Bodic, M.D.

Presenters: Stephanie Le Melle, M.D., M.S., Ludwing Alexis Florez Salamanca, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the provisions of the Cures Act and how it impacts access to mental health records; 2) Name 3 benefits of open notes for

patients and providers; and 3) Re-write a progress note from a patient centered and recovery-oriented perspective.

SUMMARY:

Mental health documentation has traditionally been classified as protected and kept away from the eyes of other providers, patients and to some extent even the law, in the case of psychotherapy process notes (1). However, on April 5th, 2021, Congress passed the 21st Century Cures Act, one of its provisions being that “healthcare providers give patients access without charge to all the health information in their electronic medical records without delay” (2)-mental health documentation included. Sharing mental health notes with patients remains a sensitive issue, largely due to clinicians’ fears that review of this content might cause harm, specifically psychiatric destabilization (3). However, studies performed over the last decade have shown the benefits of open notes including improved patient satisfaction and safety as access to their medical record has helped patients understand their medications and feel more in control and comfortable with the treatment plan (4). The issue with documentation in health care, and especially in psychiatry, is the used of terms that are not accessible to the average member of society and occasionally even stigmatizing for particular patient populations (5). Considering the CURES act, clinicians might find themselves at a crossroads between wanting to meet the medico-legal and billing requirements of documentation and not wanting the therapeutic relationship or the clinical status of their patients to deteriorate when these notes are shared without any “filtering” or opportunity to process the information jointly. While some leaders in the field have published guidelines for documentation such as Posada et al.’s 2021 article (6), theoretical guidance is not enough and practical workshops and note writing exercises are needed to improve this new skill. In this session we aim to empower the audience with recovery-oriented language and tools to produce documentation that is accurate, timely and not cumbersome, and at the same time helps bridge the gap between patients and providers and opens the conversation about mental health diagnoses and treatment. The co-facilitators of this session have experience participating in and running the Peer

Advisor program at Columbia University- a partnership between people with lived experience and public psychiatry fellows and have conducted several workshops on recovery- oriented documentation as part of this program. The insight gained from years of working directly, in a non-hierarchical relationship, with people with lived experience will be shared with the audience through an interactive note writing exercise.

Anxiety Disorders Treatment: Current State and Future Promise

Presenter: Mark Hyman Rapaport, M.D.

Moderator: Edmond H. Pi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) develop personalized treatment strategies for GAD, Panic Disorder, and SAD; 2) discuss with patients the pros and cons of current integrative therapies for anxiety; 3) discern how big data and AI may impact practice patterns in the future; and 4) identify future potentially disruptive treatment approaches.

SUMMARY:

The goal of this session is to present the busy practitioner with a concise review of GAD, panic disorder, and SAD. The presentation will briefly discuss changes in our nosology as we move from DSM 5 to DSM 5TR and any implications this may have for diagnosis of these syndromes. Next, we will discuss an approach to conceptualizing how the social determinants of health and mental health may impact the pathogenesis, recognition and treatment of anxiety disorders. The next portion of the presentation will focus on treatment options for patients with anxiety disorders. We will briefly discuss evidence-based psychotherapies and complementary and alternative treatment options but we will focus mainly on existing pharmacological treatment approaches for patients with anxiety disorders. We will discuss the value of both FDA-approved and non-FDA approved pharmacological strategies that can be employed depending on the severity and degree of treatment non-response encountered. The final component of this lecture will explore how new technologies may play a

disruptive influence on how we recognize people at risk for developing these syndromes, lead to preventative if not pre-emptive interventions, and may extend our treatment options.

Assessing Current Gaps and Opportunities in ECT, rTMS and DBS Guidelines With an Eye Toward the Future

Chair: Eric D. Achtyes, M.D.

Presenters: Georgios Petrides, Tracy Barbour, Alik Widge

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss current clinical guidelines for the use of FDA-approved psychiatric electroceutical interventions (ECT, rTMS) as well as research guidelines for DBS for severe depression.; 2) Provide an understanding of current research knowledge base and address gaps surrounding clinical/research guidelines for psychiatric electroceutical interventions for treatment-resistant depression.; and 3) Identify ways to advocate for appropriate use of PEIs in psychiatric practice and advance a research agenda to address gaps in current knowledge..

SUMMARY:

Psychiatric electroceutical interventions (PEIs) are somatic treatments that can target specific brain regions and circuits involved in the pathogenesis of major depressive disorder (MDD), providing alternative treatment approaches for those in whom standard therapies have not been effective. In the United States clinical guidelines exist for the treatment of MDD (APA 2019), electroconvulsive therapy (ECT) (APA, 2001) and repetitive transcranial magnetic stimulation (rTMS) (Perera, 2016; McClintock et al, 2018), yet emerging evidence has triggered the need to revise these existing guidelines. In a previous phase of an NIH-funded project, we found that psychiatrists cited patient selection criteria and adverse effects as key foci for clinical guideline development (Cabrera et al. 2020). This session will explore key gaps in current clinical guidelines for PEI use in MDD as the evidence base continues to evolve. Specifically, panelists will contrast recommendations from current clinical

guidelines with both 1) research advances not yet represented in published guidelines, and 2) current gaps in knowledge which require further study. Dr. Petrides will discuss current clinical guidelines in ECT. Dr. Barbour will discuss current clinical guidelines in rTMS. Dr. Widge will discuss recommendations for the use of deep brain stimulation (DBS) in clinical trials for MDD and reflect on key considerations that future clinical guidelines for DBS should include if approved. The second part of the panel, led by Dr. Cabrera, an expert in the neuroethics of PEIs, will discuss: 1) key ethical considerations to include in clinical guidelines, and 2) key opportunities and challenges in revising current clinical guidelines. To trigger discussion Dr. Cabrera will present results from a national survey with psychiatrists (N=505) focusing on their responses to the question about their main considerations when developing practical guidelines for PEIs. The session will end with a question and answer period to engage both the audience and panelists.

Beyond the Textbook: Practical Applications of Healthcare Provider Support for Burnout, Wellness, and Resilience

Chair: Adrian Jacques H. Ambrose, M.D.

Presenter: Lourival Baptista Neto, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize at least two signs and symptoms of burnout in healthcare providers; 2) Identify at least one cause of burnout for healthcare providers.; and 3) Describe at least one potential strategy to improve wellness for healthcare providers.

SUMMARY:

Even prior to the COVID pandemic, healthcare providers, especially physicians, faced an inordinate amount of stress as evidenced by the alarming prevalence of burnout symptoms for both trainees and practicing physicians, high self-reported job dissatisfaction, and concerning rates of mental health challenges. Affecting both personal and professional domains, burnout may be associated with a decrease in professionalism, higher medical

mistakes, substance use, and mood disorders. For psychiatrists, the APA Board of Trustees Workgroup on Psychiatrist Well-Being and Burnout found that 78% of respondents were at an increased risk of burnout and 16% reported symptoms consistent with moderate to severe depression. In the private sector, employee burnout has consistently ranked among the top concerns for C-suite executives, ranging from start-ups and mid-sized to Fortune 500 companies. Per the Harvard Business Review, burnout costs companies \$3400 out of every \$10,000 salary due to disengagement and poor work productivity. Integrating lessons from both the academic and private sectors, this session will explore the effects of various stressors on healthcare provider well-being and burnout as well as proposed solutions, which have ranged from individual-level changes (e.g. building resilience, yoga, meditation) to system-level changes (e.g. reducing administrative burden, increasing time available for patient care, promoting team-based work). Furthermore, we will highlight a case study of service implementation for wellness support at a large academic health system: CopeColumbia. The case study will also review challenges, possible models of care, lessons learned, and successes. There is currently a dearth of research targeting burnout solutions in minoritized and marginalized physicians, especially in the intersectional dimensions. With COVID fueling the current "Great Resignation," system leaders and healthcare organizations tackling burnout must address both individual and structural factors, such as, focusing on the individual's physical and emotional depletion, restoring the meaning and connection to their work, and reestablishing a sense of trust in the workplace and overall organization.

Bipolar Depression: Outcome and Pharmacological Treatment

Chair: Mauricio Tohen, M.D.

Presenters: Leonardo Tondo, M.D., Gustavo Vazquez, M.D., Ph.D.

Discussant: Jair C. Soares, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to identify risk

factors of emergence of mixed symptoms with the use of antidepressants; 2) At the conclusion of this session, the participant will be able to identify the challenges and opportunities of the use of antidepressants in Bipolar Depression; 3) At the conclusion of this session, the participant will be able to identify the efficacy and tolerability of antipsychotics in the treatment of Bipolar Depression; 4) At the conclusion of this session, the participant will be able to identify the efficacy and tolerability of lithium and mood stabilizers in the treatment of Bipolar Depression; and 5) At the conclusion of this session, the participant will be able to identify the challenges and opportunities of the use of Ketamine in Bipolar Depression.

SUMMARY:

Bipolar Depression is a largely understudied area. Patients are frequently misdiagnosed as Major Depression Disorder, which leads to utilization of inappropriate treatments including antidepressant monotherapy. Recent studies have shown that Patients with bipolar disorder experienced longer periods in the depressed than in manic phase. Furthermore, episodes of depression are the most frequent cause of disability among patients with bipolar disorder. Polarity of the first episode has predictive value on long-term course of the condition, including the predominance of future episodes. Polarity of patients' first reported mood episode suggests that depression-prone subtypes have a greater probability of suicidal acts. Patients with bipolar disorder who experienced a first episode of depression have a long-term predominant presentation of depressive episodes and subsyndromal depressive symptoms. Bipolar depression when accompanied by mixed features has higher risk of suicidal behavior and presence of comorbidity substance use disorder. Treatment resistant bipolar depression is highly prevalent. New pharmacological and Neuromodulation (e.g. ECT, TMS) treatments have improved the outcome of acute bipolar depression and the prevention of relapse to depression. Result from recent pharmacological treatments including Lurasidone, Cariprazine Lumateperone, and Ketamine; as well as those utilizing Neuromodulation approaches. Finally, the use of antidepressants in bipolar depression remains controversial, especially as monotherapy,

however in combination with mood stabilizers or atypical antipsychotics they appear to be a treatment option. Risk factors for antidepressants causing emerging symptoms of mania have been identified.

Building the Future of Trans+ Psychiatrists

Chair: Chelsea R. Cosner, M.D.

Presenters: Fiona D. Fonseca, M.D., M.S., Chelsea R. Cosner, M.D., Teddy G. Goetz, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the importance of supporting trans+ psychiatric trainees, serving the diverse needs of the trans+ community.; 2) Appreciate the unique structural challenges of finding mentors for trans+ trainees interested in psychiatry.; 3) Learn how to connect trans+ psychiatry trainees to mentorship and resources.; and 4) Identify the intersection of trans+ identities with other aspects of identity of psychiatrist trainees and how this interplay may impact interactions with patients and potential mentors..

SUMMARY:

There are increasing numbers of openly transgender, non-binary, and/or gender expansive (trans+) individuals each year. Mirroring overall demography, there are increasing ranks of trans+ psychiatrists. These trans+ psychiatrists can offer unique perspectives on how to serve their communities; Trans+ trainees often lack mentorship from senior trans+ psychiatrists. This session will describe specific examples of mentorship and sponsorship needs for trans+ psychiatry trainees. It also acknowledges the intersectionality of being trans+ with other aspects of identity including race and class and how those intersections affect interactions with patients and their ability to find mentors. We will also provide suggestions for fostering more inclusive and affirming institutions. We believe that better trained and mentored trans+ psychiatrists will be better able to help combat trans+ people's disproportionately worse mental health outcomes and increased threats to safety due to legislative action and discrimination. This workshop was designed by trans+ psychiatry residents for trans+ psychiatry

trainees and those who wish to support them. In a highly interactive format, attendees will learn from a panel of trans+ psychiatry residents who will share experiences, lessons learned, and tips for how institutions could have better supported them in hindsight. This workshop will move from an overview of the challenges that trans+ psychiatry trainees face to a discussion of specific strategies that helped the trans+ residents navigate psychiatry training. The workshop will then discuss ways to identify trans+ mentors and ways to recognize and seek out trans+ friendly work environments. We will then employ the use of role plays to allow participants to explore and apply concepts learned during this workshop. Throughout the workshop, the panelists will elicit audience participation in a moderated question and answer format. The workshop will end with a dedicated question and answer format.

Buprenorphine Update and Evolving Standards of Care

Chair: John A. Renner, M.D.

Presenters: Dongchan Park, M.D., Stephen A Wyatt, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain changes in patterns of opioid use disorder since 2002; 2) Describe regulatory changes relevant to buprenorphine in DATA 2000 and CARA 2016; and 3) Describe changing standards of care in the use of buprenorphine in the treatment of opioid use disorder.

SUMMARY:

This session will describe recent changes in the epidemiology of opioid use disorder, including the current epidemic of fentanyl, carfentanil, and other fentanyl analogs. We will review: 1) Recent regulatory changes and their effect on clinical practice and collaborative care models 2) The results of research studies comparing buprenorphine and extended-release naltrexone 3) The impact of new medication formulations, including injectable buprenorphine 4) Evolving standards of care for medication-assisted treatment including models for

the management of opioid over-dose and the efforts to reduce or eliminate barriers to admission to long-term medication treatment. 5) Plans to expand access to evidence-based treatment within the justice system.

Climate Psychiatry 101

Chair: Elizabeth Haase, M.D.

Presenters: John W. Sullenbarger, M.D., Peter L. Chien, M.D., Emily Margaret Schutzenhofer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the neuropsychiatric impacts of increasing temperatures and air pollution across the lifespan; 2) Understand how changes in infectious disease and nutritional content of food will impact psychiatric presentations; 3) Describe the subtypes of ecoanxiety, the psychological distress generated by climate change; 4) Understand how climate change multiplies adverse impacts on social determinants of mental health; and 5) Discuss the role of the psychiatrist in prevention and treatment of these impacts.

SUMMARY:

Climate change is advancing quickly, impacting psychiatric symptoms through effects on neurobiology, psychological distress, and social determinants of health. This panel will provide an overview of what the general psychiatrist needs to know about climate change impacts on the mental health of their patients. We will review: 1) the neuropsychiatric impacts of heat and increased air pollution on the brain, 2) how changes in vector-borne encephalitis and the nutritional content of food will change psychiatric presentations and epidemiology, and 3) the kinds of eco-distress that are associated with increasing natural disasters and their future impacts on humanity. Attendees will emerge with a good basic understand of what "Climate Psychiatry" is, and what it means for real patients, social determinants of health, and mental health equity. They will also consider the unique demands imposed on the human psyche by the scale and quality of climate impacts and the roles that

psychiatrists can play to reduce the various types of climate-related distress.

Clinical Management of the Homeless Patient; Social, Psychiatric and Medical Issues

Chair: Elspeth Cameron Ritchie, M.D., M.P.H.

Presenters: Maria Llorente, Rita Hargrave

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the historical context of homelessness; 2) Address the common medical and psychiatric issues of the homeless; 3) Describe best practices and models of care to house people and maintain housing; 4) Describe after care medical follow up to promote healing; and 5) Identify why LGBT youth are more likely to end up homeless.

SUMMARY:

Even prior to the COVID-19 pandemic, several policy makers and prognosticators have predicted a housing “apocalypse” as people lose their incomes, the stimulus checks are spent, unemployment runs out, and the “stay eviction” orders expire. Homelessness takes a psychological and physical toll on the person who experiences it. At this time of a pandemic, homelessness also increases the potential exposure risk to becoming infected, lacking health insurance to seek medical care, and experiencing adverse outcomes. Unbelievably, perhaps, this is also happening at a time when the United States of America is arguably the wealthiest nation on the planet. Per the International Monetary Fund the US Gross Domestic Product in 2019 was \$21.44 trillion, which represented the largest single proportion (23.6%) of the total global economy. The US has retained this position since 1871, and has advanced infrastructure, technology and a wealth of natural resources. And yet, at the same time, the US still has more than half a million people who are homeless on any given night, with nearly a quarter in either New York City or Los Angeles. These two cities also have some of the highest rates of COVID positive tests. At the same time, we also are able to see, firsthand, the very positive impact of the concerted federal, state and local government efforts to end homelessness, particularly in partnership with

community and private agencies. That effort led to a 50% reduction among our nation’s veterans since 2010. National homelessness, has decreased by 12% since 2007, with a reduction of 29% among families. Unfortunately, the impact of COVID-19 has the potential to eradicate these gains. First, we want to offer an overview of the historical context of homelessness in the US. This includes taking into consideration the justice system, our economic structure and priorities, and multiple psychosocial determinants that can contribute to homelessness. Second, we want to address the common medical and psychiatric illnesses that we have encountered in our clinical work, and reach out to our colleagues with specialty expertise in the management of these illnesses, particularly among the homeless. Third, we want to better understand how did we get here? How do we come to have so many homeless persons in the wealthiest country on the planet? Last, we want to describe for you the best practices and models of care that have shown promise and/or effectiveness, not only in housing people, but also in helping them to sustain a housed status permanently. We also hope that this presentation will enable you to better understand that there are many reasons an individual finds themselves in a homeless situation, and that will perhaps reduce the initial impulse to judge. We ask that you consider the words of Dame Sheila McKechnie “People who are homeless not social inadequates. They are people without homes.” As a society, we can help each other so that ultimately, everyone has a home.

Clinical Update on Managing Schizophrenia: Drugs and Other Treatments

Presenter: Stephen R. Marder, M.D.

Moderator: Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to describe the clinical implications of recent research that affects the choice and dose of an antipsychotic medication.; 2) At the conclusion of this session, the participant will be able to describe the clinical implications of recent research that affects the clinical management of antipsychotic adverse effects.; and 3) At the

conclusion of this session, the participant will be able to describe the clinical implications of recent research on the use of non-pharmacological treatments for schizophrenia including ECT an.

SUMMARY:

This session will focus on research findings from the past three years that have implications for the management of patients with schizophrenia. In important areas including the management of acute schizophrenia, first episodes of psychosis, long-term treatment, and treatment resistant schizophrenia selected published studies that include clinical trials, large cohort studies, expert consensus reports, and meta-analyses will be described. will be followed by a summary of the presenter's view on how the findings should affect clinical practice. A similar approach will address recent research on physical health concerns of patients with schizophrenia and the adverse effects of antipsychotic medications. will include research on metabolic problems including type 2 diabetes, obesity, and dyslipidemia as well as neurological effects and brain health. Clinical trial reports of newer antipsychotics including lumateperone and olanzapine/samidorphan will be presented as well as the implications of these new agents for practitioners. Reports of new formulations of antipsychotic medications including new long-acting formulations of paliperidone, aripiprazole, and risperidone and transdermal asenapine will be described. The clinical implications of new research on non-pharmacologic somatic treatments including aerobic exercise, transcranial magnetic stimulation, and electroconvulsive therapy will be discussed. Finally, there will be a discussion of new drugs for schizophrenia that are in Phase 3 trials.

Clozapine 101: How to Incorporate a Potentially Lifesaving Tool Into Your Armamentarium

Chair: Robert Osterman Cotes, M.D.

Presenters: Frederick Nucifora, Oliver Freudenreich

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to describe two hypotheses as to why clozapine has a unique efficacy.; 2) Participants will be able to state

three reasons for using clozapine levels.; 3) Participants will be able to list and describe strategies to mitigate the most common serious side effects of clozapine including neutropenia and myocarditis.; and 4) Participants will be able to define ultra-treatment resistant schizophrenia and list three proposed interventions for these individuals..

SUMMARY:

Treatment Resistant Schizophrenia adds 34 billion dollars per year in direct medical costs in the US. Clozapine is the only medication that is approved by the US FDA for Resistant Schizophrenia. As many as 20-25% of individuals with schizophrenia may meet criteria for treatment resistance, yet clozapine remains highly underutilized in the US. Some of the barriers to clozapine's use include weekly blood work, coordination with pharmacies, administrative burden for registry-based prescribing, the potential for multiple side effects, and prescriber lack of knowledge. Psychiatrists working in community mental health and inpatient settings are likely to routinely encounter individuals who may benefit from clozapine. This session seeks to increase the participant's comfort on clozapine and has been developed for clozapine prescribers of all levels. The presenters will provide a clinical update of clozapine's indications; its pharmacodynamics and pharmacokinetics; and management of side effects, including neutropenia, constipation, and myocarditis. This session will also help the participant fine-tune approaches for how to talk to a patient about clozapine, and how to utilize and interpret clozapine blood levels. The session will also show/explain participants how to navigate the new Clozapine REMS system. Finally, we will provide some suggestions of pharmacological and psychosocial interventions for how clinicians can help their patients who have persistent positive, negative, and/or cognitive symptoms despite taking clozapine.

Clozapine Clinics: Interdisciplinary Perspectives on Best Practices, Successes, and Challenges

Chair: Robert Osterman Cotes, M.D.

Presenters: Donna Rolin, Megan Ehret, Balwinder Singh, M.D., M.S., Robert J. Olson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the research on what is known about clozapine clinics in the US; 2) Describe successful models on how to develop a clozapine clinic and identify three potential challenges in their development; and 3) Discuss the potential role of nurse practitioners, nurses, pharmacists, and trainees in a clozapine clinic..

SUMMARY:

The US Food and Drug Administration (FDA) indications for clozapine use include treatment-resistant schizophrenia (TRS) and reducing suicidal behavior in patients with schizophrenia or schizoaffective disorder. Clozapine is accepted by the clinical community as the treatment of choice for TRS. Despite its proven efficacy and guidelines recommending its use, actual rates of prescribing have remained low. While 20-30% of patients with schizophrenia meet clozapine use criteria, only a fraction of these patients end up receiving a clozapine trial. Although clozapine has proven to be highly efficacious, its utilization remains low in the US. Investigation into the origins of the reduced use have implicated prescriber's fear of using clozapine, citing concerns centered on side effects and comorbidities, increased frequency of clinic visits, and reluctance to enter patients into the weekly blood monitoring program. However, studies have shown clozapine actually reduces mortality, possibly secondary to reducing the risk of suicide with the reduction reaching 85%. Treatment with clozapine is cost-effective, and the significant decrease in suicide risk far outweighs the low risk of mortality from severe neutropenia. Importantly, the risks of poorly treated illness (i.e., treatment-resistant schizophrenia patients receiving ineffective treatments) extends beyond suicide. It comes with polypharmacy, poor quality of life, poor physical health (resulting in morbidity and mortality), and disability. To foster effective use of clozapine, recent studies have highlighted the importance of developing clozapine clinics, which could expand access and include experienced clinicians that would effectively manage adverse events. A recent survey from SMI Adviser that included 32 clozapine clinics

found there was significant variation in the staffing models and services offered. Over half of clozapine clinics surveyed included psychiatrists, pharmacists, nurses, psychiatric nurse practitioners, and case managers. The median caseload of patients on clozapine in the clinics was 45. In this session, we will share interdisciplinary perspectives on clozapine clinics from psychiatrists, nurse practitioners, nurses, and pharmacists. We will discuss how psychiatry residents can be involved, which would result in the graduation of clinicians that could promote future clozapine use. The session will also include a panel discussion with the presenters which will explore current challenges in clozapine clinics, and will brainstorm solutions.

Digital Navigators: Your Guides to Making Technology Work for Your Patients With SMI

Chair: John Torous, M.D.

Presenters: Sherin Khan, Erica Camacho, Danielle Currey

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize signs of low digital literacy in your patients; 2) Assess which aspects of digital navigator training can best help your patients connect to care; and 3) Know how to obtain digital navigator training and deploy the role for your patients.

SUMMARY:

The need to increase access to care for those with SMI is clear. Hybrid models that involve both in person or telehealth but also asynchronous care (ie using tools like apps) have shown promise towards accomplishing this vision of radically increased access to high quality care. In this interactive presentation, we present the concept of the Digital Navigator as a new team member and the key to hybrid care for SMI. The Digital Navigator is able to serve both the patient and the clinician through filling three key roles 1) Teaching digital literacy and technology setup/ troubleshooting), 2) App evaluation and 3) Engagement support for patients and data aggregation for clinicians. Outlining each of the five modules in the training of a Digital Navigator, we will present a case example through

an interactive role play to highlight the real-world clinic need. After each role play, we will outline the curriculum, learning objectives, and metrics for that module. This will be followed with a problem solving and interactive learning experience from that module that the audience will be asked to assist and engage with. In completing this exercise for all five modules, learners will have a full understanding of the Digital Navigator role, its implementation, and importance for radically increase access to high quality care for SMI.

Eliminating Health Disparities in the Treatment of Hispanics With Psychiatric Disorders

Presenter: Carlos Blanco-Jerez, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify differences in the prevalence of psychiatric disorders between Hispanics and non-Hispanics; 2) Identify differences in rates of treatment between Hispanics and non-Hispanics; 3) Identify reasons for the differences in treatment rates; and 4) Promote changes to eliminates treatment disparities between Hispanics and non-Hispanics.

SUMMARY:

Epidemiological studies suggest that Hispanics generally have lower prevalence of psychiatric disorders than their non-Hispanic counterparts, a phenomenon often called the Hispanic paradox. At the same time, Hispanic individuals with psychiatric disorders seek treatment at lower rates than non-Hispanics. In this presentation, we will first examine different theories that try to explain the Hispanic paradox, as well as recent data suggesting that the paradox may not apply to all Hispanics only to certain subgroups. Second, we will examine predictors of treatment-seeking, including social determinants of help, how they may help explain rates of treatment for psychiatric disorders for Hispanic populations and how they can assist in identifying barriers to care for these populations. Third, we will suggest some ways to remove those barriers and increase rates of treatment among Hispanic with psychiatric disorders. We will also point out areas of research that can increase rates of

treatment and quality of care for Hispanics. This presentation will seek to stimulate discussion to accelerate the implementation of approaches at the patient, clinician, health system and population levels geared towards the elimination of disparities in the treatment of psychiatric disorders among Hispanics.

Empowering Trainees to Engage in Scholarly Work and Leadership Roles

Chair: Donna Marie Sudak, M.D.

Presenters: Muhammad Zeshan, M.D., Sadiq Naveed, M.D., Cathryn A. Galanter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • Incorporate novel strategies to improve interests of residents in scholarly work and facilitate development of academic clinicians; 2) • Utilize various resources to help medical students and residents in writing/publishing posters, abstracts, case reports, and articles; and 3) • Address apprehensions around the challenges of research work, especially among residents with limited research experience.

SUMMARY:

Residency-based exposure to research will help trainees to assimilate emerging theoretical knowledge about biology, neurotransmitters, genetics, epigenetics, impact of trauma and other psychosocial stressors on patient's current presentation, and strengthen the evolution of best psychiatry practices on routinely basis. Although, the Accreditation Council for Graduate Medical Education (ACGME) requires that programs provide list of residents' annual scholarly activities, but there is scarcity of specific recommendations on how to achieve this professional milestone, especially for programs who have limited funding and resources. As a result, different programs have designed various strategies to meet the mandatory ACGME requirement, resulting in inconsistencies in satisfaction among residents across the US. Studies have repeatedly demonstrated that engaging in scholarly projects during training helps residents to interpret the literature, apply evidence to patient care, demonstrate competency in research methods,

pursue a career in academic medicine, and ultimately achieve higher academic ranks. It also adds to the program's ranking and enhances its profile by increasing the departmental publications, poster and oral presentation at conferences, and nomination of their residents for regional and national awards. Despite the overarching benefits, residents find it challenging to pursue scholarly work due to limited number of formal research training opportunities, increasing pressure on mentors to maintain revenue based clinical activities, lack of clarity and consistency among programs about setting scholarly goals and providing protected scholarly/research time. A trainee's lack of enthusiasm, possibly due to apprehensive beliefs around the meticulousness of research work, and prospects regarding utility of research in their clinical practice may also serve as impediments. The National Institute of Mental Health has also noted a decline in the number of psychiatrist-researchers as compared to other medical specialties. The aim of our workshop is to enable programs, with limited funding and resources, to overcome some of the aforementioned challenges by providing lists of short courses on putting together research proposals, abstracts, as well as designing a poster. We will also share names of resident friendly journals and conferences along with useful strategies to start with reachable / sustainable goals like case reports and literature reviews. Moreover, we will discuss how to find a topic, approach a mentor, and create a research friendly environment during training. We will also furnish some tips to assist program directors to write letters supporting their residents, often necessary to obtain research grants and applications for prestigious leadership awards and honorary fellowships.

End of Life Care and Guardianship for People With Intellectual Disabilities

Chair: Nina Bihani, M.D.

Presenters: Leah Smith, M.P.A., Harold Braswell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understanding how guardianship differs for people with intellectual disabilities and people with dementia; 2) Recognize

the challenges faced in accessing and withdrawing end-of-life care by people with intellectual disabilities; 3) Discussing novel approaches to improving end-of-life care for patients with intellectual disabilities, and the role of psychiatrists in implementing these approaches; and 4) Delineating the role that psychiatrists play in assisting patients and other medical providers with navigating end-of-life care decisions for patients with intellectual disabilities.

SUMMARY:

Guardians are appointed by the court to assist patients in making medical decisions and in determining where they will live. This occurs when patients cannot express clear choices of what they want, provide a rationale for choosing that option over another, demonstrate understanding of the various options available, and show appreciation for the consequences associated with each choice. The medical field uses the term "decision-making capacity" and the legal field uses the term "decision-making competency," but the two concepts are largely interchangeable. In medical practice, many patients will temporarily not have decision-making capacity for various reversible causes, and once mentation improves, they resume decision-making capacity for themselves. However, for some patients, such as those with dementia, decision-making capacity cannot be restored, and a guardian is appointed to make decisions in the patient's best interest, incorporating the patient's personal beliefs as much as possible. In yet other cases, such as with neurodevelopmental disorders, decision-making capacity was never intact in the first place. The COVID-19 pandemic has placed issues of decision-making capacity at the forefront of our international consciousness, as numerous individuals were placed on ventilators. Within the disability community, there was grave concern that when resources were scarce, those who were deemed to have low quality of life at baseline would not have access to life-saving intensive care. Conversely, for years, families of people with intellectual disabilities have struggled to withdraw life support from their loved ones as it is often an arduous process to do so. In many states, the laws require knowledge of a person's wishes prior to withdrawing care, which is not possible to know for people who have never had capacity to

make such wishes known. The Center of Dignity in Healthcare for People with Disabilities Aging Subcommittee has been working to develop guidelines to assist medical practitioners with end-of-life care needs for this patient population. As this patient population grows into adulthood and geriatric age, psychiatrists will likely be called upon more to liaise between various medical, family, and legal entities. This session will present the case of Sue Sweeney to outline this issue and discuss current and newly proposed models for supported decision making of individuals with intellectual disabilities.

Ethical Issues in Treating LGBTQ Patients

Chair: Jack Drescher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize clinical issues specific to the treatment of LGBTQ patients; 2) be prepared to answer the kind of questions LGBTQ patients frequently ask of clinicians; and 3) recognize important ethical principles salient to the treatment of LGBTQ patients.

SUMMARY:

The American Psychiatric Association's Principles of Medical Ethics emphasize competence, respect and up-to-date knowledge as a basis for appropriate professional behavior toward lesbian, gay, bisexual, transgender and queer (LGBTQ) patients. This presentation first reviews historical psychiatric attitudes towards LGBTQ patients that could be construed, at best, as patronizing and, at worst, overtly hostile. In modern clinical practice, as opposed to trying to "cure" homosexuality or "transsexualism," LGBTQ patients are helped to live their lives according to their own natures and desires. This presentation outlines some common clinical questions raised by LGBTQ patients—what is known and not known about the origins of homosexuality and transgender expression, sexual orientation conversion efforts (SOCE), therapist self-disclosure, how therapists should address LGBTQ patients, and controversies surrounding treatment of transgender children—as well as ethical issues raised in these clinical encounters.

Good Psychiatric Management for Adolescents With Borderline Personality Disorder

Chairs: Lois W. Choi-Kain, M.D., Carla Sharp, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the diagnosis to adolescent patients and families and establish reasonable expectations for change (psychoeducation).; 2) Identify when to prioritize BPD's treatment and when to defer until a comorbid disorder is resolved.; and 3) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and professional liability by adhering to standards of care.

SUMMARY:

Every health professional will care for patients with BPD. The prevalence of BPD in adolescents matches or exceeds that of adults in both the community and in mental health settings. Symptoms of BPD first emerge during childhood or adolescence, normally increase after the onset of puberty, peak during early adulthood, and decline during subsequent decades. By age 16, 1.4% of adolescents in a prospective community-based longitudinal study met criteria for BPD, and the cumulative prevalence doubled during the remainder of adolescence into the early twenties. While BPD features rise and fall between childhood and adulthood, those who develop more significant personality dysfunction early in life are most likely to develop significant functional impairment academically, occupationally, and socially regardless of the decline in symptoms. The progressive separation of young people with BPD symptoms from their peers and usual developmental trajectories precedes significant and ongoing disability in their adult years. Those who do not remit remain at risk for becoming more disabled and dependent on care systems as they become adults. The opportunities for intervention are ample during this critical developmental period because adolescents with BPD, and their families, actively seek care. Adolescents with both BPD traits and a BPD diagnosis are more likely to report histories of inpatient hospitalization and psychopharmacology, interventions with no proven efficacy in the treatment of BPD, than previous psychotherapy.

Discomfort with diagnosis of BPD in adolescence is likely compounded by the absence of treatment options. While a number of evidence-based psychotherapies for BPD tested in adults have been adapted to treat adolescents, the small number of randomized controlled trials (RCTs) for these adaptations has not yet provided conclusive guidelines for treatment in this age group. Using ingredients that all health professionals use to manage patient care- such as diagnostic disclosure, psychoeducation, goal settings, management of safety and comorbidities, and conservative prescribing- Good Psychiatric Management (GPM) is a generic pragmatic approach to treating BPD that can become a fixture in any psychiatric setting and is the most apt of BPD's evidence-based options for translation into primary care. We adapted GPM to adolescents (GPM-A) to promote earlier intervention. BPD is an outcome, not just a starting point. As prevalent in adolescence as it is in adults, BPD develops for those who are emotionally, interpersonally, and stress sensitive who endure unmanageable adversities without adequate support. These risk factors put all of us at risk for mental illness, whether in adolescence or adulthood. This session will provide a basic overview of the rationale for and basic toolkit in GPM for adolescents.

How Science Can Transform Treatments for OCD

Chair: Helen Blair Simpson, M.D., Ph.D.

Moderator: Edmond H. Pi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Diagnose OCD; 2) Discuss medications for OCD; 3) Discuss psychotherapy for OCD; and 4) Appreciate how different types of patient-oriented research can improve clinical practice.

SUMMARY:

Obsessive-compulsive disorder (OCD) is a severe neuropsychiatric illness characterized by intrusive thoughts and repetitive behaviors. It has a lifetime prevalence of approximately 2%, (i.e., twice as common as schizophrenia), a relatively early age of onset (half of cases of OCD start by age 19 and a

quarter by age 14), and typically chronic, waxing and waning course. Given its early onset and typically chronic course, OCD is associated with substantially reduced quality of life and impairments in occupational functioning. This session will present a clinical research update on OCD, focusing on scientific findings that can be used by clinicians to improve their practice. The speaker will review: 1) how to diagnose OCD and differentiate it from other disorders with intrusive thoughts and behaviors; 2) what are evidence-based medications and therapy for OCD and how best to deliver each; and 3) what to do when first-line treatments do not work. It will conclude by discussing two challenges in the field: why many patients do not receive first-line treatments; and why first-line treatments work well for only about half of patients.

International Medical Graduates and the Care of Older Adults With Mental Health Disorders in the United States

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define an international medical graduate (IMG); 2) Describe the care needs of older adults with mental health disorders in the United States; 3) Discuss the role of international medical graduate (IMG) in the care of older adults with mental health disorders in the United States; 4) Enumerate how the APA can play a greater role in attracting larger number of IMGs to join the geriatric psychiatry workforce; and 5) Question and answers.

SUMMARY:

The population of the United States is aging. Currently people over the age of 65 years constitute 13% of the general population. By 2050 this number will rise to about 25% of the population. As the population ages, the number of older adults with mental illness will also rise. Available data indicates that there are inadequate numbers of trained geriatric psychiatrists in United States to care for older adults with mental illness. The additional burden for services in the future on an already strained healthcare system can lead to catastrophic failure of the system. International Medical

Graduates (IMGs) constitute almost half of the work force of geriatric psychiatrists. The IMGs have had successful career as clinicians, educators, academics and researchers in geriatric psychiatry. In this symposium I will enumerate the unique challenges faced by the IMGs and strategies on how to enable them to integrate into the mainstream geriatric psychiatry workforce. I will review the roles of IMGs as private practitioners, educators, academicians and as researchers. I will also discuss how organizations like the APA can play a greater role in attracting larger number of IMGs to join the geriatric psychiatry workforce. This will enable greater access to care for the older adults with mental illness.

Internet Gaming Disorder: From Harmless Fun to Dependence

Chair: Anil A. Thomas, M.D.

Presenters: James Sherer, M.D., Rober Aziz, M.D., Elon Richman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Educate the audience on the DSM criteria for Internet Gaming Disorder (IGD) and distinguish IGD from normal, healthy engagement; 2) Review the latest research regarding the natural history, course, and clinical features of IGD; 3) Compare IGD to its co-morbid conditions both diagnostically and neurologically; and 4) Present the latest research regarding evidence based treatments for IGD.

SUMMARY:

When the World Health Organization (WHO) added gaming disorder (GD) to the International Classification of Diseases (ICD-11), both mental health professionals and video game industry insiders found it controversial. Prior to this, there were only a few behaviors seen as problematic enough to earn the moniker of “addiction,” gambling chief amount them. The question was complicated by the fact that, while Internet Gaming Disorder (IGD) is listed in the Diagnostic and Statistic Manual (DSM-5), it is classified as requiring further research. Are video games addictive, like gambling? Does playing video games in excess truly qualify as a disorder? What separates problematic gaming from

healthy engagement? There has been a flurry of research into this area, and the answers are becoming clearer. Furthermore, IGD cuts across age groups and socioeconomic strata. A working knowledge of IGD and possible treatments can benefit any psychiatric provider. To understand IGD, providers should know what makes video games so appealing in the first place. Immersive games provide an opportunity for self-actualization that many desire, from kids to adults (Przybylski et al. 2012). Players have an opportunity to control everything about their in-game appearance, from their gender to their hair style. In fact, gamers often believe that their in-game characters are a more accurate expression of their true selves than what people see in real life (Triberti et al. 2015). The most addictive video games put players into a state of mind called the “flow state,” where their skills are put to the test but they aren’t overly taxed (Michailidis et al. 2018). In this way, video games attenuate difficulty based on the player’s acumen. Players can remain engaged for hours on end, or even days, neglecting sleep and nutrition (Velikovskiy 2014). IGD is remarkably common compared to other behavioral addictions. It is possible that 10% of the Chinese population and 9% of the U.S. population qualify as having video game addiction (Fam 2018). It is uncertain how the COVID-19 epidemic has affected rates of IGD, but if video game sales and social media engagement with games are any measure to go by, there will certainly be an increase. Standard cognitive-behavioral therapy (CBT) and CBT techniques designed to treat internet addiction specifically (CBT-IA), can improve outcomes for those with IGD (TorresRodríguez et al. 2018). Motivational interviewing is also effective for IGD (Kuss and Lopez-Fernandez 2016). Both bupropion and methylphenidate have shown promising results in small studies (Han et al. 2010). Bupropion is the most studied medication for IGD thus far (Han and Renshaw 2012). Other studies show that atomoxetine and even naltrexone may be effective (Park et al. 2016) (Bullock and Potenza 2012). Further research is needed, but early results are promising.

Leveraging Large Neuroimaging Studies to Elucidate Socioeconomic Impacts on Neurocognitive Development

Chair: Gayathri J. Dowling, Ph.D.

Presenters: Nicholas Judd, Marybel Gonzalez, Ph.D.,

Carlos Cardenas-Iniguez, Ph.D.

Discussant: Cynthia Rogers

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand relative contributions of genetics and socioeconomic status on brain development and cognition; 2) Describe biosocial eco-developmental contexts and how they influence neurodevelopment in early adolescence; and 3) Identify environmental exposures and neighborhood-conditions associated with socioeconomic status, and describe associated effects with early-adolescent brain health.

SUMMARY:

The developing brain is particularly vulnerable to genetic and environmental influences. Socioeconomic inequalities, for example, are associated with differences in neurocognition, which could also impact risk for psychopathology. However, socioeconomic status, adversity, environmental exposures, and genetic factors are often confounded, making it difficult to determine the relative contributions of these factors to neurodevelopment. The panelists in this symposium will highlight recent findings from two longitudinal neuroimaging cohort studies (i.e., IMAGEN and the ABCD Study®) that strive to disentangle the unique vs. additive impacts of individual level factors (e.g., genetics, early life adversity), family and community influences (e.g., socioeconomic status, school setting), and environmental exposures (e.g., neighborhood deprivation, air pollution) on cognition, brain structure and function, and risk for psychopathology. These studies are poised to identify protective factors that can inform the development of targeted interventions that could improve neurodevelopmental trajectories.

Living DACA: The Impact of the Emotional Rollercoaster on Youth

Chair: Gabrielle L. Shapiro, M.D.

Presenters: German E. Velez, M.D., Balkozar Seif Eldin Adam, M.D., Rakin Hoq, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand historical changes in the Deferred Action for Childhood Arrivals (DACA) and related policies; 2) Understand the complexity of acculturation for unauthorized immigrants and Identify the most relevant social determinants that affect the mental health of young migrants.; 3) Appraise the individual experiences of youth affected by DACA, its effects on their well-being, and opportunities for the future. With the participation of United We Dream's Undocuhealth team.; 4) Propose mental health interventions at different levels of care that promote the well-being of young migrants and their families; and 5) Provide culturally informed care and use appropriate tools to address the mental health of young migrants..

SUMMARY:

August 15th of this year was the nine-year anniversary of when Deferred Action for Childhood Arrivals (DACA) applications were first accepted by the Department of Homeland Security. "Deferred action" status means the individual is a low priority for immigration enforcement, and the DHS has chosen to exercise its discretion and not to deport the individual.¹ Deferred action provides only temporary relief and may be revoked at any time. Being granted deferred action is not amnesty or immunity. It does not provide lawful immigration status or a path to a green card or citizenship. As of July 16, 2021, Judge Hanen from the U.S. District Court for the Southern District of Texas held that the DACA policy "is illegal." and new applications will no longer be approved.² Our session will orient participants to the complexity of the acculturation process for unauthorized immigrants and introduce participants to available evidence on the stressors associated with migration and its detrimental effect on mental health. Immigrants' legal status has been linked to socioeconomic disparities,³ and unauthorized immigrants are at risk of poor mental health outcomes, reporting symptoms of depression and anxiety.⁴ Studies from both the USA and Europe suggest that immigration policies that raise the risk

of deportation or place limits on legal rights and access to social services might also increase the risk of poor mental health outcomes.^{5,6} Current immigration policies also affect the younger and future generations. It has been documented that DACA decreased children's fear of parental deportation and loss.⁷ However, the suffering of DACA-ineligible parents and family members may stress their children and influence their health-seeking behavior in adulthood.⁸⁻⁹ Although there is evidence of the positive estimated effects of DACA on mental health, this disappeared rapidly after 2016. The effect of such temporary programs can be rapidly undermined by uncertainty about their future. Thus, permanent legalization programs may be more effective at achieving long-term effects.¹⁰ During our session, participants will understand the dynamics of the legal and social determinants of this complex issue through scientific data and the personal experience of affected individuals through pre-recorded interviews. This is a crucial step in setting the basis for future research and policies. Our aim is to support policies that protect the mental well-being of current and future generations of immigrants. The health sector has the important task of creating and sharing objective evidence of the effects of immigration policies on mental health. The analysis and discussion of the data should facilitate critical reflections about past experiences and outline the way forward. Our hope is that this analysis and discussion will be the catalyst for the adoption of culturally sensitive tools that will allow health care to provide fairer and better-quality care for immigrants.

Loneliness Versus Wisdom in the Era of Pandemics

Chair: Samantha Boardman, M.D.

Presenter: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess loneliness and social isolation; 2) Evaluate wisdom and its components including compassion; and 3) Use strategies to increase compassion and reduce loneliness.

SUMMARY:

The COVID-19 pandemic has wreaked havoc with health, longevity, and economy in 2020-21. However, few people are aware of a silent behavioral pandemic of loneliness and social isolation that has led to millions of deaths from physical illnesses and deaths of despair from suicides and opioid use over the last 25 years. Loneliness and social isolation are important social determinants of mental health and are especially common among mentally ill persons and those from racial/ethnic minorities, LGBTQ, and immigrants. Fortunately, recent research presents some good news. Just as the new vaccines are largely winning the war against the coronavirus, there is emerging evidence for a promising behavioral vaccine against loneliness in the form of wisdom. Discussed in religions and philosophies for millennia, wisdom has been a topic of growing empirical research since the 1970s. Wisdom is a complex personality trait with specific components: empathy/compassion, emotional regulation, self-reflection, acceptance of uncertainty, and spirituality. Neuroimaging, neurochemical, neuropathological, and genetic studies, and clinical cases of loss of these components following localized brain injuries and diseases point to neurobiological underpinnings of wisdom. Unlike IQ, components of wisdom tend to increase with age and experience. Neuroplasticity of the brain in active older adults contributes to greater wisdom with aging. Studies in orca, dolphins, and humans support Grandmother Hypothesis of wisdom. Many randomized controlled trials of behavioral interventions have shown increases in emotional regulation, empathy/compassion, and spirituality with moderate to large effect sizes. In near future, neurobiological procedures such as targeted brain stimulation as well as neuro-psycho-tropic agents may be developed to enhance components of wisdom. Our recent research has shown a strong inverse association between loneliness and wisdom, especially its compassion component. Loneliness is associated with worse physical and mental health while the reverse is true for wisdom and compassion. Our recent studies of EEG responses to emotional stimuli as well as alpha and beta diversity in gut microbiome showed opposing biological patterns characterizing loneliness and wisdom. I will present practice guidelines for detecting loneliness

in our patients as well as evidence-based interventions like compassion training and loneliness-targeted cognitive behavioral therapy. Enhancement of components of wisdom at individual and societal levels can help reduce the unprecedented levels of loneliness-related mortality. There is a need for societal level changes such as greater emphasis on compassion and other wisdom components in our education systems from kindergarten through professional schools and businesses. Psychiatry has an opportunity to help transform today's lonely, distressed, depressed, and polarized society into a wiser, happier, and healthier world.

**Mental Health Policy and Legislative Advocacy:
Growing Your Voice**

Chair: Mandar Jadhav, M.D.

Presenters: Laura Willing, M.D., Eric Rafla-Yuan, M.D., Bill Cassidy, M.D., Katherine Gershman Kennedy, M.D.

Discussant: Laura Willing, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn fundamentals of effective legislative advocacy; 2) Identify psychiatrists' unique strengths as mental health policy advocates; and 3) Recognize intricacies of policy development from inception to legislation.

SUMMARY:

In the past few years there have been several positive developments that reduce social stigma toward people with mental illness and those seeking treatment. However, the psychiatric profession and the people we serve continue to face significant challenges in increasing equitable access to care. These have been further compounded by the COVID-19 pandemic. In addition to improving the quality of clinical care that we deliver, psychiatrists can play a pivotal role in improving our patients' lives through getting involved in legislative advocacy. The impact of local, state, and federal policy far exceeds that of clinical excellence at a population health level though initiatives that reduce workforce shortages, increase use of collaborative care model, remove barriers to licensing and telehealth utilization, and

improve payment parity. Nurturing psychiatric trainees' interest in mental health policy advocacy at an early stage can lead to sustained participation in advocacy efforts throughout their careers, and improve the profession for current and future psychiatrist. In this session we therefore focus on facilitating members-in-training introduction to the fundamentals of effective legislative advocacy. We delineate the unique strengths that trainees and practicing psychiatrists bring to the table in advocacy roles. We also acknowledge the multifactorial challenges in policy development and how the seed of a good idea ultimately becomes enshrined in law. The session presents attendees with several unique learning opportunities. Two presenters shall share their perspectives on their experience leading up to being awarded the APA Foundation's Jeanne Spurlock Congressional Fellowship, and during the fellowship term. One presenter shall highlight their continuing leadership in advocacy after completing this fellowship. The discussant shall share insights into their expert role as chair of the APA Council on Advocacy and Government Relations. Furthermore, the session highlight shall be the participation of a Congressional staffer, providing attendees with practical tips on effective advocacy strategies, and noting common hurdles that prevent or delay enactment of legislation.

Military Support for the U.S. Health System During COVID-19: A Framework to Enhance Workforce Well-Being and Sustainment in Future Disasters

Chair: Joshua C. Morganstein, M.D.

Presenters: Olli Toukolehto, Eric G. Meyer, M.D., Ph.D., James Curtis West Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the range of psychological and behavioral responses to disasters and other crisis events that creates extremes of stress; 2) Review activities of the United States active duty military in support of the nation's public mental health during COVID-19; 3) Consider lessons learned during COVID-19 during public-private partnerships involving the military and non-military healthcare systems during the pandemic; and 4) List actions used by the military to protect health and

sustain operations in prolonged, unsafe, high-stress environments adapted for use in non-military work.

SUMMARY:

The COVID-19 pandemic was a global disaster with far-reaching impact on mental health. The scope and duration of the event created unique challenges for workforce and organizational sustainment with most unprepared to protect workforce mental health during a protracted global disaster. Healthcare workers were at particularly high risk, many of whom were required to work extended hours under constant threat of infection to themselves and family members. In addition, healthcare systems were overwhelmed and resources unable to meet demands, requiring a transition to crisis standards of care in which healthcare workers had to make life and death decisions about which patients would receive life-saving interventions. Exposure to these extreme and frequently unprecedented conditions led to a range of responses for healthcare workers, including fear, anger, moral distress, insomnia, substance use, and others. The United States active duty military trains to work within environments that involve high stress and risk to safety for prolonged periods of time and often with limited resources and protects mental health using the principles of Combat and Operational Stress Control (COSC). Early in the pandemic, partnerships emerged in which the military provided support to healthcare systems, embedding within community hospital teams to augment delivery of care as well as to share and adapt COSC principles to enhance sustainment of the civilian healthcare workforce. One of the largest and earliest partnerships occurred in New York City, beginning with military deployment to the Javits Center, which was transformed into a COVID-19 field hospital. The military also provided consultation to New York City's healthcare and first responder leadership, collaboratively developing the HERO-NY resilience program, which incorporates COSC principles to support healthcare workers and responders within the largest public health system in the country. Additional military deployments during the pandemic provided critical resources to augment health systems and dissemination of COSC principles to our nation's healthcare systems. COSC principles can be adapted within healthcare and other work settings to fundamentally enhance worker well-

being and operational sustainment during future disasters and other crisis events. This session will review unique principles of public mental health in disasters, how these inform a military COSC framework, partnerships during the pandemic that enhanced workforce sustainment and public health, adaptation of military principles to support national mental health during COVID-19, and bidirectional lessons learned during these partnerships. Presenters will share robust resources that can be freely used and adapted to enhance workforce well-being and operational sustainment during future disasters, including pandemics, earthquakes, wildfires, mass violence, and others. Presenters will engage the audience through a variety of interactive modalities.

Moving Practice to Measurement Based Care

Chairs: Erik Vanderlip, M.D., M.P.H., Kathryn Ridout, M.D., Ph.D.

Presenters: Kathryn Ridout, M.D., Ph.D., Erik Vanderlip, M.D., M.P.H., Andrew Carlo, M.D., Cecilia Livesey

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the evidence base and value behind MBC in psychiatric care.; 2) Be knowledgeable of implementation tools and strategies for MBC; 3) Be informed of APA resources in place to support implementation of MBC in specialty care; and 4) Be able to apply new and upcoming strategies utilizing MBC.

SUMMARY:

Measurement-based care (MBC) is an evidence-based strategy to improve outcomes in multiple psychiatric disorders and comorbidities, including but not limited to depressive, anxiety, and psychotic disorders. Tenants of MBC include: (1) routine and systematic symptom measurement using evidence-based instruments, (2) timely sharing of results with patients, and (3) the incorporation of outcome measurement into real-time medical decision making. Benefits of MBC include: (1) defining treatment targets and identifying progress, (2) reducing symptom progression, and (3) better patient outcomes (e.g., improvement in symptoms

from medication or psychotherapy, reduction in acute care utilization). In recent years, emerging standards from The Joint Commission and the Utilization Review Accreditation Commission (URAC), as well as payer pressure to tie reimbursement to outcome improvement, have placed increased emphasis on MBC in standard clinical management. Still, data show that less than 20% of specialty mental health providers report integrating MBC into their clinical practice. Perceived barriers to implementation exist at the patient, provider, and system levels. However, recent research provides insights on how to address these barriers and facilitate implementation of MBC. In this session, the presenters will first summarize the evidence supporting MBC in mental health care and provide implementation strategies for various treatment settings. Next, the presenters will describe the ways in which The American Psychiatric Association PsychPRO registry is facilitating MBC implementation, and outline practical strategies for providers to meet key Healthcare Effectiveness Data and Information Set (HEDIS) quality measures. The presenters will then review emerging MBC tools and strategies, including Computerized Adaptive Testing (CAT) and digital health applications. Finally, the presenters will discuss how MBC fits into a larger or system-wide revenue strategy and invite participant dialogue on how MBC can advance mental health practice broadly.

NIDA Clinical Trial Network: Research Updates and Future Directions in the Treatment of Methamphetamine Use Disorder

Chair: Geetha A. Subramaniam, M.D.

Presenters: Madhukar H. Trivedi, M.D., Kathleen T. Brady, M.D., Ph.D., Manish Jha

Discussant: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) demonstrate an increased knowledge of pharmacotherapy options for the management of methamphetamine use disorder; 2) discover the mechanisms and utility of brain stimulation techniques including transcranial magnetic stimulation in the management of me; and 3) articulate the role of glutamatergic dysregulation

in methamphetamine use disorder, and potential therapeutic options to address this problem.

SUMMARY:

Rates of past year methamphetamine continues to rise, and according to a CDC report, 52.9% of the methamphetamine users, met criteria for a methamphetamine use disorder (MUD). There has been a 10-fold increase among Blacks; 3-fold rise among Whites; and a doubling of rates among non-White Hispanics. From 2013 to 2019, age-adjusted overdose death rate involving psychostimulant (mainly illicit methamphetamine) rose by 317% next only to synthetic opioids, further compounding the raging opioid epidemic. More than half of those with MUD are women. However, there is little evidence for effective MUD treatments, and there are no FDA approved medications, to date. In this session, three presenters will summarize research updates on treatments for MUD focusing on pharmacotherapy; brain stimulation, including transcranial stimulation (TMS); and ketamine. Each of these presenters will also share the rationale and outline for clinical trials planned to be conducted by National Institute on Drug Abuse (NIDA's) National Drug Abuse Treatment Clinical Trials Network (CTN). Madhukar Trivedi, MD will review the pharmacology and emerging pharmacotherapy options for MUD, in addition to presenting the results of a recently completed multi-site, placebo controlled RCT conducted in the CTN, the Pharmacotherapy Treatment for Methamphetamine Use Disorder (or ADAPT-2) study, in which the combination of injectable naltrexone and oral bupropion was effective in reducing methamphetamine use. Kathleen Brady, MD will highlight research updates describing the underlying mechanisms of TMS's therapeutic action on neurocircuitry, brain targets and preliminary efficacy data for the management of MUD. Manish Jha, MD will present cover the neuropsychology and the potential utility of N-methyl-D-aspartate (NMDA) glutamatergic receptor antagonist ketamine. Nora Volkow, MD will serve as the discussant. The session will end with a Chair-moderated panel discussion and audience question and answer segment.

Our Women Patients: Clear Lessons for Turbulent Times

Introductions: Catherine C. Crone, M.D., Steven Samuel Sharfstein, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) help women patients negotiate episodes of sexual abuse and discrimination; 2) educate women patients about the scientific evidence for the impact of reproductive health care options; and 3) prepare women to cope with barriers to reproductive health care.

SUMMARY:

Nothing could be a clearer demonstration of the social determinants of health than the effects of CoVid, the MeToo movement, and the increasingly stringent limitations on abortion, on women's mental health. This abstract is being written, by necessity, over 6 months before the lecture will be presented; of necessity, relevant factors will change. The lecture itself will reflect the status of the issues in May 2022. The CoVid pandemic has wreaked havoc all over the world, but there has been a differential impact on women. Women have been more likely to stop or cut back on their jobs; women in medical academia published fewer papers; their male partners did not. Women assumed most responsibility for the education of children in chaotic and unpredictable school situations. The MeToo movement, which addresses hitherto suppressed revelations about the sexual abuse of and discrimination against women, raises ongoing concerns. Apart from the unmasking, firing, and prosecution of a number of prominent men, has the movement really changed the workplace and home reality for the average woman/female psychiatric patient? What are the effects of the backlash against MeToo? Does MeToo exacerbate the perceptions and experiences of women as victims? The increasing attempts to outlaw abortion place every woman of childbearing potential, and her family, at risk of unwanted pregnancy, interrupted education and/or job, decreased energy and time for existing children, and poverty, not to mention the dangers of illicit abortions. Though there is compelling evidence

of abortion's psychological and physical safety, misinformation about its effects is promulgated, believed, and used as a basis for restrictive legislation. At least one quarter of the women in the United States have abortions; many others are affected by the unwanted pregnancies of their loved ones; our patients are among both. As psychiatrists, we can explore the disparity between the pro-choice majority of Americans and our election of anti-choice legislators. The frequent exceptions for incest and rape reveal that continuing an unwanted pregnancy is a generally, if unconsciously, considered just punishment for women who voluntarily engage in sexual intercourse and become pregnant. As psychiatrists, we are somewhat prepared to help the woman overburdened by the demands of CoVid. We also need to help the woman suffering sexual exploitation or workplace discrimination weigh the risks and benefits of coming forward, changing jobs, or coping in place. We can provide accurate information, and the opportunity to work through abortion decisions both past and present. All of these challenges are greatly magnified for women of color, immigrants, and other marginalized groups. For purposes of this lecture, women in the world includes all people presenting as women in society; with respect to pregnancy-related issues, women are those with female genitalia.

Outside the Box: Using Your Degree to Influence Beyond the Field

Chair: Nina Vasan, M.D., M.B.A.

Presenters: Jessica A. Gold, M.D., M.S., Amir K. Ahuja, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the impact potential physicians pursuing nontraditional career paths can have on the social determinants of mental health across industries.; 2) Identify ways to pursue nontraditional paths and expand the mental health conversation beyond the field of psychiatry.; and 3) Understand the importance of collaborating across industries and specialties to make transformative change in our mental health care system..

SUMMARY:

After many years of education and training, most clinicians are laser focused on jumping into direct service — setting up a practice, onboarding at a hospital, or even teaching at an academic institution. But what about using your training as a clinician to make an impact outside of the field of psychiatry? The many social determinants of mental health tell us that the need across society has never been more urgent. It is necessary to learn how to evaluate opportunities and apply our training outside the field to support the treatment and understanding of mental health. Drawing on their experiences as licensed psychiatrists, the speakers in this session will discuss how they integrated their training into alternative career paths as a Chief Medical Officer at a mental health care company, Director of Psychiatry at an LGBT Center, and a nationally renowned freelance writer and TV commentator shaping the stories media is writing and contributing to outlets including Forbes, Glamour, Newsweek, and Time.

Palliative Psychiatry: A New Field for Treatment-Resistant Mental Illness

Chair: Manuel Trachsel, M.D., Ph.D.

Presenters: June Elgudin, M.D., Manuel Trachsel, M.D., Ph.D., Clark Johnsen

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define “palliative psychiatry” and its application to patients with severe and persistent mental illness.; 2) Discuss the challenges and limitations of applying the concept of medical futility to psychiatric patients.; 3) Identify barriers and ethical issues surrounding potential treatment of psychiatric patients with a palliative care framework.; and 4) Recognize other psychiatric disorders, in addition to schizophrenia as presented in the case, that would benefit from consideration of palliative approaches..

SUMMARY:

“Palliative psychiatry” is an emerging and poorly understood field that describes the potential role of palliative interventions in the management of treatment-refractory mental illness. In contrast to terminal medical illnesses, there are no current

guidelines for improving the quality of life for psychiatric patients with severe and persistent mental illness (SPMI) who suffer from deteriorating psychiatric conditions after all known treatments fail. Most psychiatrists will treat patients with SPMI that do not respond adequately to the current evidence-based interventions, and further futile treatments are commonly pursued due to lack of knowledge, experience or comfort with palliative approaches in psychiatry. During this session we will present the case of a 49-year-old Black man with schizophrenia and severe chronic agitated/malignant catatonia who was hospitalized on the inpatient psychiatric unit for ten months and who intermittently required intubation and sedation to control intractable behavioral and psychiatric disturbances. Ultimately with collaboration with neurology, ethics, intensive care and palliative care teams, the patient’s parents decided to forgo further diagnostic testing and life-sustaining treatments. The patient died of aspiration pneumonia weeks later. This case permits a framework for considering and discussing palliative interventions in patients with SPMI. Our session will include a thorough review of palliative psychiatry and discuss psychiatric conditions that represent potential indications. We will facilitate understanding regarding the concept of futility and difficulties inherent in consensus building on this topic within the psychiatric community. We will review survey data regarding physician attitudes toward this challenging topic and review barriers to improving awareness and understanding. We will present differences between palliative psychiatry and physician-assisted suicide and discuss ethical considerations. Finally, we will provide a framework for discussion with patients, families, and other medical providers to facilitate communication in cases where this approach may improve the quality of life of patients with SPMI.

Parental Alienation and DSM-5: The Rubber Hits the Road

Chair: William Bernet, M.D.

Presenters: Amy J. L. Baker, Ph.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • State the components of the Five-Factor Model for the diagnosis of parental alienation.; 2) • Explain why child psychiatrists should be able to identify parental alienation when they see it, since this condition damages thousands of children and families in the U.S.; 3) • Explain research that demonstrates a consensus among mental health practitioners regarding definitions and terminology related to parental alienation theory.; 4) • Explain research that demonstrates there are questionnaires and psychological tests that discriminate between parental alienation and other causes of contact refusal.; and 5) • Identify the evidence that would be needed for the addition of parental alienation to the DSM..

SUMMARY:

Although many psychiatrists—both clinicians and forensic practitioners—are likely to encounter cases of parental alienation, they may fail to recognize this serious mental condition that affects thousands of children and families in the U.S. This session is intended to (1) provide a general introduction and overview of parental alienation and (2) consider whether there is enough substantive research regarding parental alienation for it to be included in DSM-5. The first presenter (Bernet) will explain the features of parental alienation and will describe how it appears in both clinical and forensic contexts. He will explain the Five-Factor Model for the identification of parental alienation and will summarize the research that shows it is possible to distinguish in a systematic manner parental alienation from other causes of contact refusal. The five factors are: the child's contact resistance or refusal; a prior positive relationship between the child and the now rejected parent; the absence of abuse, neglect, or seriously deficient parenting on the part of the rejected parent; the use of multiple alienating behaviors on the part of the favored parent; and the child's manifesting the behavioral signs of alienation. He will also address the forensic considerations if parental alienation is added to DSM-5. The second presenter (Baker) will describe and summarize several research projects that polled psychologists, psychiatrists, and other mental health professionals regarding their understanding of

parental alienation. The concept of parental alienation is almost 40 years old, so a consensus has evolved regarding definitions and terminology for the most important features of parental alienation theory. There is a large amount of qualitative, descriptive research regarding parental alienation, and more limited quantitative research. The second presenter will summarize research that led to the widely recognized list of 17 common alienating behaviors and research that supports the 8 traditional signs of parental alienation manifested by alienated children. The third presenter (Appelbaum) will discuss what would be needed for parental alienation to be included as a mental disorder (the term for traditional psychiatric diagnoses) or a condition that is not a disorder but may be the focus of clinical attention (which includes relational problems) in the DSM. He will also explain the criteria and the process for adding a mental disorder or a relational problem to DSM-5 and will comment on the current state of research regarding parental alienation vis-à-vis the criteria. Some participants at this session may consider this a controversial topic; there will be plenty of opportunity for their comments and questions.

Pathways to Psychiatry: Pipeline Programs

Chairs: Alicia A. Barnes, D.O., M.P.H., Ellen Joo Kim, M.D.

Presenters: Desiree Nicolette Shapiro, M.D., Cecilia Maya Rangel-Garcia, M.D., Carolyn M. King, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate the importance of early outreach and partnerships to address the shortage of psychiatrists and increase representation in our psychiatry workforce; 2) Learn about adaptations of medical school and resident curricula for high school students to engage them in psychiatry; 3) Define the key elements and stakeholders to build a sustainable psychiatry pipeline program in one's region; and 4) Develop a roadmap for building a psychiatry pipeline program at participants' institutions.

SUMMARY:

The mental health crisis our society is facing must be met with greater access to quality care that is culturally and linguistically appropriate. It is essential to direct our resources towards nourishing a pipeline that can meet the needs of our communities. While national pipeline programs such as the Summer Health Professions Education Program (SHPEP) have proven to be essential in increasing minority representation in medicine, they lack a robust psychiatry curriculum. Additionally, psychiatry is unique from other medical fields in that it is mired in stigma and misconceptions, leading to a shortage of psychiatrists in general. We would collectively benefit if elementary to high school students are exposed to developmentally appropriate lessons on emotional well-being and mental health careers. This session will review the relevance and benefit of pipeline programs in growing a psychiatry workforce. In addition to general information, the session will highlight pipeline examples targeting underrepresented minorities including 1) a novel high school program created to advance the (URMs) in psychiatry and destigmatize mental health, 2) an established and successful program, Reach out to Youth, that increases exposure to healthcare careers led by a CAP, and 3) a school mental health literacy outreach experience led by medical students designed to increase exposure to and interest in CAP. The experiences of these program leaders have the potential to generate discussions and solutions. During our session, there will be small group breakout rooms in which participants will be tasked with building a model of a psychiatry pipeline program for their institutions. Additionally, participants will learn about resources (various teaching modalities such as gamification, think-pair-share etc.) Session leaders aim to inspire audience members to act on their ideas during and after the session.

Physician Roles, Cannabis Policies, Telemedicine Access and More: Advancing Our Profession, and Serving Our Patients in a Time of Political Turmoil

Chair: Craig Obey, J.D.

Presenters: Eric R. Williams, M.D., Jasleen Chhatwal, M.D., M.B.B.S., John J. Wernert III, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Increase knowledge about legislative measures at the federal/state levels that can impact the practice of psychiatry and patient access/safety; 2) Enhance understanding of the role of APAPAC in APA's advocacy; 3) Enhance understanding for how APA members benefit from, affect, and can participate in APA's federal advocacy; 4) Enhance understanding for how APA members can engage with District Branches in advocacy, and how those DBs benefit from APA's state government relations program; and 5) Expand knowledge about the various tools, platforms and forms of customized assistance from APA staff they may utilize to become effective advocates.

SUMMARY:

If you're not in the room where it happens, you're on the menu. The stakes for psychiatry and our patients in current debates in state houses and Congress are high. When it comes to issues like the role of our profession, the safety of our patients, mental health equity, reimbursement practices, cannabis and psilocybin promotion, suicide prevention, crisis response, involuntary commitment, and others, it is imperative that the voice of psychiatry—and individual psychiatrists—be heard. Participants in this session will learn about how hot policy debates at the state and federal levels could impact our profession and our patients, and what we each can do to make a difference. APA members who are active in many of these efforts will share their insights and guide you toward advocacy opportunities that we hope you will find energizing, fulfilling, and even essential for your practice and your patients.

PRESENTER UPDATE: Craig Obey, J.D., will replace Katherine Gershman Kennedy, M.D.

Providing Supportive Therapy in Primary Care Settings

Chair: Randon Scott Welton, M.D.

Presenters: Erin M. Crocker, M.D., Claire McKinley, M.D., M.Sc., Holly Van Den Beldt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the benefits of Supportive Therapy in mental and medical illness; 2) Review the basic attitudes and priorities of a Supportive Therapist in a primary care setting; 3) Demonstrate Supportive Therapy approaches and techniques for use in patients with medical conditions; and 4) Train medical students, residents, and other clinicians to provide Supportive Therapy interventions.

SUMMARY:

Supportive Therapy has long been called the Cinderella of Therapies within psychiatry; optimizing patient's psychological functioning but receiving little of the attention and praise that other forms of psychotherapy receive. As unappreciated as it is in psychiatry, its potential value in primary care is hardly ever recognized or utilized. Considerable evidence supports Supportive Therapy's efficacy in minimizing distress and enhancing functioning in a wide variety of mental illnesses and medical conditions. Most primary care providers, however, have no more than an intuitive sense of its approaches and principles. This session will highlight the practicality and value of Supportive Therapy on medical/surgical units and outpatient primary care clinics. We will start with a review of the basic principles and literature support for Supportive Therapy and present five basic attitudes and priorities of a Supportive Therapist - including 1) Focusing on the Therapeutic Alliance, 2) Nonjudgmental Acceptance, 3) Empathy, 4) Demonstrating Respect, and 5) Active Listening. We will present an easy to remember, yet powerful mnemonic for understanding and organizing Supportive Therapy technique using the acronym HOPE – H – Hear and understand the patient's emotions; O – Organize their narrative; P – Promote adaptive functioning, E – Effect change in stressors and social support. The HOPE model can assist providers in developing a comprehensive treatment strategy for medically ill patients. It is a means of adding the "psychosocial" back into biopsychosocial treatment. We will discuss each category and demonstrate specific interventions within the category. Once the basics of the approach have been discussed and demonstrated, we will turn to

vignettes to help attendees solidify their understanding of the concepts. The vignettes will be written and video recorded with a wide variety of medical illnesses. Attendees will be asked to develop practical strategies to address the psychosocial needs of these medical patients and then compare their strategies with the strategies devised by other attendees. The goal is to highlight that an individual patient may present with numerous valid foci for Supportive Therapy. Attendees will be encouraged to teach this approach to medical students, residents and other providers. To assist with this future training, we will distribute the "AADPRT Supportive Therapy Rating Scale – Attitudes/Interactions" form which was created by the American Association of Directors of Psychiatry Residency Training's Psychotherapy Committee. This instrument lists the five basic approaches and priorities of Supportive Therapy and gives anchor points for rating provider performance. It can be used to improve self-assessment and/or feedback to learners. This form along with the HOPE Model provides an accessible means of teaching and promoting Supportive Therapy in primary care settings.

Psychedelics in Psychiatry: Past, Present, and Pressing Issues

Chair: David B. Yaden, Ph.D.

Presenters: Mary E. Yaden, M.D., M.S., Roland R. Griffiths, Ph.D.

Discussant: James B. Potash, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the history of the re-start of clinical trials with psychedelics in the past decade at institutions such as Johns Hopkins; 2) Review the current state of the evidence for psychedelics in mood and substance use disorders; 3) Identify clinical challenges and opportunities with potential psychedelic treatments; 4) Identify methodological issues in past and on-going psychedelic research; and 5) Provide guidance on sensible and evidence-based science communication regarding psychedelics.

SUMMARY:

After a decades-long pause, psychedelics are being tested as potential treatments for mood and substance use disorders. We will provide a brief review of the major findings from clinical psilocybin trials from the past two decades at Johns Hopkins and elsewhere. Taken together, recent and on-going clinical trials provide promising results. Such findings, however, must still be considered preliminary. Enthusiasm regarding the prospect of psychedelic treatments has, in many cases, gone beyond the available evidence. In this session, we will describe the recent past and present of psychedelic research and then then identify several pressing issues in the field: 1) clinical challenges, 2) research challenges, and 3) challenges in public science communication. Clinically, we will describe the safety guidelines and procedures currently in place for psilocybin studies conducted at Johns Hopkins. We will comment on various proposals for altering aspects of these procedures to expand access to psilocybin treatments. Additionally, an eclectic mix of psychotherapeutic approaches are currently being paired with psilocybin treatments in research contexts. We offer some comments in support of concepts from evidence-based therapies such as Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT), which have been historically less common in psilocybin research contexts. Research methods in psilocybin trials have been steadily improving, but challenges remain. Psychedelic studies are difficult to adequately control, due to issues with blinding. Extra-pharmacological factors such as expectations play a heightened role in psychedelic trials. Additionally, valid concerns about safety have resulted in strict exclusion criteria for previous and on-going psychedelic trials, but more heterogeneous samples must be included in future trials to improve generalizability. We provide several examples of recent improvements in the rigor of clinical trials on psilocybin and suggest ways forward. Public science communication about psychedelics has historically tended to be either overly alarmist or overly enthusiastic. We advocate for acknowledging the limitations of the available evidence as well as the inevitable risks and contraindications in clinical contexts. We believe it is incumbent upon

researchers and clinicians to provide scientifically grounded and clinically sensible public messaging about psychedelic treatments, so as to temper a growing trend towards unrealistic expectations. We conclude by underscoring the myriad ways in which psilocybin research and clinical practice can be mismanaged in the coming years—while voicing a cautious optimism about the near-future of psilocybin research and potential treatments in psychiatry.

Psychedelics: Therapeutic Mechanisms

Introduction: Catherine C. Crone, M.D.

Presenter: Robin Carhart-Harris, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain pharmacology of psychedelics; 2) Explain system level effects of psychedelics; and 3) Explain latest clinical research findings on safety and efficacy of psychedelics.

SUMMARY:

The talk takes a multi-level approach to the question of how psychedelics work in the brain. Key themes include: the pharmacology of classic serotonergic psychedelics, what this tells us about the function and evolutionary purpose of the serotonin 2A receptor, the acute brain effects of psychedelics as determined by functional brain imaging, the entropic brain hypothesis, current evidence for psychedelic therapy, the new 'REBUS' hierarchical predictive processing model of the action of psychedelics, and how this maps on to the phenomenology of the acute psychedelic experience and therapeutic outcomes.

Psychiatrists With Lived Experience: Change Agents and Beloved Allies

Chair: Michael F. Myers, M.D.

Presenters: Rahael Gupta, M.D., M.S., Frank Clark, M.D., John Mark Budin, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define what is meant by 'lived experience'; 2) Describe the barriers to self-disclosure in psychiatrists.; 3) Discuss the

authenticity that is attached to ‘coming out’ in psychiatrists.; and 4) Itemize the ways in which all of us in psychiatry can support our lived experience colleagues (who may be us tomorrow), in a healthy and collegial manner..

SUMMARY:

Individuals with lived experience have become our much-lauded and essential allies in explaining mental illness and dismantling stigma worldwide. This movement is gaining traction in the house of medicine as increasing numbers of medical students and physicians are telling their stories, writing narratives, or giving oral histories to interviewers. This includes a few psychiatrists, but the numbers remain small. Too many psychiatrists with lived experience remain silent, anxious, defeated, ashamed, in the shadows, and alone. Even those who speak openly experience avoidance by psychiatrist colleagues. What else can we do as psychiatrists to help ourselves with self-compassion and our colleagues with transparency? What are the personal, familial, interpersonal, ethnocultural, and systemic forces that are impeding this process? In this session, Rahael Gupta, MD and PGY 2 resident in psychiatry at UCLA, will share a short film she produced, the intent of which is to inspire empathy and awareness about depression among physician trainees. She will talk about her experience of battling severe depression while in medical school, as well as barriers to self-disclosure faced by students and physician trainees. Frank Clark, MD, and early-career adult psychiatrist will share his struggles as a Black male battling depression in medical school. He will discuss how writing poetry has become his cathartic antidote that he enjoys sharing with a diverse audience, in addition to his advocacy work with both the APA and AMA. John Budin, MD, and semi-retired psychiatrist will examine navigating professional and institutional barriers as he contemplated publicly sharing his bipolar diagnosis. He will also share his experiences initiating an online support group for physicians with lived experience and his rationale for making a documentary film about his professional journey. Michael Myers, MD, a specialist in physician health, will introduce the notion of caste in our medical culture and give examples of physicians being “kept down” or “kept out” as a result of their openness

about their lived experience. He will explain its perniciousness and suggest ways in which all of us can come together and fight this scourge. This will be a highly interactive session with more than one-third of the time preserved for discussion and Q & A.

Real World Solutions to Implementing and Sustaining the Collaborative Care Model

Chair: Anna Ratzliff, M.D., Ph.D.

Presenters: William Beecroft, Brandon Kitay, M.D., Ph.D., Jennifer Thomas

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what is CoCM and its evidence-base; 2) Understand how to engage PCPs as partners in integrated care; 3) Understand how to overcome barriers to implementing and sustaining CoCM; 4) Understand how to finance the collaborative care model; and 5) Understand how to encourage system leadership to implement CoCM.

SUMMARY:

As the rate of mental health and substance use disorders increase more and more individuals are seeking care from their primary care physician. Primary care physicians often feel overwhelmed and unprepared to care for these patients and often cannot refer to psychiatrist for specialty care. This has resulted in many practices beginning to learn about the collaborative care model – the only evidence-based model for improving patient outcomes in primary care. You will hear how psychiatrists can help their primary care colleagues with the care of these patients – in as little as a few hours a week, how primary care practices have overcome some of the parries of implementation, how payors are stepping in to assist with training and technical assistance, as well as how large systems are seeing not only the improvement patient outcomes but the financial costs of providing care through this model.

Recovery in Psychiatry: A Challenge for Social Reintegration—From the World Association of Social Psychiatry (WASP)

Chair: Eliot Sorel, M.D.

Presenters: Andrew Molodynski, Vincenzo F. Di Nicola, M.D., Rakesh Kumar Chadda, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the essential components of recovery in mental disorders; 2) Identify the challenges in recovery in schizophrenia and related disorders; 3) Identify the challenges in recovery from exposure to trauma; and 4) Identify the challenges in recovery in substance use disorders.

SUMMARY:

Introduction of antipsychotics in 1950s revolutionized the treatment of severe mental illnesses (SMIs), especially schizophrenia, and was accompanied by discharge of large number of patients to the community. The discharged patients had limited social skills and were often not able to get an employment. Thus, deinstitutionalization was associated with increasing unemployment, homelessness, and incarceration of many such people into prisons. This led to the introduction of the concept of recovery in psychiatry since symptomatic improvement was not enough for integrating an improved patient with mental illness into society. Recovery remains a serious challenge in psychiatry across a range of disorders including SMIs, substance use disorders and trauma related mental health problems. In a working definition of recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) 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. SAMHSA identifies four domains which may need to be targeted including health, home, purpose, and the community. Taking care of mental and physical health, safe places to reside, and meaningful daily activities, including employment and social networks and relationships, contribute to recovery. The medical model, i.e., treating the mental disorder per se is not enough, and once the target symptoms get controlled, there is a need to recover lost abilities and functions, and to help the person to deal with residual symptoms, reintegrate socially, and live purposefully. The process may vary across different

disorders and an individualized management plan would need to be made depending on the person's assets, disabilities, and nature of illness. This session will focus on challenges faced in managing recovery in schizophrenia, trauma related mental health problems, and substance use disorders.

Roadmap to the Ideal Crisis System: What Every Psychiatrist Needs to Know

Chair: Kenneth Minkoff, M.D.

Presenters: Margaret E. Balfour, M.D., Ph.D., Joseph John Parks, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the difference between a behavioral health crisis; 2) Identify three major trends that have led to a new vision for crisis systems in every community; 3) Understand the interactions between an Accountable Entity, a continuum of crisis capacities, and clinical best practice in an ideal system; and 4) Recognize how psychiatrists can make important contributions to crisis systems, both as clinical leaders and advocates.

SUMMARY:

Behavioral health crisis services in the US are significantly underdeveloped, especially in comparison to other safety net services like EMS, fire, and police. In many parts of the US, first response to BH crisis may only be available through law enforcement, leading to inappropriate incarceration for people with clinical needs, particularly those experiencing social determinant challenges (e.g. homelessness). Fortunately, we are now on the cusp of a dramatic change, akin to the development of the 911 system decades ago. New legislation has mandated implementation of a national 988 BH crisis number by 2022, and new funding has been allocated for planning and implementation. 988 implementation creates both a driver and an opportunity for re-envisioning the BH Crisis System, and daring to conceptualize and implement an Ideal Crisis System rather than hoping for a barely adequate one. This transformation of crisis services will affect psychiatrists at all levels, as well as providing opportunity for psychiatrists to participate in making these efforts successful. This

workshop is designed to provide the specifics that psychiatrists need to know to be effective partners in change. The first part of this presentation describes a new (2021) report prepared by the Group for the Advancement of Psychiatry (GAP) and published by the National Council, entitled: Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards, and Best Practices. This report creates a new vision of BH crisis systems as an “essential community safety net service” (just like police and EMS) and describes how any community can make progress in developing its system. It recognizes three major building blocks: Accountable Entity for each local system, coordinating multiple funding sources and monitoring performance; Continuum of Components and Capacities, including clinical/medical leadership throughout, and Best Practices for crisis intervention for diverse populations. It includes guides for communities to make progress (Ten Steps, Report Card), and will describe how psychiatrists can participate in local development. The second part provides a real world example of how progress to an Ideal Crisis System has occurred in Arizona, and specifically in Pima County (Tucson). This includes description of not only the Crisis Resource Center, but the way in which the state, local managed care entities, counties, and providers have partnered to create an effective system. The third part describes how the National Council is on the cutting edge of advocacy for Ideal Crisis Systems, including advocating for CCBHCs, other innovative funding strategies, supporting local implementation, and providing materials to reinforce psychiatric leadership roles through the National Council Medical Director’s Institute. Participants will be engaged in discussion to help answer questions about how to best make progress in their own organizations, communities, and state systems.

SAMHSA’s Efforts to Close the Treatment Gap for People With Co-Occurring Substance Use Disorders and Mental Illness

Introduction: John Luo, M.D.

Chair: Miriam E. Delphin-Rittmon, Ph.D.

Presenter: Yngvild Olsen, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the data characterizing co-occurring disorders and treatment gaps; 2) Explain the basic functions of Certified Community Behavioral Health Centers (CCBHCs) designed to bridge treatment gaps for people with SUD and mental illness; and 3) Discuss other SAMHSA policies and programs to address the SUD and mental health treatment gaps.

SUMMARY:

An estimated 6.7% of adults aged 18 or older in 2020 (or 17.0 million people) had any mental illness (AMI) co-occurring with Substance Use Disorder (SUD), and 2.2% (or 5.7 million people) had co-occurring serious mental illness (SMI) and SUD in the past year. About half of adults aged 18 or older in 2020 with a co-occurring SUD and AMI in the past year received either substance use treatment at a specialty facility or mental health services in the past year (50.5%), but only 5.7% received both services. Only 9.3% received both services if they had co-occurring SMI and SUD. The dearth of services for co-occurring disorders is evident and results in poorly managed conditions leading to high morbidity and mortality, over reliance on emergency services, and escalating health care costs. 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93) authorizes demonstration programs in up to eight states to improve community behavioral health services by establishing and evaluating certified community behavioral health clinics (CCBHCs). CCBHCs bring a comprehensive range of services together, incorporating evidence-based practices and other supports based on a community needs assessment. They provide a minimum standard for access to mental health/SUD services, including increased capacity to respond to mental health and SUD crises. The COVID-19 pandemic also ushered in flexibilities for people with SUD and AMI to access and maintain evidence-based care. This included the expansion of telehealth platforms and best practices as outlined in SAMHSA’s Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders (2021), through extended methadone take-home flexibilities for Opioid Treatment Programs (OTPs), and the release in April 2021 of the Health and Human Services (HHS) Buprenorphine

Practice Guideline. All of these efforts have dramatically changed the treatment landscape in historic ways with lessons learned and considerations for permanent change.

Seeking Value: Balancing Cost and Quality in Psychiatric Care

Chair: Wesley Eugene Sowers, M.D.

Presenter: Sosunmolu Shoyinka, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the concept of value in psychiatric care; 2) Discuss the historical forces that have shaped US health care systems; 3) Identify strategies that can be employed to enhance value; and 4) Implement practices and policies that will achieve greater value in psychiatric care.

SUMMARY:

The US health care system is the most expensive in the world by a considerable margin, yet health indicators are among the worst in the developed world. This book examines the factors that have contributed to this disparity and offers a holistic vision for health care reform, one in which the psychiatric profession plays a critical role. Value is the product of Quality/Cost. In healthcare, systems that deliver high quality outcomes at a low cost would be considered to have high value. Thus, the definitions of both value and quality have a great impact on the perceived value of the services provided. Additionally, different stakeholders may define value and quality quite differently, depending on how they interact with the healthcare system. Overall, however, data indicates that the US healthcare system delivers very low value when considered from a population health perspective. This session will examine the roots of the conflicts that have shaped our current systems. The major emphasis of the session will be on strategies that could improve the value of the services if we were determined to do so. While some of these strategies are specifically targeted to emotional health issues and psychiatry, many encompass the entirety of health care systems. Each strategy discussed has implications for the overall health and wellbeing of the community at large. Overall systems changes

leading to higher value include better methods of financing care that reduce administrative waste, provide incentives for prevention and primary care and enhance integration of services. Additionally, these methods would incentivize efficient use of health records and of other new technologies. They would promote diversification and enhancement of the workforce. Proposed changes within the psychiatric professions include expansion of the role of psychiatrists and allied psychiatric care providers, changes in prescribing and diagnostic processes, and the evolution of training curricula to emphasize recovery-oriented care, health maintenance, leadership and advocacy. In addition to these changes, it will be critical to consider social and policy changes which have significant impact on the well-being of communities. These include harm reduction interventions related to substance use, mitigation of the effects of climate change, reduction in the rate of incarceration and the discriminatory practices that permeate penal systems, creating healthier workplaces, and adopting more compassionate approaches to end-of-life care. The session will conclude by outlining various approaches to health care reform and a practical vision for implementing many of the strategies considered earlier in the discussion. Participants will be encouraged to share their reactions to these proposals and offer their own views on the evolution to a high value system for maintaining the overall health of communities and the value of the services we provide for emotional health care.

Shared Decision-Making in Child Psychiatry and Beyond: A Close Look at the Practice, Evidence, and Tools

Chair: Erin R. Barnett, Ph.D.

Presenters: Jennifer Lyn McLaren, M.D., Milangel Concepcion Zayas

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe what shared decision-making is and is not; 2) Identify the evidence-base and limits to the evidence for the use of shared decision-making and decision aids in child psychiatry; 3) Recognize provider, youth/parent, and system

level challenges to making shared decisions with children and families; 4) Demonstrate use of an Option Grid decision aid during a clinical encounter; and 5) Choose two clinical behaviors aligned with shared decision-making to try with patients.

SUMMARY:

Shared decision-making (SDM) is a model of patient-centered care that encourages people to play an active role in decisions that directly affect their bodies and brains. Psychiatry practice guidelines universally recommend SDM, which may be most important for patients experiencing poverty, racial minority status, and other inequities that further tip the balance of power. Although the evidence-base is growing, there are gaps, and training and tools are far and few between. SDM is also hard to do and clinicians are not sure how to do it. In this session, psychiatrists and psychologists with expertise in children's mental health, psychiatric care, and SDM will describe and define what SDM is and is not, review practice guidelines, and describe the evidence-base underlying SDM. Based on their own research and others, and with input from participants, the presenters will acknowledge the multitude of challenges associated with SDM at a provider, patient/family, and system level. The presenters will highlight why SDM is particularly important for patients experiencing unequal social and economic circumstances. They will also discuss various levers to help the process of SDM. The presenters will showcase one specific tool in detail, an option grid decision aid for children's psychiatric care. The option grid is a 1-page display of evidence-based answers to parents' most frequently asked questions specific to various treatment options (classes of medications, therapy), side by side, for children's common mental health problems. The option grid has been pilot-tested and published, and the presenters will review those findings. The presenters will also review other shared decision making tools for children, adolescent and adults. The presenters will facilitate a whole-group discussion on clinical barriers and facilitators of the SDM process, a small group role-play exercise on introducing the concept of SDM and tools to patients, and a final question and answer segment. The presenters will motivate and

encourage participants to identify two specific behavior changes for their practice that align with SDM principles and practices.

Structural Racism: Biopsychosocial Consequences

Introduction: Danielle Hairston, M.D.

Presenter: William Bradford Lawson, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the role of systematic racism in providing a historical perspective of persistent racial discrimination; 2) Explain why issues such as racial misdiagnosis persist; and 3) Understand why prescribing practices show racial disparities despite the ethnopharmacological literature.

SUMMARY:

There has been an increasing recognition that racism is not simply having negative or hateful attitudes toward people of color. Rather it is embedded historically and cultural in America and broadly impact individuals individually and collectively. It helps to explain diagnostic issues such as overdiagnosis of sociopathy and schizophrenia, failure to appreciate mood disorders and anxiety, and lack of attention to consequences such as suicide and excessive institutionalization and incarceration. Institutional racism will be discussed in terms of its effects through determining perceptual beliefs, cultural consequences, and resistance to behavioral change. These findings provide an opportunity for psychiatry to play a major role in addressing national problems by helping to explain seemingly self destructive behavior and to provide a path for effective advocacy.

Teaching Physician Advocacy to Advance Health Equity: Advocacy Training in Residency and Fellowship Programs

Chair: Enrico Castillo, M.D.

Presenters: Katherine Gershman Kennedy, M.D.,

Laura Willing, M.D., Colin Buzza, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least 2 educational

strategies for increasing psychiatry trainees' awareness of social and structural inequities in their communities; 2) Identify at least 3 educational strategies that prepare psychiatry trainees to be effective advocates for policies to reduce social and structural inequities; and 3) Identify at least 2 strategies for the development of partnerships between residency and fellowship training programs and policymakers.

SUMMARY:

Psychiatry residents and fellows are poised to be effective advocates for political change. Their status as physicians and their first-hand experiences, witnessing health inequities and inequities in the social and structural determinants of health, position them to be important advocates to legislators and other policy leaders. In this time of rapid social and political flux, advocacy has the potential to enhance residents' and fellows' sense of self-efficacy and strengthen their belief in their ability to be successful at effecting change. Studies have shown associations between increased self-efficacy and greater job satisfaction and decreased burnout. Opportunities within psychiatric education for political advocacy can help trainees translate their growing medical expertise into social and policy action, preparing them for careers as physician leaders. While advocacy can be focused on a range of topics, this workshop will focus on physician advocacy in anti-racism and health equity for the benefit of diverse, under-resourced communities. This workshop will highlight the growing activities of 3 psychiatry residency programs and a child and adolescent psychiatry fellowship program that train and involve residents and fellows in direct political action. Each program uses different modalities to involve trainees in advocacy. Drs. Castillo from UCLA will describe a didactics module and seminar series that trains residents how to develop community partnerships together with a range of advocacy skills, from legislative to media advocacy. Dr. Kennedy from Yale will describe their residency program's advocacy curriculum within Yale's Social Justice and Health Equity Curriculum. Dr. Kennedy's curriculum trains residents in key advocacy skills, including how to collaborate with state legislators, identify useful clinical and research data for use in advocacy initiatives, present oral and written

testimonies, and write for lay audiences. Dr. Buzza from UCSF will describe their efforts, together with their residents, to partner with state legislators on a bill to promote careers in public and community psychiatry. Dr. Willing from Children's National Hospital will describe their 2-year advocacy curriculum for child and adolescent psychiatry fellows. The interactive group exercise will use the example of media (op-eds) advocacy to help attendees formulate their personal advocacy focus and educational goals for their training programs or other settings. Group discussion will focus on engaging audience members in strategies to encourage mental health policy action in their programs and institutions.

The Ascendance of the Glutamatergic Synapse in the Pathophysiology of Schizophrenia

Presenter: Joseph Thomas Coyle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the three neurotransmitters systems implicated in the pathophysiology of schizophrenia (Glutamate, GABA, Dopamine); 2) Understand the unique role of the NMDA subtype of the glutamate receptor in brain function (Mediator of synaptic plasticity); and 3) Enumerate the evidence implicating NMDA receptor hypofunction in the pathophysiology of schizophrenia.

SUMMARY:

For over forty years, the dopamine hypothesis has dominated our understanding of the pathophysiology of schizophrenia. The hypothesis is based on the finding that antipsychotic medications exert their therapeutic effects by reducing the activity of dopamine D2 receptors. However, most patients with schizophrenia treated with antipsychotics remain persistently disabled because of the inability of antipsychotics to affect the negative symptoms and cognitive impairments, the most disabling components of the disorder. Furthermore, the neuropathology of schizophrenia with the pyramidal cell synaptic loss, GABAergic neuronal down-regulation and cortical atrophy cannot be ascribed to dopaminergic dysfunction. In

recent years, evidence from pharmacologic challenges with antagonists of glutamatergic neurotransmission, post-mortem studies, EEG results and genetic findings have implicated glutamatergic neurotransmission, especially at the N-methyl-D-aspartate (NMDA) receptor, in the pathophysiology of schizophrenia. The NMDA receptor is critical for synaptic plasticity, both functional and structural, and mediates memory. Notably, Genome Wide Association Studies (GWAS) with 200,000 subjects with schizophrenia and controls have identified over a hundred risk genes for schizophrenia (with a conservative statistical threshold for significance of 5×10^{-8}). Two dozen of these risk genes affect glutamatergic neurotransmission and NMDA receptor signaling. My laboratory created a mouse in which the expression of a gene that encodes serine racemase (SR), a risk gene for schizophrenia, has been genetically silenced. SR synthesizes the co-agonist for forebrain NMDA receptors, D-serine so that genetically silencing SR expression in the mouse reduces brain D-serine by 90%, resulting in impaired forebrain NMDA receptor function. The SR mutant mice recapitulate the cognitive-behavioral deficits, neural pathology and the electrophysiologic abnormalities characteristic of schizophrenia including reduction in GABAergic recurrent inhibition, disinhibition of glutamatergic pyramidal neurons, which drives striatal dopamine release. Two additional findings implicate NMDA receptors in schizophrenia. The most statistically robust risk gene for schizophrenia encodes the innate immune protein, Complement C-4. C-4 also targets glutamatergic synapses for elimination, especially with normal synaptic pruning during adolescence. The risk variant increases its pruning activity consistent with cortical atrophy and symptomatic onset of schizophrenia. An autoimmune disorder has been discovered in which the affected individual develops antibodies against NMDA receptors causing them to be inactivated and the development of psychotic and cognitive symptoms like schizophrenia. Thus, the glutamatergic risk genes, the NMDA receptor autoimmune disorder and the C-4 risk gene reveal quite distinct mechanisms resulting in NMDA receptor hypofunction and the schizophrenia syndrome.

The BITE of Cults in Our Culture in the Age of COVID

Chair: Karen B. Rosenbaum, M.D.

Presenters: Susan Hatters-Friedman, M.D., Ryan C. Hall, M.D., Cathleen Cerny-Suelzer, M.D.

Discussant: Steven Hassan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the concept of the BITE model; 2) Critically examine news media outlets for bias and indoctrination; 3) Understand the prevalence of cult mentality in the current era and possible correlations with the pandemic; and 4) Take steps to counteract the influence of Cult mentality and group-think..

SUMMARY:

The attack on the Capitol on January 6, 2021 was not an isolated, bizarre incident perpetrated by a fringe group. This was a culmination of the propagation of “the Big Lie” by people in power and high positions in this country. Dr. Steven Hassan all but predicted an outbreak of violence due to the mind control that many supporters of Trump and other extremist groups have experienced. This panel will attempt to draw a thru line between the dissemination of disinformation and “the Big Lie” (that Trump won the 2020 election by a landslide), mind control as seen in other cults like NXIVM led by Keith Raniere (who is a convicted trafficker- sentenced to 120 years), and violence such as seen on January 6, 2021. Dr. Hassan’s BITE (Behavior, Information, Thought, and Emotion) Model will be explained as a tool to help evaluate cases that involve a person under undue influence of authoritative or exploitative control. Psychiatrists, especially forensic psychiatrists, may have a responsibility to take an active role in teaching students and trainees, educating the court, and helping survivors of mind control. Psychiatrists can also help heal family rifts over differences in ideology. This panel will help explain how and why our expertise is needed in the area of undue influence and mind control, especially in the time of and in the aftermath of the current pandemic due to the fear and anxiety of conflicting messages, the undermining of science, isolation, and economic insecurity making everyone more susceptible to recruitment online.

**The Challenges of Interprofessional Practice:
Lessons From the World of Jazz**

Introduction: Carlyle Hung-Lun Chan, M.D.

Presenter: Paul Haidet, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe two paradoxes at the heart of interprofessional and team practice; 2) Evaluate the effects of the paradoxes in their own practice; and 3) Brainstorm ways to foster high quality interprofessional practice in their own clinical environment.

SUMMARY:

Interprofessional and team practice is of great interest to health systems, but has been slow to develop in actual practice. Important efforts to speed adoption have mostly focused on changes in structure or educational interventions. It turns out that the field of jazz music was grappling with similar issues in the early 1960s. In this session, we will draw lessons from the experiences of jazz musicians during a time of transition in practice. Using musical examples from the world of jazz, we will explore two paradoxes, related to significant cultural transformation, that will be necessary to achieve ideal interprofessional healthcare practice.

The Development of an Antidepressant Stepped Treatment Algorithm Application

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

Presenters: J. John Mann, M.D., Ravi Shah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe key updates to depression treatment sequencing given updates in research since the STAR*D trial.; 2) Describe the role that technology can play to enhance the dissemination of evidence-based care models both within psychiatry and for primary care providers treating mental illness.; and 3) Learn how to apply quicker antidepressant medication titrations in clinical practice..

SUMMARY:

Despite large increases in antidepressant prescription rates in many countries, major depressive disorder is emerging as the largest cause of worldwide disease burden. Part of the reason for this is that initial response rates are poor and there is less emphasis on reduction of recurrence rates in this recurrent episodic disorder. Current clinical guidelines for the treatment of major depression recommend a sequence of six-week long medication trials or steps that leave half of the patients still depressed even after four steps or six months of treatment. Response rates after the first three months are abysmally low, suggesting the optimization of treatment in the first three months may be crucial. We have designed an application that does two main things that differ from major current treatment guidelines. First, it uses 3-week long sequenced treatment steps. Second, progression moves after only one step to medications that target more than one neurotransmitter system or two combinations of medications with different treatment targets. The session will explain the scientific evidence supporting these two modifications and describes how combinations of antidepressant medications can have a higher response rate than single medications, because the antidepressant effects of different classes of medication are potentially additive. Moreover, the use of multiple drugs, each from a different pharmacological class, explains reports of comparable side effects compared with single medications. The application and its convenient features for aiding the treating primary care physician and early career trainees will be described. The role for such an application in improving quality of care will be outlined.

The Future Is Here: Innovative Models of Outpatient Psychiatric Service Delivery

Chair: Justin A. Chen, M.D.

Presenters: Carlene M. MacMillan, M.D., David Samuel Kroll, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Name major challenges facing traditional models of outpatient psychiatric care

delivery; 2) Learn how to increase access to quality outpatient psychiatric care within a finitely-resourced system; and 3) Learn how to facilitate measurement-based care in real-world practice, including innovative approaches such as remote patient monitoring.

SUMMARY:

The United States faces a critical shortage of access to psychiatric care. High demand and limited supply causes many psychiatrists' caseloads to rapidly fill and close to new patients. Clinicians in private practice frequently select for the "worried well," meaning that individuals with serious mental illness paradoxically face the greatest barriers to accessing high-quality care. Traditional psychiatric care models rely heavily on individual relationships between clinicians and patients and "outside of session" work such as care coordination and treatment review remains largely unreimbursed, resulting in negative outcomes for clinicians—e.g., isolation, dissatisfaction, and burnout—and patients alike. Furthermore, measuring outcomes and leveraging new technology have been found to be relevant for nearly every other industry both within and outside of healthcare, but both have remained poorly operationalized within psychiatry. An urgent need has been described for radical re-envisioning of the paradigm and practices of mental health care to address issues of patient access, quality-driven and value-based care, and clinician satisfaction. In this session, two outpatient psychiatry leaders from academic medical settings and one from a private practice setting will present three innovative models of outpatient psychiatric care delivery: 1) A walk-in psychiatry model with longitudinal follow-up capability to improve access for a primarily Medicaid-insured population of patients who traditionally miss appointments; 2) A team-based, tech-enabled comprehensive mental health practice specializing in higher complexity and higher acuity cases, and 3) A multidisciplinary team-based outpatient psychiatry program designed to address access needs within a large outpatient psychiatry clinic in a general hospital. There will be plenty of opportunities for audience interaction and Q&A.

The Shame of Suicide and Attempted Suicide in Physicians: Five Individuals Who Are Speaking Out

Chair: Michael F. Myers, M.D.

Presenters: Katherine Termini, William Lynes, M.D., Linda Wrede-Seaman, M.D., Betsy Gall

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate how shame complicates and worsens the symptom picture of mental states that drive suicide attempts and suicide in physicians; 2) Give examples of situations in which physicians' attempts to be open and transparent about current or past suicidality have been shut down; and 3) Describe ways in which we can all become more comfortable discussing the uncomfortable subject of suicide.

SUMMARY:

Physicians are known to be a group of individuals who are more at risk of suicide than the general public. Data are sparse about attempted suicide, but we do know that medical students and residents have rates of suicidal ideation that are higher than age-matched peers. Robust and well-intentioned efforts to study and treat the painful cognitive and affective states that drive suicidal impulses in physicians are thwarted by shame. Physicians do not feel comfortable or safe sharing something so private and frightening or so dark with their peers, families, training directors and treating professionals. What's worse is that medicine itself, the so-called culture of medicine, is too often a partner in this scourge of embarrassment, unacceptance, judgment, denial and suppression. This is dangerous. The intent of this session is to unravel these forces, present new learning from look-back research, share personal narratives, and offer ways to save doctors' lives. Michael Myers, MD specialist in physician health, will discuss findings from his qualitative postvention research on shame with two groups: families of doctors who have died by suicide and doctors who have made near lethal attempts at suicide. He will also introduce the notion of caste in the house of medicine, a pernicious force that shuns and shames doctors who speak openly about their mental health challenges. Katherine Termini, MD PGY-1 resident in psychiatry at

Vanderbilt University will share her story of entering medicine after grappling with mental illness and suicidality years prior. She will discuss her perspective on stigma within medical training, how it may be contributing to physician suicide, and why it is important to shine a light on mental health. William Lynes, MD board-certified urologist, will share his story of medical practice and suicide attempts, and the shame felt during his practice and in the years that followed. He will chronicle his writing and speaking on the subject of physician suicide and the resulting restorative result. Linda Wrede-Seaman, MD a primary care and palliative care physician and former emergency medicine physician is a survivor of her husband Dr Matthew Seaman's suicide. He was an emergency physician who was sued during his first year of retirement. The stress was prodigious, unrelenting, and included publicly humiliating disclosure of details. He crashed into a severe depression and required hospitalization. Following an onerous deposition and feeling unsupported by counsel, Dr Seaman took his life on March 28, 2019. Dr Wrede-Seaman will argue that shame is real, stigma is real, litigation stress is real, and that something must be done to end this abuse of America's physicians. One-third of the session will be preserved for interaction with attendees and the panelists.

The Trauma-Informed 15 Minute Med Check: A Humanistic and Evidence-Based Perspective for Busy Psychiatrists

Chair: David H. Jiang, M.D.

Presenter: Swapnil Gupta, M.D., M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate trauma exposure as an adverse social determinant of mental and physical health.; 2) Take an accurate trauma history efficiently and utilize a trauma-informed lens in assessment and diagnosis.; 3) Describe the ramifications of trauma-informed versus trauma-omitting case formulation on treatment planning and prescribing.; 4) List medications that are particularly efficacious in patients with histories of trauma who present with depression, anxiety, psychosis, and insomnia.; and 5) Understand the

neurobiological basis and clinical efficacy of certain medications in trauma related psychopathology..

SUMMARY:

Since the publication of the Adverse Childhood Experiences (ACEs) study and decades of work by trauma researchers, there has been a tide of interest in trauma-informed care. Childhood and adult trauma have robust correlations with a range of psychiatric disorders beyond post-traumatic stress disorder (PTSD). Trauma contributes to depression and bipolar mood disorders, anxiety disorders, dissociative disorders, personality disorders, and even psychotic disorders. These findings are consistent with trauma being a factor in the "social and community context" determinant of mental health--with trauma involving disruption to this important determinant. Trauma has demonstrated neurobiological impacts on patients and has an immense prevalence in psychiatric populations. This suggests that trauma-informed care should be the standard of care in all mental health care settings. However, applying the latest trauma research to psychiatric practice remains challenging in many settings. For the psychiatrist, whose primary role is often evaluation and medication management, it can be difficult to know how to address trauma with patients. There is usually little time for learning and implementing trauma psychotherapies. It is for this reason that our session will discuss evidence-based and trauma-informed psychopharmacological intervention. Trauma-informed prescribing firstly requires trauma-informed evaluation and formulation. As such, our session will begin by discussing good trauma history taking and trauma-informed case formulation. These will involve teaching points such as the importance of using descriptive language instead of labeling language when taking a trauma history (i.e. "did a parent ever swear at you, insult you, put you down, humiliate you?" instead of "were you ever emotionally abused?"). Other teaching points include trauma-informed differential diagnosis, such as considering whether a patient's suspiciousness might be better conceptualized as trauma-related vigilance instead of psychotic paranoid ideation. After this groundwork is laid, we will discuss medication options that are efficacious for the various sequelae of trauma. These will include medications for PTSD

symptoms, but also for other sequelae and diagnoses that are associated with trauma. Furthermore, we will discuss trauma neurobiology and medications' mechanisms of action--especially where they are particularly relevant and interesting. For example, bupropion is an interesting medication choice in patients with depression and a history of childhood trauma. This is because of childhood trauma's association with chronic inflammation, inflammation's suppression of dopamine and the resulting depressant effect, and bupropion's mechanism of action involving dopamine. The session will involve didactics, eliciting audience experience, discussion, and question-answer periods. A sample case will be used to facilitate for attendees an experience of applying presented concepts.

**“They Have No Insight and Won't Take Meds”:
Rethinking ‘Insight’ and ‘Engagement’ in Early
Psychosis**

Chairs: Nev Jones, Ph.D., Lisa Dixon, M.D., M.P.H.

Presenters: Angela Anita Coombs, M.D., Micah Pearson, Ronda Speight

Moderator: Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe strategies to address problems related to perceived or actual “lack of insight” in early psychosis; 2) Describe strategies to address problems related to perceived or actual medication non-adherence in early psychosis; and 3) Describe strategies to deepen decision-making regarding involuntary holds or hospitalization in early psychosis.

SUMMARY:

Perceived or actual ‘lack of insight,’ medication non-adherence, and decisions about involuntary holds/hospitalization are perennial challenges confronting psychiatrists working with patients experiencing early psychosis. In this clinical update, we will provide a state-of-the-science update on insight and medication decision making, and then segue into a discussion by a diverse panel including two community psychiatrists and three national leaders with personal experience of psychosis.

Weaving together personal, family, practice- and research-based experiences and insights, the panel aims to collectively deepen and complicate thinking about and strategies designed to address these long-standing practice problems.

Transforming Mental Health Care

Introduction: Helen Lavretsky, M.D.

Presenter: Vikram Patel, Ph.D., M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To be familiar with the large unmet needs for care even in settings with significant mental health resources and the structural reasons for these unmet needs.; 2) To describe the evidence on ‘task-sharing’ of mental health care by non-specialist providers; 3) To explain the innovations to optimize access, acceptability and quality of the delivery of psychosocial interventions by non-specialist providers.; and 4) To understand the process through which this evidence can be scaled-up, leveraging digital tools to build and support a community based workforce..

SUMMARY:

The large and unequally distributed unmet needs for care for mental health problems have been amplified by the pandemic in all countries, including the US. Pouring more money into the existing mental health care system will not shift the needle on this crisis. This presentation will describe the rich body of clinical and implementation science which has sought to address this crisis by redefining the content of mental health care and its delivery by non-specialist providers (“task-sharing”) to optimize access, acceptability, feasibility and affordability. The convergence of these innovations, catalyzed by the use of digital tools to scale up the task-sharing of psychosocial interventions, offers a unique opportunity to transform our mental health care systems.

**Tug-of-War: Facing Conflict as Underrepresented
Trainee Leaders in Psychiatry**

Chair: Margaret Wang

Presenters: Badr Ratnakaran, M.B.B.S., Sarah Hanafi, Karen Dionesotes, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify unique challenges that trainee-leaders face, particularly those from under-represented backgrounds; 2) Define and recognize conflicts of interest in trainee leadership settings; 3) Utilize conflict resolution strategies in a trainee leadership setting; 4) Utilize negotiation techniques in a trainee leadership setting; and 5) Utilize team management techniques as under-represented trainees leading healthcare teams.

SUMMARY:

Effective leadership is vital to quality healthcare, and leadership positions in residency or fellowship are often the first stage of one's professional development as a leader. Trainees, however, receive little preparation for these roles within their programs. Trainee-leaders often serve in important roles within their program's administration and function as chiefs, class representatives, task force chairs, et cetera. They promote resident cohesion, liaise between faculty and residents, and hold key administrative, management, and mentoring duties. Resident leaders must negotiate between being in the position of a trainee and of an administrator who serves both the interests of the program and that of their peers. Resident leaders, therefore, face a unique set of dilemmas. They must balance advocating for their peers with managing professionalism, gain an understanding of the institution's needs and how to best serve them even when it might conflict with that of residents, find solutions between groups with conflicting agendas while holding no formal authority, and be attentive to how their decisions affect their peers, such as in scheduling. These challenges are amplified when trainee leaders are from under-represented backgrounds, and face additional layers of microaggression, biases and different cultural practices. In addition, trainees within an institution are often more diverse than the faculty and have different viewpoints and concerns than faculty, and trainee-leaders are tasked with the challenge of bridging this gap and serving both sides. This session presents tools and techniques to mitigate these dilemmas and is tailored to the needs of resident

leaders, particularly those from under-represented backgrounds. As a group of first-generation, minority, female, or international medical graduate APA/APAF Leadership Fellows, we will share common conflicts and challenges for trainees in leadership positions and the most useful strategies we have found to tackle these challenges. Participants will identify common challenges for trainee leaders and highlight special challenges faced by those under-represented in medicine. Participants will learn applicable leadership skills, such as conflict management, negotiation, team management, and how to use them as trainee leaders. Participants will be provided with real-life cases from the Leadership Fellows highlighting challenges and work in small groups to identify the challenges and leadership strategies to solve them. Participants will then discuss how to apply these strategies and practice them in small groups. As a large group, participants will share and reconcile reflections from each small group to incorporate into their leadership development. By the end of the session, participants will have learned strategies that they can use to teach colleagues on how to increase their efficacy as resident leaders through skills such as conflict management, negotiation, and team management.

Monday, May 23, 2022

2022 APA Medical Marijuana Debate

Chair: Rajiv Radhakrishnan, M.D.

Presenters: Deepak D'Souza, M.D., Kevin Patrick Hill, M.D., M.H.S., Deborah Hasin, Ph.D., Michael Van Ameringen, M.D., Kevin Sabet

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an overview of laws governing the use of "medical marijuana" in different states in the US.; 2) Provide an update on the epidemiological evidence for the effects of marijuana on psychiatric outcomes.; 3) Provide an update on the effects of marijuana relevant to addiction.; 4) Provide an update on the evidence for the use of medical marijuana in anxiety disorders and PTSD; and 5) Provide an update on evidence for

harmful and beneficial effects of various cannabinoids in psychotic disorders.

SUMMARY:

As of May 2021, “medical marijuana” has been approved in 36 states, District of Columbia, Guam, Puerto Rico and US Virgin Islands in the US and Canada¹. Additionally 18 states have approved recreational adult-use of marijuana. Marijuana, however remains a Schedule-1 drug per the US Drug Enforcement Administration (DEA). Nevertheless, today the market-place is flooded with over 2500 “strains” of the marijuana plant and marijuana-infused products (including edibles, concentrates, dabs, waxes, oils, vaping fluids). These products are not regulated by the Food and Drug Administration (FDA) and don’t meet the FDA standards for approval of other medications, although the product labels accompanying these products may appear similar to that seen with pharmaceutical medications. Evidence supporting the use of “medical marijuana” for specific medical conditions is of low quality at the present time. Furthermore, individuals with certain psychiatric disorders may be at greater risk for adverse effects. This presents a challenge for physicians treating patients who use “medical marijuana” and tout the benefits of the products based on manufacturer’s product labels. Furthermore, it is possible that psychiatrists encounter patients who are using medical marijuana for a psychiatric indication or may be co-managing a patient who is receiving medical marijuana for a no psychiatric (medical) condition. Patients also often echo ill-informed counter-arguments against the scientific evidence, making it important for physicians to keep up-to-date with scientific literature on the topic. This general session at the APA will provide practitioners with an update on marijuana laws in the US and the evidence for the use of ‘medical marijuana’ as a treatment for psychiatric disorders. The session will follow a debate format where each speaker will provide an update on the topic of their expertise. Dr. Kevin Sebat will provide overview of marijuana laws in the US, and the provisions under decriminalization vs legalization, use for “medical” purposes vs recreational use. Dr. Deborah Hasin will then discuss the epidemiological evidence for the effects of marijuana on psychiatric outcomes, including data

on risk of psychiatric disorders. Dr. Kevin Hill will provide an update on the effects of marijuana as it relates to addiction and brain reward circuitry. An update on the evidence for the use of medical marijuana in anxiety disorders (including PTSD); and on schizophrenia and psychotic disorders will be provided by Dr. Michael van Ameringen and Dr. Deepak D’Souza, respectively. This will be followed by an open debate where the moderator (Dr. Rajiv Radhakrishnan) will present the speakers with commonly encountered counter-arguments. The audience will also have an opportunity to debate the speakers on their presentations. Live audience polling will be used to make the session interactive and to generate discussion.

A Roundtable Discussion With the Experts on the Future of the DSM: Striving to Remain Relevant to the Field of Psychiatry

Chair: Nitin Gogtay, M.D.

Presenters: Diana Clarke, Ph.D., Bruce Cuthbert, Ph.D., Altha J. Stewart, M.D., Roberto Lewis-Fernández

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of harmonizing DSM and Research Domain Criteria (RDoc) in efforts to move towards objective measures of psychopathology; 2) Understand the importance of addressing race, ethnicity and nationality in the DSM and clinical care; 3) Understand the importance of incorporating Social Determinants of Health in the DSM and how this can be done; and 4) Understand the importance of bringing functioning front and center in future DSM.

SUMMARY:

The current practice of medicine in the US is facing a major paradigm shift wherein precision medicine is increasingly being used to improve treatment efficacy, medication selection and response, and patient outcomes. This paradigm shift emphasizes the need for objective measures of psychopathology, which can be informed by advances in machine learning, neurobiology, genetics, neuropsychology, imaging and pharmacology. As such, a comprehensive approach needs to be envisioned for

future DSM. For example, advances in neurobiology, genetics, neuropsychology, imaging and pharmacology indicate that mental disorder are better understood as dimensional rather than categorical construct, which is the diagnostic approach of DSM-5. In contrast, RDoC, a theoretical framework for classifying mental disorders aims to capture this dimensionality of mental and substance use disorders but requires validation to understand the relationship between the hypothetical dimensional domains identified and psychopathology. The harmonization of these two systems may help to move the field forward by identifying objective measures of psychopathology thus improving the diagnosis of mental and substance use disorders. Another important area to emphasize in future DSM would be to understand the influence of the social determinants of health (e.g., patient's living situation, exposure to advantages and disadvantages in life course, education level, race, etc.) on mental health, especially in the marginalized populations, and their implications for diagnosis and treatment. How race, ethnicity and nationality are handled in the DSM is also an important factor. As done in DSM-5-TR, future DSMs need to implement strategies to avoid biases in how symptom presentations across ethno-racial groups are interpreted given the potential for this to lead to misdiagnosis for certain conditions. Additionally, to bring a more personalized care, assessments of functioning using a valid and reliable tool at the time of diagnosis and over the course of treatment is important since impairment in functioning is a key factor that causes patient experiencing mental health symptoms to seek care. Understanding the patient's level of functioning could provide valuable insights about their integration in the society and their coping mechanisms while serving as proxy measure for assessing the progress of care. In this session, we ask the field to come be part of the solution in addressing these issues. Experts in the field will give brief updates on the importance of each of these issues. Next, breakout groups will work with an expert to take a deep dive into each topic to identify education, training, and clinical implications and potential strategies that could be leveraged to improve future DSM.

A Systems Approach to Health Care Worker Burnout and Secondary Traumatic Stress

Chair: Royce J. Lee, M.D.

Presenter: Fabiana Araujo

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Implement a resilience program in a quality improvement framework; 2) Use validated measures of wellbeing as part of the PDSA cycle of QI; 3) Understand evidence-supported and evidence approaches to resilience; 4) Deploy resources in a way that is equitable in complex healthcare systems; and 5) Understand the need to address stakeholders in healthcare professional wellness.

SUMMARY:

Background: Health professional worker wellbeing has suffered during the COVID-19 pandemic, with studies finding high rates of burnout and secondary traumatic stress, sometimes called compassion fatigue. The problem is nationwide and requires system-wide interventions. In order to scale-up resilience training to the entire workforce at an urban academic medical center on the South Side of Chicago, we developed a video conference format, CBT based, peer-training program called Compassion Fatigue Training (CFT). This brief virtual format was chosen to adjust to the time-pressures and social distancing demands of the pandemic. A second, more intense training program, Self-Compassion for Healthcare Communities (SCHC), was piloted. Some of the approaches will be demonstrated with small-group exercises in this presentation. We deployed the training in a system-wide program designed to enhance the resilience of the health professional workers at The University of Chicago Medicine, a South Side Chicago academic medical center, beginning March 2020, near the beginning of the COVID-19 pandemic. **Methods:** CFT was deployed and outcome measurements were taken as part of quality improvement program. Burnout and secondary traumatic stress were measured longitudinally using the Professional Quality of Life (ProQoL) survey. Additionally, a self-compassion training program was piloted. The effect of interventions and system factors on wellbeing were

tested with a linear mixed model, with individuals as a random effect. **Results:** Over 950 survey responses were returned. In 12 months of training activity, more than 900 health professional workers completed Compassion Fatigue Training. Training was associated with decreased burnout and increased compassion satisfaction over time. While attending a wellness seminar was not associated with decreased burnout over time, pre-post session measures showed that participation reduced stress levels. Treating COVID-19 inpatients was associated with increased secondary traumatic stress. Somewhat surprisingly, seeing more patients in telehealth was associated with higher levels of burnout. Nonclinical staff, who are more likely to be Black/African-American, had higher burnout and secondary stress levels than MD faculty, clinical trainees, or nurses. **Conclusions:** We provide data supporting the feasibility of a large scale program to address health professional worker wellbeing in a large medical center. Resilience training was found to decrease burnout. System factors were important for wellbeing: caring for inpatients with SARS-CoV-2 was associated with secondary traumatic stress and caring for patients in telehealth was associated with increased burnout. A key finding was that wellbeing was not equitably distributed in the healthcare system, pointing to the need for universal and systematic approaches to resilience in healthcare systems during the pandemic and beyond.

An Antiracist Approach to Teaching Social Determinants of Mental Health Curriculum for Child and Adolescent Psychiatrists

Chairs: Kimberly Gordon-Achebe, M.D., Dolores Malaspina, M.D.

Presenters: Anique Forrester, Crystal Han, M.D., Tiffany Beason

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an overview of the limitations of child and adolescent psychiatry training related to social determinants of mental health.; 2) Propose an anti-racist approach to addressing social determinants of mental health in children and adolescents to achieve health equity for BIPOC.; 3) Describe a DEI infrastructure that

supports the implementation and sustainability of social justice in medical education curriculum development in child psychiatry.; 4) Discuss the development of an antiracist approach to SDOMH curriculum and the results of preliminary evaluations.; and 5) Review some of the challenges, successes and next steps in teaching an antiracist approach to SDOMH for Child Psychiatry Trainees..

SUMMARY:

Amidst heightened recognition of a national public health crisis, individual practitioners, academic departments, and healthcare organizations are contemplating strategies and solutions to dismantle health inequities. Few training programs have reported curriculum specifically on Social Determinants of Mental Health (SDoMH) for child and adolescent psychiatry (CAP) training, and fewer have offered strategies to incorporate social justice and anti-racism in its development. Even fewer academic centers have been transparent about their diversity, equity, and inclusion (DEI) process and implementation efforts, creating a schism of developmental approaches in building strong CAP curricula for program directors across institutions. This workgroup outlines how an academic institution and a psychiatry department alignment of a DEI infrastructure helped to foster the creation of an antiracist approach to teaching SDOMH and has merit in achieving mental health equity for future generations, especially children and adolescents. In this abstract, we report on the pre-development and implementation phase of a novel Antiracist social determinants of mental health curriculum for child and adolescent psychiatry trainees at University of Maryland. Child psychiatrists have a key role in addressing the social, structural, and environmental determinants of mental health and fostering the building of healthier communities especially for our most vulnerable populations, such as children and adolescents whose developing brains are significantly heavily influenced by these factors. However, child psychiatrists received limited training in both understanding and addressing the impacts of racism as a Social Determinants of Mental Health (SDoMH) in their standard medical training. Antiracism and Social Determinants of Mental Health (SDoMH) must become central knowledge in child psychiatry and not be deemed a specialty topic by

program directors. We believe that this workshop will share a novel Anti-Racism Social Determinants of Mental Health curriculum that is innovative, demonstrates academic leadership and advocacy, and that aligns well with values of social justice and health equity for all, especially those most vulnerable.

Assessing Psychic Pain and Proximal States of Mind Associated With Suicidal Thinking and Behavior

Chair: Jane G. Tillman, Ph.D.

Presenter: Katie Lewis, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of psychic pain in suicidal thinking and behavior; 2) Discuss suicidal thinking and behavior in the context of developmental psychopathology; 3) Identify research-based states of mind proximal to a near lethal suicide attempt; and 4) Assess multiple factors contributing to persistent suicidal thinking and behavior.

SUMMARY:

Suicidal thinking and behavior often involve a complex interaction between affective states, cognitive processes, impulse dysregulation, and other biopsychosocial vulnerabilities. Mental states and psychological processes preceding a near lethal suicide attempt are highly variable and are often embedded in long standing developmental and characterological processes. In this session we will present the results of several of our recent research studies of psychiatric patients who have survived a near lethal suicide attempt. We will review a new theoretically derived and empirically validated measure of psychic pain as a marker for elevated suicide risk. We will then present the findings of a study of near lethal suicide attempt survivors and the proximal states of mind associated with the near lethal attempt. The findings of our clinical research studies contribute to understanding the persistence of suicidal thinking and behavior in patients contending with complex psychiatric concerns and chronically elevated suicide risk, and will support clinicians in becoming more aware of potential *ideation-to-action* processes underlying trajectories

toward suicidal behavior. This presentation will expand participants' knowledge of skills in dynamic interviewing, risk assessment, and treatment factors affecting interventions with suicidal patients, particularly those patients who have survived prior suicide attempts. Following this session attendees will be able to identify the role of psychic pain, multimethod assessment of risk, and both short and long-term vulnerabilities to suicidal thinking and behavior.

Beyond Cultural Competency: Contemporary Psychiatry in a Raced Society

Presenter: Dionne R. Powell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the historical legacy and tension points between psychiatry and communities of color, especially African Americans.; 2) Better understand our silence about race and racism, with steps on how to break our silence to improve clinician-patient interactions.; 3) Understand the limitations of cultural competency within psychiatry.; 4) Build a multi-cultural educational residency experience.; and 5) Understand the foundational, familial aspects to racial development in mind..

SUMMARY:

Twenty first century psychiatry is marked by significant advancements in the pharmacological and behavioral treatment of psychiatric conditions. Less successful is our ongoing attempt at the recruitment, retention and advancement of psychiatric trainees of color, and treatment of patients that represent our diverse, multi-ethnic society. While the need for mental health care in communities of color have never been greater, contributed by the Covid pandemic along with persistent mental health inequities and disparities, our ability to match the societal needs with diverse clinicians remain significantly compromised. Simultaneously, clinicians of color, especially African American clinicians, are leaving academic psychiatry in increasingly greater numbers. Our need to understand, mitigate, including not remain silent, and reverse this trend is paramount to the relevance of our field. This presentation intends

to explore the challenges and opportunities of appreciating that we are, as Toni Morrison states, a raced society. Meaning, the impact of our historical past has solidified the intra-psychic development of being raced as integral and foundational to the development of mind in America in all its complexities. By taking a biopsychosocial approach I will elevate the psyche of race to its rightful place in mind. Today's session is an attempt to move us beyond cultural competence towards a dynamic consideration of how race is a foundational exploration discoverable within the clinician, how mental health clinicians are trained, and within the therapeutic discourse.

Boards, Bullies, and Bogus Peer Review:

Understanding and Managing Professional Risks

Chair: Brian Holoyda, M.D., M.B.A., M.P.H.

Presenters: Jacqueline Landess, M.D., J.D., Ashley H. VanDercar, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the various professional risks that may impact a physician's career, including medical board complaints, peer review processes, and negative references.; 2) Define the development of the state medical board system and the regulatory and disciplinary activities of state medical boards.; 3) Demonstrate how to approach and manage a state medical board complaint or a peer review.; and 4) Delineate how peer review and reference processes can be manipulated to bully or negatively affect one's career..

SUMMARY:

Medical board complaints, peer review processes, and even simple reference requests can negatively impact one's career opportunities and ability to practice medicine. Such activities are designed to improve the quality of care that patients receive and identify physicians potentially in need of help or sanction, but they are generally far less transparent than malpractice claims. They also vary widely in terms of specific processes and a physician's ability to respond to them. Because of these complexities, medical board complaints, peer review processes,

and references are more susceptible to manipulation, resulting in "sham" review activities. This session seeks to educate psychiatrists on the basics of medical boards, peer review, and other evaluative procedures; to describe available data regarding psychiatrists and professional sanctions; and to teach psychiatrists the practical steps they should take when facing these review activities. By 1910, nearly all states had established state medical boards (SMBs). Though originally developed to protect physicians' scope of practice and to prevent unlicensed physicians from practicing medicine, by the mid-twentieth century SMBs increasingly focused on the detection, investigation, and discipline of unprofessional physicians. The Federation of State Medical Boards recommends that SMBs be empowered to initiate proceedings against the unprofessional practice of medicine. What constitutes "unprofessional" practice of medicine remains unclear. SMBs are responsible for carrying out investigations of physicians against whom complaints are filed. States differ in terms of who is allowed to file a complaint, whether complaints may be anonymous, and potential sanctions against physicians. Though data is limited, some research suggests that psychiatrists are most likely to be disciplined for inappropriate conduct and negligence or incompetence. Peer review refers to a process of evaluating a professional colleague's work. Some peer reviews are conducted as a routine component of quality improvement programs, while others occur in response to complaints or an adverse event. When peer review results in sanctions against physicians, such actions may be reportable to the National Practitioner Database (NPDB). What may appear to be a routine investigation into one's clinical practice, then, could actually result in a reportable event that will follow a physician for the rest of his or her life. Because medical board procedures and peer review processes are often convoluted, psychiatrists should understand how to approach them. Relevant initial steps include obtaining information regarding the process and determining whether to retain an attorney. Other important considerations are to manage one's stress and to respond to information requests in a timely and conscientious manner. It is also important to know if there are any potential remedies in the case

of a negative finding, and how to pursue such remedies.

Catatonia: Contemporary Perspectives on a Classic Illness

Chair: Jeremy Weleff, D.O.

Presenters: Brian Barnett, Brendan Carroll, Andrew Francis

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the core texts influencing the evolution of psychiatry's conceptualization of catatonia; 2) Understand the diagnostic approach to catatonia; 3) Distinguish common catatonia screening and rating scales used in clinical care and research; 4) Identify current theories on the pathophysiology of catatonia; and 5) Provide appropriate treatment for catatonia, including in patients who fail benzodiazepines.

SUMMARY:

Since Kahlbaum's seminal description of catatonia in 1874, this often-perplexing syndrome, with its unique mix of behavioral, motor, and affective components, has held a special place within psychiatry. Refuting the notion of mind/body dualism in a more striking manner than perhaps any other condition, many psychiatrists vividly recall their first patients with catatonia. Whether it was hearing the striking repetition of verbigeration, feeling the variable resistance of *gegenhalten* in their muscles, or seeing them hold bizarre postures after their limbs were manipulated like warm candle wax, elements of those initial encounters often are emblematic and enduring experiences. Catatonia is a condition long marked by nosological disagreement. Psychiatry's understanding of catatonia has morphed dramatically since Kahlbaum and that evolution continues as scientific methods improve. Though Kahlbaum unquestionably recognized catatonia's association with mood disorders, medical conditions, and neurological conditions, later psychiatrists, such as Kraepelin and Bleuler, relegated catatonia to a form of schizophrenia, which colored psychiatry's understanding of the syndrome for more than a century. Psychiatry now recognizes catatonia's broadening association with

mood disorders, intellectual disability, autism, and general medical conditions. In 1994, DSM-IV finally permitted catatonia to stand diagnostically apart from schizophrenia in the form of "catatonia secondary to a medical disorder." Only with DSM-5 in 2013 was catatonia finally recognized as an independent coded syndrome. Still, catatonia's clinical recognition remains hindered by this unfortunate historical legacy and the persistent misconception that it exists only in its stuporous form. In this session Dr. Barnett will provide an overview of the conceptual evolution of catatonia, highlighting important publications that have often dramatically altered psychiatry's understanding of the syndrome. Given the potentially life-threatening nature of catatonia, Dr. Francis will review its diagnosis, with a focus on features and presentations of catatonia that are frequently missed. Dr. Francis will also discuss the importance of rating scales in diagnosing catatonia and evaluating its treatment progress. Dr. Carroll will then discuss the pathophysiology of catatonia, as well as management options, including mainstay treatments such as benzodiazepines and electroconvulsive therapy, as well as other options including mood stabilizers, second generation antipsychotics, NMDA-antagonists, and stimulants. The session will then conclude with questions for the panel from Dr. Weleff and a discussion between panelists and the audience focusing on persisting confusion around contentious aspects of catatonia.

Challenges in Psychotherapy Supervision

Chair: Katherine Gershman Kennedy, M.D.

Presenters: Allison E. Cowan, M.D., Flavia Alecia Ruth De Souza, M.D., M.H.S., Nathan Gwilliam, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify components of a supervisor-supervisee relationship; 2) Discuss ways to foster a positive supervisory relationship; 3) Discuss examples of how race, culture, gender identity and sexual orientation may impact the supervisory dyad; and 4) Employ a variety of strategies to address a range of challenges that may occur in supervision.

SUMMARY:

Psychiatry residents continue to be highly interested in learning psychotherapy, and psychotherapy supervision remains the cornerstone for training psychiatrists to become psychotherapists. Despite this fact, psychiatry has not developed evidenced-based methods for developing and training psychotherapy supervisors. Instead, supervisors follow an apprenticeship model where they mimic the behavior of former supervisors. Several trends threaten the field's ability to create enough competent psychotherapy supervisors to train future psychiatrists. Over the past 30 years, many psychiatrists have traded the biopsychosocial model for the biomedical model, leaving psychosocial interventions to other mental health care providers. These psychiatrists may have less clinical experience providing psychotherapy and may be concerned about their ability to provide effective psychotherapy supervision. Many senior psychiatric supervisors are expected to retire from practice in the coming years further worsening this situation. Psychiatry training programs are facing a deficit of psychotherapy supervisors and need new supervisors to fill this gap. This workshop will offer perspectives for understanding how to navigate some of the challenges of psychotherapy supervision. Providing these tools to early- and mid-career psychiatrists will increase their comfort and effectiveness as psychotherapy supervisors. This workshop will help current and would-be supervisors understand the components of the supervisor-supervisee relationship, including the real relationship, the supervisory alliance, the unconscious component, and the requisite foundation of trust that must be developed. Attendees will discuss what can be done to enhance each of these aspects of the relationship. Differences in social identity such as race, culture, gender identity, and sexual orientation can create issues within supervision that, if ignored or avoided, may create problems. We will practice identifying these issues and starting these difficult but important conversations. We will also consider challenges that may arise during supervision stemming from a strain on the supervisory alliance, a lack of focus on the work of supervision, or issues of social identity. Both supervisor and trainee perspectives will be offered on the "challenging supervisee" and the "challenging

supervisor" such as the trainee who is seen as unengaged, non-disclosing, or anxious, and the supervisor who is unempathic, domineering, micromanaging, or distracted. Supervision can also be challenged by the power differential between supervisor and supervisee and the fear of retaliation or the presence of microaggressions. Vignettes will be presented, followed by discussion about appropriate interventions and "next steps" to address these issues. The workshop will provide psychiatrists with practical, actionable steps to improve the quality of their supervision and help their peers to become better supervisors.

Clinically Relevant Forensic Psychiatry for Nonforensic Clinicians

Chair: Tobias Wasser, M.D.

Presenters: Paul Abbott Bryant, M.D., Charles Dike, M.D., Katherine Michaelsen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the implications of forensic topics in the daily clinical practice; 2) Demonstrate basic knowledge of clinically relevant forensic questions and principles; and 3) Apply forensic knowledge to clinical encounters with patients.

SUMMARY:

Many psychiatrists feel uncomfortable when "forensic issues" arise in clinical practice. Although the Accreditation Council for Graduate Medical Education (ACGME) requires education in forensic psychiatry as a component of general psychiatry training, the quality of this educational experience varies widely. Some institutions lack access to forensic psychiatrists and, despite the ACGME requirements, some psychiatrists leave residency without a thorough understanding of forensic psychiatry or its application to clinical practice. Furthermore, although an understanding of the legal regulation of psychiatric practice is relevant to all psychiatrists, many are intimidated or overwhelmed by this aspect of their work due to a fear of the legal system or its potential consequences (e.g., litigation). In this session, presenters will address this knowledge gap by discussing clinically relevant

forensic concepts targeted at general clinicians. The presenters, who are all experts in the field, will cover clinically relevant topics in forensic psychiatry. Time will also be devoted at the end of the session for participants to ask their own clinical questions of the presenters and other session participants. Utilizing this format, participants will improve their understanding not only of important forensic principles, but also their application in everyday clinical practice.

Disasters and Mental Health: Helping Your Patients Deal With Adverse Effects of Climate Change, Pandemics, and Mass Violence Part 1

Chair: Joshua C. Morganstein, M.D.

Presenter: James Curtis West Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the range of behavioral and psychological responses to disasters; 2) Describe risk and protective factors that disproportionately impact various populations in disasters; 3) Understand the framework for early interventions to reduce distress and protect health during and after disasters; and 4) Discuss specific interventions to enhance well-being and sustain operations during disasters.

SUMMARY:

Recent years have seen unprecedented impact of disasters throughout the world. Natural disasters, mass violence, and infectious disease outbreaks, such as the COVID-19 pandemics generate adverse behavioral and psychological responses. Distress reactions, risky health behaviors, and psychiatric disorders produce significant morbidity and mortality, making it difficult for individuals to function and recover. Certain populations may be at increased risk, such as those with pre-existing mental health conditions, children, elderly, responders and emergency workers, those of low socioeconomic status, and communities of color. Awareness of risk and protective factors can enhance cultural competence and reduce health disparities in disaster response and recovery. Early interventions reduce individual and community distress by enhancing feelings of safety, calming, social connectedness,

self- and community efficacy, and hope or optimism. Risk and crisis communication is a critical population health intervention following disaster that builds trust and enhances patient engagement in health-promoting disaster behaviors. Those leading disaster management are critical in restoring community well-being; consultation and support to leaders is an important intervention in sustaining their effectiveness and optimizing overall response efforts. An understanding of the unique facets of different disasters enhances the ability to support patients and their communities. Extreme and slow-moving weather events are occurring with increasing frequency and severity around the globe. An understanding of mental health in climate-related disasters enables providers to better prepare their patients for these events. Pandemic infectious diseases and other disasters involving exposure and contamination result in unique fear-based responses. Isolation and quarantine as well as fear of inadequate treatment measures and mistrust in government further shape community responses. Mass violence events amplify fear and undermine feelings of safety, increasing adverse effects. Part one of this two-part workshop will review fundamental disaster principles, highlighting ways in which attendees can leverage existing clinical skills to aid their patients and organizations to more effectively prepare for and respond to disasters. Participants will be provided with numerous high-quality, easy-to-use, online resources to enhance their clinical practice.

Disasters and Mental Health: Helping Your Patients Deal With Adverse Effects of Climate Change, Pandemics, and Mass Violence Part 2

Chair: Joshua C. Morganstein, M.D.

Presenters: James Curtis West Jr., M.D., Jonah Sidney Winakor

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Engage in an evolving and case-based disaster scenario in collaboration with other participants.; 2) Determine various actions throughout the disaster scenario using evidence-based aspects of disaster mental health impacts, risks, and interventions.; and 3) Discuss strategies for

approaching challenges in patient care delivery and other measures to protect public mental health for individuals and communities through a disaster..

SUMMARY:

Recent years have seen unprecedented impact of disasters throughout the world. Natural disasters, mass violence, and infectious disease outbreaks, such as the COVID-19 pandemics generate adverse behavioral and psychological responses. Distress reactions, risky health behaviors, and psychiatric disorders produce significant morbidity and mortality, making it difficult for individuals to function and recover. Certain populations may be at increased risk, such as those with pre-existing mental health conditions, children, elderly, responders and emergency workers, those of low socioeconomic status, and communities of color. Awareness of risk and protective factors can enhance cultural competence and reduce health disparities in disaster response and recovery. Early interventions reduce individual and community distress by enhancing feelings of safety, calming, social connectedness, self- and community efficacy, and hope or optimism. Risk and crisis communication is a critical population health intervention following disaster that builds trust and enhances patient engagement in health-promoting disaster behaviors. Those leading disaster management are critical in restoring community well-being; consultation and support to leaders is an important intervention in sustaining their effectiveness and optimizing overall response efforts. An understanding of the unique facets of different disasters enhances the ability to support patients and their communities. Extreme and slow-moving weather events are occurring with increasing frequency and severity around the globe. An understanding of mental health and climate change factors enables providers to better prepare their patients for these disasters. Pandemic infectious diseases and other disasters involving exposure and contamination result in unique fear-based responses. Isolation and quarantine as well as fear of inadequate treatment measures and mistrust in government further shape community responses. Mass shooting events amplify fear and undermine feelings of safety, increasing adverse effects. Part 2 of this workshop will engage participants in an interactive “Disaster Challenge” simulation affecting

a major metropolitan area to reinforce knowledge and skills used to support patients and their communities in response and recovery from disaster events.

Efficacy and Pitfalls of Real-World Long-Term Ketamine/Esketamine Therapy

Chair: Balwinder Singh, M.D., M.S.

Presenters: Jennifer Vande Voort, M.D., Simon Kung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the evidence base of intravenous ketamine and intranasal esketamine in Treatment-Resistant Depression; 2) Through presentation and audience Q&A, review real-world evidence of long-term ketamine/esketamine therapy; and 3) To review the pitfalls of long-term ketamine/esketamine use and lesson learned..

SUMMARY:

Ketamine is a novel glutamatergic anesthetic agent, “repurposed” as a rapid-acting antidepressant for treatment-resistant depression (TRD). The enantiomer esketamine is now FDA approved, in conjunction with an oral antidepressant, for patients with TRD and major depressive disorder (MDD) with acute suicidal ideation or behavior. While there are numerous studies of the efficacy, safety, and tolerability of short-term off-label intravenous (IV) racemic ketamine and intranasal esketamine for TRD, the evidence base for long-term ketamine, especially IV ketamine is much less. While ketamine’s rapid antidepressant effect is revolutionary, the effect of a single infusion dissipates quickly. Hence, the natural response is to extend the number of treatments to prolong antidepressant effects. For TRD, studies have provided continuation infusions, for example up to 6, and then maintenance treatments every few weeks. However, the evidence base is limited regarding the duration and efficacy of long-term ketamine use, with the risk of ketamine tachyphylaxis/tolerance. There are also large gaps in the literature regarding the long-term side effects of using ketamine on a maintenance basis. Ketamine is

considered a third line treatment with Level 3 evidence for acute bipolar I and II depression. Thus, highlighting a potential role of ketamine in acutely treating bipolar depression. Multicenter intranasal esketamine trials excluded patients with bipolar depression, thus limiting the generalizability of esketamine MDD trials' findings to bipolar depression. Ketamine clinics providing off-label ketamine infusions to patients have flourished throughout the United States, with many being run by prescribers with limited to no mental health experience. Additionally, some of these clinics will treat a wide range of diagnoses including substance use disorder, at times with limited supervision. This symposium will discuss the real-world efficacy and challenges of a ketamine clinic that has been operating for 4 years. This session will cover off-label use of IV ketamine and the FDA-approved esketamine for TRD. We will review the evidence base synthesis of ketamine/esketamine in treatment-resistant unipolar and bipolar depression, clinical pearls, and efficacy and outcomes of long-term ketamine use at Mayo Clinic. Presenters will be Dr. Jennifer Vande Voort (IV ketamine), Dr. Balwinder Singh (long-term ketamine use), and Dr. Simon Kung (esketamine and pitfalls).

Ethnopsychopharmacology of Clozapine

Chair: Robert Osterman Cotes, M.D.

Presenters: Donna Rolin, Ph.D., A.P.R.N., Deanna Kelly, Pharm.D., Jonathan M. Meyer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define ethnopsychopharmacology; 2) List one clinically relevant example of how someone from a specific ethnic or cultural background may respond differently to clozapine; 3) Explain how to use clozapine levels to help individualize titrations and monitor for efficacy; and 4) Describe how individuals with BEN can be safely prescribed clozapine.

SUMMARY:

Clozapine is the gold-standard pharmacotherapy for people with treatment resistant schizophrenia, and it is highly underutilized in the US.? One of the many barriers to greater clozapine utilization is lack of

prescriber knowledge and comfort with the medication.? Some prescribers hesitate to use clozapine due to its unique side effect profile, which includes neutropenia, myocarditis, constipation, seizures, and others.? In addition, clozapine has a relatively narrow therapeutic index (blood levels ideally within a range of 350 – 600 ng/mL), possesses unique pharmacokinetic properties, and has a potential to cause drug-drug interactions with commonly used medications. Knowledge of how to use clozapine is particularly important because often clozapine is the only option for individuals who have failed multiple trials of medication, and response rates for non-clozapine medications for treatment resistant schizophrenia are poor. In this session, to build prescriber confidence using clozapine, we will take a deep dive into the ethnopsychopharmacology of clozapine.? Ethnopsychopharmacology is defined as the area of study that addresses how genetic variations and cultural differences can influence the effectiveness of psychiatric medications.? Clozapine is particularly underutilized among racial and ethnic minorities in the US, we will examine the potential reasons for this disparity in care. We will discuss how clozapine's metabolism is affected by different genetic variations in the CYP P450 system, as well as how and when to obtain and interpret clozapine levels.? We will discuss how to evaluate for benign ethnic neutropenia (BEN), a condition seen more frequently in people of African or Middle Eastern descent, and present treatment considerations for people with BEN.? Upon completion of this session, attendees will be able to take a more individualized approach for clozapine titration and dosing for their patients.

Exploring Social Determinants of Firearm Access and Suicidality Among Children and Adolescents

Chair: Jordan Andrew Wong, M.D.

Presenters: Rahn K. Bailey, M.D., Brian Levins, M.D., Brian P. Kurtz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate a relationship between firearm access and suicide risk in youth. At the conclusion of this session, the participant will be able to describe this intersectionality.; 2) Illustrate

social determinants that influence firearm use and suicidality. At the conclusion of this session, the participant will be able to appreciate how social factors impact these topics.; 3) Promote suicide screening to identify youth with access to firearms. At the conclusion of this session, the participant will be able to understand the need for suicide screening in this population.; and 4) Discuss culturally sensitive approaches to safety planning for suicide and firearm access. At the conclusion of this session, the participant will be able to create appropriate safety plans..

SUMMARY:

2020 proved to be the deadliest year of gun violence in at least two decades, with the burgeoning epidemic of guns in urban centers taking a substantial toll on communities of color.^[1] The number of deadly firearm incidents involving children also rose by 45 percent, presumably as a result of gaining access to improperly stored guns owned by adults in the home.^[2] Literature also suggests racial and social factors impact firearm access. For example, data from the 2019 Youth Risk Behavior Surveillance System reveals the rate of gun carrying among black male high school students was 11.9% (compared to 5.6% for white adolescent males).^[3] Furthermore, data from adolescents living in Mobile, Alabama between 1998 and 2011 suggests gun carrying among youth is influenced by social determinants of health, including racialized trauma and poor familial support.^[4,5] Access to firearms among children and adolescents is concerning because it increases the risk of suicide.^[6] Nearly three in four firearm suicides by youth take place in or around a home,^[7] and over 80 percent of firearm suicides by children under the age of 18 involve a gun belonging to a family member.^[8] Yet, recent literature suggests a parent's decision to have firearms or properly store firearms at home is not influenced by having a child with self harm risk factors.^[9] As such, it is unsurprising that the need for suicide screening is promoted in several healthcare settings, including pediatric emergency rooms, inpatient pediatric units, and primary care clinics.^[10,11] However, these settings often include only a subset of children and adolescents with mental illness and are not adequate to address the growing rates of youth suicide, especially those with

access to firearms. During this general session, we aim to (i) explore social determinants that influence firearm access and suicide risk amongst youth as well as (ii) promote ways to mitigate suicide risk among youth with access to firearms. After beginning the session with a multimedia video showcasing gun violence amongst youth, two clinical cases (one from an urban area and one from a suburban area) about youth impacted by gun violence and suicide will be presented. One expert speaker will discuss social factors contributing to of firearm access and suicidality among youth while another expert speaker will shed light on challenges and opportunities for suicide prevention strategies. We will facilitate audience participation through an engaging turn and talk format, where attendees will engage in discussions about the clinical application of each speaker's topic. Lastly, we aim to end with a discussion of culturally appropriate firearm and suicide safety planning to further enhance and individualize the discussion about this topic for the attendees.

Fostering International Medical Graduate Growth

Chairs: Raman Marwaha, M.D., Tanuja Gandhi

Presenters: Zeeshan Mansuri, Raman Baweja

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to understand social determinants and challenges faced by IMG physicians; 2) Participants will gain knowledge on barriers and solutions to develop academic IMG Psychiatrists.; and 3) Participants will integrate this knowledge on how to foster IMG growth..

SUMMARY:

International Medical Graduates (IMGs) are physicians who graduated from a medical school outside the United States and Canada. IMGs have significant roles in providing health care delivery including mental health in the United States. In the USA, IMGs comprise 30% of practicing psychiatrists and 33% of psychiatry residents in the U.S. Despite facing numerous challenges, IMGs make considerable contributions to psychiatry through work in the basic sciences, research and health-care

delivery. The World Health Organization defines Social determinants of health as conditions that people are born, grow, live, work and age that affect health which are shaped by money, power and resources which are linked to public policy, social norms and opportunities. IMGs face challenges like immigration, job insecurity, economic instability, and acculturation. Physical distance from their families/ countries of origin during the pandemic has added to the stress. There have been reports of IMG suicide during the pandemic. IMGs also face bias and microaggression. These determinants have led to challenges with developing and fostering IMG psychiatrists specially in the academic setting. Our panel comprises non-US IMG residents and attending psychiatrists who will be discussing unique challenges often faced by IMGs, resources and opportunities for them for overall growth. They will discuss barriers and socio-cultural challenges including the complex immigrants process in integrating in the US Health systems. Panelists will also discuss their vast experience across a spectrum ranging from a trainee to early career psychiatrist, from research to leadership in training programs, and advocacy to leadership at APA.

Getting Psyched-Out: Innovations and Challenges of Psychedelics in Psychiatric Research and Private Industry

Chair: Adrian Jacques H. Ambrose, M.D.

Presenter: Michael Avissar, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least one broad application of psychedelics in neuroscience and psychiatry.; 2) Describe the evidence for and against the necessity of an acute subjective effect for treatment of neurotic disorders.; 3) List at least two potential or proposed clinical indications for psychedelics and their current level of evidence.; and 4) Articulate the importance of establishing predictive and treatment-tracking biomarkers for psychedelic therapy.

SUMMARY:

Recent years have seen a surge of interests in both scientific research and private industry communities

on psychedelic agents and their applications. Classic psychedelics such as LSD and psilocybin exert their acute subjective effects through agonism or partial agonism of the serotonin 5HT_{2A} receptor whereas dissociatives such as ketamine are thought to act via antagonism of the glutamate NMDA receptor. This session highlights key intersections of psychedelic innovations in research and potential applications in the general market and clinical practices. Scientific interest in these agents falls under three broad categories: 1) the neurobiology of consciousness, 2) as psychotomimetic models (i.e. models of psychosis) and 3) as therapeutics for several neurotic and substance use disorders such as depression, anxiety, psychological impact of life-threatening illness, OCD, eating disorders, body dysmorphic disorder, alcohol use disorder, and smoking cessation. Esketamine, “a psychedelic-like agent,” is FDA-approved for the treatment of depression, whereas psilocybin is entering a phase 3 clinical trial. In the business sector, the psychedelic drug market is anticipated to grow rapidly within the next two decades. Given the large unmet needs of mental health challenges, the psychedelic market is forecasted to grow to a 6.5 trillion dollar industry within the next decade with an impressive compound annual growth rate of 14.5%-16.3%. However, the limited clinical operations and scarcity of expert clinicians may circumscribe the scalability of widespread evidence-based clinical practices. Current theories propose that a loss of sense of self (i.e. ego dissolution) and mystical experiences are subjective predictors of treatment response; however, rodent translational research has shown antidepressant-like effects of classic psychedelics even when blocking the acute subjective effects of 5HT_{2A} agonism. Promising future directions incorporating selective 5HT_{1A/2A} blockers or nonhallucinogenic 5HT_{2A} agonist analogs may help to address important clinical research questions in psychedelic-based psychiatric treatments: Is “tripping” necessary? In addition, the current scarcity of diagnostic and clinical tools in psychedelic treatments may serve as critical innovative opportunities. For example, there has been a scarcity of clinically-relevant biomarker work, and the little that exists is typically based on functional neuroimaging, which is not practical for wider dissemination to the community. Furthermore,

neurophysiological biomarkers based on EEG may hold the key to more practical biomarkers that could be used to predict and track treatment response. A number of findings related to sensory-evoked potentials, ongoing neural oscillations, and information-theoretic (i.e. signal diversity) measures have shown promise and we propose they should be increasingly studied in clinical applications to enhance objectivity and reproducibility of findings.

Growing GRASS: Group Reflection and Support Sessions for Physician Wellness During Global Crisis

Chair: Neha S. Hudepohl, M.D.

Presenters: Megan White Zappitelli, M.D., Karen Lommel, D.O., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the process of creating a support and reflection group for psychiatric clinicians.; 2) Identify the components required to develop a Group Reflection and Support Session (GRASS); 3) Appreciate the experience of a GRASS participant.; 4) Create and lead a support and reflection group that can be used to support healthcare professionals in any clinical setting; and 5) Identify ways that physicians can incorporate a GRASS program into their home institution..

SUMMARY:

The practice of healthcare is ever-changing. The constant change, while essential, can be stressful and is a contributing factor to physician burnout. All of this is true, even without a global pandemic. Considering the rapid and drastic changes that have happened due to the COVID-19 virus, burnout and physician stress seem to be at an all-time high. While burnout and wellness are frequently part of the curriculum within training programs, intentional and structured wellness activities for physicians in practice are lacking. Wellness activities can be viewed as time consuming and burdensome, and therefore often have the opposite of the intended effect and further contribute to physician burnout. An efficient, helpful, and generalizable tool is needed to help physician leadership model activities that support wellness and can be used to support all healthcare workers, particularly in the unsettling

time of COVID-19. Almost overnight, the global COVID-19 pandemic changed many lives as well as the practice of psychiatry. The rapid and drastic change both at home and at work contributed to uncertainty and anxiety for many, particularly for those who work in healthcare. In effort to provide physician support and to help others in the healthcare system, the speakers created a Group Reflection and Support (GRASS) series. These sessions were modeled after clinician support groups from Maine Medical Center (1,3) and were modified to fit the needs of psychiatry physicians. A template for hosting the meetings was created and was used for each session. By using the template, each session only took minutes of preparation time, and the session was easily customizable to the audience and the time allowed for each session. Due to the social distancing restrictions of COVID-19, all sessions were held virtually; however, they can be easily adjusted for face-to-face meetings. The GRASS sessions were incorporated in various physician meetings and were well received by the physicians and resulted in a noticeable change in morale. During this workshop, the speakers will outline the methods that were used to create the GRASS series and will lead participants in a GRASS session. By modeling the methods used to create and lead a session, participants will be able to facilitate the GRASS sessions at their home institution following the session. Additionally, participants will be asked at the end of the session to reflect on ways that they can modify the sessions to fit the needs of their home department. Finally, participants will learn ways to generalize the sessions so that their physicians can help other departments and healthcare workers to decrease burnout and to improve wellness across all facets of the changing healthcare system.

HIV: A Model of Health Inequities

Presenter: Kenneth Bryan Ashley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand HIV Health inequities; 2) identify the role of social and structural factors in HIV health inequities; 3) identify strategies to address HIV health inequities; and 4) understand

the unique role of psychiatrists in addressing HIV health inequities.

SUMMARY:

Although great strides have been made in the diagnosis and treatment of HIV infection, many people remain at risk for infection and in need of HIV testing, treatment for the consequences of untreated infection, and care for the significant psychosocial and neuropsychiatric sequelae of HIV and AIDS. HIV has transformed from a uniformly and rapidly fatal illness to one that is chronic and manageable for most persons with both access and ability to adhere to HIV care and antiretroviral treatment. Nonetheless, there are still approximately 40,000 new infections yearly in the United States. Of these new infections, the burden is disproportionately experienced by specific populations, including Black and Latinx Americans, men who have sex with men, and transgender women. Early diagnosis and rapid introduction to HIV care are crucial for HIV to be a chronic manageable illness, to prevent progression, and even to decrease the likelihood of HIV-associated neurocognitive disorders. Deaths continue to occur in persons who do not access care or adhere to life-saving regimens. This presentation will trace the history of HIV in the United States related to inequities in diagnosis, treatment, and health outcomes. There will be a review of the various social and structural factors that contribute to these inequities, including: bias, stigma, historical abuse/mistreatment, and issues with access. There will be an exploration of strategies to address inequities, as well as the specific role psychiatrists can play. There will also be a discussion of the similarities and differences between HIV and COVID-19 relative to inequities, the response of the public/government/health care/media, and lessons learned, or lack thereof.

“I Want to Choose When I Pass”: Assessing Patients Who Are Considering Ending Their Lives

Chair: Theodore James Fallon, M.D., M.P.H.

Presenters: Edmund Howe, Sheila Gray

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) assess from the perspective of normative emotional development, patients who are seeking help with ending their lives; 2) describe how to do a narrative inquiry elucidating a patient’s life, past coping, and reversible emotional states resulting in an understanding rather than judgment of a patient’s request to die; 3) carry out an assessment that goes beyond the usual mental status and capacity assessment to include consideration for emotional and developmental capacities; and 4) maintain patient primacy and personal integrity when interviewing patients who request medical assistance in dying.

SUMMARY:

Ten states currently require physician assessment of “mental competence” before allowing patients to end their lives with medical assistance (Dugdale, 2019). Three panelists representing the Committee on Professionalism and Ethics of the Group for the Advancement of Psychiatry in collaboration with the Scattergood Ethics Program at the University of Pennsylvania and St. Elizabeths Hospital (Washington DC) will present specific approaches to assessing patients making end-of-life decisions. In this presentation, we propose that the aim of the physician is not to write the prescription, but rather, to assess the capacity of the patient to determine the time of their own death. Such assessments cannot follow the mere technicalities of common clinical interviews, not simply because of the finality of the choice, but also because of the limitations of common cognitive assessments. General psychiatrists are not unique in their ability to perform these assessments but because of their training and professional experiences, are well suited to make these assessments (Owen, 2018). There are already models to assess these capacities; however, an under-appreciated element of this decision-making lies in the emotional components that invariably accompany life-and-death decisions. The assessment we are proposing includes seeking a narrative about the patient’s life, past coping, and reversible emotional states. A narrative inquiry seeks to understand rather than judge the appropriateness of end-of-life requests. This approach expands the present, prevailing capacity assessment model, thus

providing guidance for assessing the full range of cognitive and emotional capacities necessary for making these difficult and permanent decisions. This theory-neutral and belief-neutral approach may be implemented by general psychiatrists who themselves may have a different personal outlooks on participating in medical assistance in dying. The approach focuses on understanding the patient, not making a decision about the appropriateness of the patient's request. A tool as common as the psychiatric interview and the Defensive Functioning Scale (Perry, 1998) can allow psychiatrists to understand not only how patients think and feel about dying, but also how and whether they can consider their context, choices, and desired outcomes. In this session, the panelists will enumerate selected key features of this expanded approach in more detail, including considering the emotional and development capacities necessary for making this decision (Hafter Gray, Submitted for publication).

**Impact of COVID-19 on Women's Mental Health:
How Latinx/Hispanic America Is Addressing
Socioeconomic Disparities**

Chair: Ruby C. Castilla Puentes, M.D.

Presenters: Pamela Carolina Montano, M.D., Ana Maria Saavedra Sanchez, Victoria Valdez, M.D., Nancy Colimon, M.D.

Discussant: Silvia Gaviria, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To investigate the social determinants of depression among Hispanic women in US and Latin American countries.; 2) Recognize the differences of the Impact of COVID-19 on Women's depression based in the socioeconomical context among Latinx/Hispanic populations.; and 3) Understand how countries in Latin America are addressing economic gender disparities during COVID-19.

SUMMARY:

Background: The Coronavirus, first declared as a global pandemic on March 11th, 2020, has impacted millions of individuals in a variety of ways. A prominent population that has been heavily

impacted have been women. **Methods:** Latinx/Hispanic Women have suffered financially, physically, and emotionally from the virus. Presenters will address the differential impact of COVID in three countries based in the income classifications for the World Bank's (High-income economy, Upper-middle-income economy and Low-income economy). Also, the Impact of COVID-19 on Mothers and Newborns in Latin American Countries. **Analysis:** Women are assuming the emergence of care and paid and unpaid domestic work, a situation that not only carries an increased risk of infection, but also has impacts on their mental health. Recent studies in Latin American countries demonstrate the deterioration in mental health was stronger for women with lower education or pre-existing mental health conditions, and for those reporting a higher number of stressors, including food insecurity and job loss. **Conclusion:** As the pandemic deepens economic and social stress, violence against women is intensifying, which has serious consequences for women's mental health. While the pandemic risks exacerbating existing gender economic gaps, leaders have put in place sensible, innovative policies and strategies to close these gaps, as seen in Latinx/Hispanic America and the Caribbean. This symposium is in collaboration with the American Society for Hispanic Psychiatry (ASHP) and WARMH (Mental Health Network for Women's Mental Health in LA).

Is There a Need for a Military Cultural Formulation Interview?

Chairs: Ravi B. Desilva, M.D., Eric G. Meyer, M.D., Ph.D.

Presenters: Roberto Lewis-Fernández, Neil Krishan Aggarwal, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) By the end of the session the learner will become familiar with issues related to military and civilian cultural divide; 2) By the end of the session the learner will be able to utilize the Cultural Formulation Interview (CFI) found in DSM 5; and 3) By the end of the session the learner will understand the proposed steps for evaluation where

a cultural subgroup may benefit from having a modified CFI..

SUMMARY:

U.S. military service members, veterans, and their families are increasingly needing to seek care from providers with limited knowledge of the military system and military culture. The sixteen-item “core” Cultural Formulation Interview (CFI) originally published in DSM 5 was designed to integrate cultural factors into assessment and treatment of mental health disorders and problems. While the CFI was designed for use with all patients in all clinical settings, at its introduction there were also a series of CFI supplementary modules created by expert consensus to address specific patient populations such as children, immigrants and refugees, and caregivers. At the time of the introduction of the CFI and supplementary modules, the military was not highlighted as one of these specific subcultures addressed, but it was not known if the CFI adequately assesses military culture. This session reviews a proposed methodology to assess and determine both the need for specific versions of the CFI for any identified cultural subgroup and specific consideration for the steps taken to create a version of the CFI for use with persons affiliated with the military. This development process can inform the need for proposed other versions of the CFI when the core CFI potentially does not comprehensively assess cultural needs for specific populations.

Leading, Creating and Working in Interdisciplinary Psychiatric Teams

Chair: Rashi Aggarwal, M.D.

Presenters: Kari M. Wolf, M.D., Rebecca Sue Lundquist, M.D., Lindsey S. Pershern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the scope of the problem of the psychiatrist shortage in the US; 2) Describe the training models for other mental health professionals especially psychiatric APNs; 3) List 2 practical differences in training for APNs and psychiatrists; and 4) Identify 2 practical implications of differences in training.

SUMMARY:

The growing shortage of psychiatrists has exacerbated problems with access to psychiatric care in America. An important aspect of addressing this shortage is to focus on expanding the number of psychiatrists being trained in United States. However, to meet the psychiatric care needs of the population, it will also be necessary to utilize other trained professionals, including psychiatric advanced practice nurses (APNs), physician assistants (PAs) and other mental health professionals. Increasingly, psychiatrists will need to work effectively in teams with APNs and PAs, which requires mutual understanding of training, roles, and scope of practice. Given the psychiatric workforce shortage, it is important that each practitioner be able to fully utilize their education, skills, knowledge, and expertise. In this workshop, participants will build understanding of the training and skill set of the various mental health disciplines with focus on psychiatric APNs. Understanding the educational background of APNs is an important first step for psychiatrists seeking such partnership and for leaders in psychiatry who are hiring. The workshop will also highlight and discuss noteworthy differences between APN training and psychiatrists training and the practical implications for workplace settings. We hope that better understanding each other’s educational background will allow the participants to brainstorm models of effective collaboration that optimize the health and well-being of our patients while minimizing unnecessary costs.

Learning to Breathe Again: Mental Health Care for Diverse Medical Trainees in the Age of COVID-19

Chair: Amy Alexander, M.D.

Presenters: Diane Beth Gottlieb, M.D., Vanika Chawla, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the increased need for mental health treatment for physicians-in-training and the need for additional knowledge.; 2) Participants will identify the risks, vulnerabilities, special treatment considerations, and recommendations for providing mental health care

to medical students.; 3) Participants will identify the risks, and recommendations for providing mental health care to residents and fellows.; 4) Participants will increase their knowledge base and competency in working with diverse populations including racial, ethnic, and sexual minorities, and first-generation medical students and residents.; and 5) Participants will understand the unique impact of the COVID-19 pandemic on medical trainees, as well as policy considerations and recommendations..

SUMMARY:

Mental illness among trainee physicians is an increasingly pressing issue with significant personal and professional consequences. A high proportion of trainees experience significant work-related stress and burnout, (Dyrbye, 2015), and increased depression, anxiety (Roberts, 2018, Rotenstein, 2016, Mata, 2015), and suicide rates compared with the general population (Daskivich, 2015). In this workshop, we focus on the vulnerabilities, treatment considerations, and recommendations for working with medical trainees. We also address unique considerations for supporting trainees during the COVID-19 pandemic, as well as for diverse and underrepresented trainees. Current providers who specialize in working with medical students and residents will give presentations on these topics, with opportunities for case-based learning and interactive discussion. **MEDICAL STUDENTS:** Medical students are unlikely to seek help for their own psychiatric problems, often due to concerns about privacy, stigma, & time (Hankir, 2014). Telehealth has decreased some treatment barriers. Challenges posed by COVID-19 include disruptions to in-person clinical training; isolation; new challenges with virtual exams and residency applications; and personal experiences such as loved ones or themselves becoming ill with COVID-19. This has led to increased rates of anxiety and distress (Chandratre, 2021), especially in those with pre-existing mental health conditions (Guo, 2021). Clinicians and institutions must modify and enhance existing supports. **RESIDENTS:** Factors in the work environment contribute to the high rates of burnout and stress which residents experience. (Zhou, 2020). During the COVID-19 pandemic, residents have been exposed to new stressors, such as redeployment, potentially unsafe and increased workloads, and fear

of becoming infected, which increase their vulnerability to mental health difficulties. (Gregory, 2020) (Cabarkpa, 2020). **DIVERSE POPULATIONS:** Research has shown that Black, Latinx, native American trainees experience additional burdens due to factors such as microaggressions, being tasked as race ambassadors and identity challenges (Osseo-Asare, 2018). Sexual minority residents also experience higher levels of depression and anxiety attributable to lower perceived levels of a sense of belonging (Wang, 2020). First generation medical students report higher levels of stress, fatigue and financial stress, and lower levels of support, when compared to non-first-generation students. (Romero, 2020). There have been increased anti-Asian harassment and violence during the COVID-19 pandemic, affecting medical trainees as well. In summary, we explore considerations for mental health assessment of diverse populations of trainees and discuss recommendations for care of these populations in the setting of COVID-19.

Networking Skills for Future Career Advancement

Chair: John Luo, M.D.

Presenters: Josepha A. Cheong, M.D., Robert Joseph Boland, M.D.

Discussant: Marcia Verduin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize the common mistakes in an elevator pitch; 2) develop a strategy for connecting to the target audience; and 3) utilize tools to enhance networking efforts.

SUMMARY:

Networking an important skill in the career of an academician. It is often the conduit to future colleagues for collaboration in writing, workshops, organized psychiatry committees, and patient referrals. Networking may not be a natural skill for learners but it is easily learned. This workshop utilizes the 'elevator pitch' approach to concisely deliver a message to engage the target audience. There will be an interactive exercise as well as small groups to practice tips learned in this workshop. This workshop will also review strategies on how to

enhance networking efforts with technology such as social media, mnemonics, and the digital Rolodex.

Neurobiology of Inter-Relationship Between Sleep and Substance Use Disorders

Chairs: Sunila Nair, Ph.D., Gina Poe, Ph.D.

Presenters: Yanhua Huang, Ph.D., Ryan W. Logan, Ph.D., Jerome Siegel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relationship between sleep signatures and drug craving and seeking behaviors.; 2) Define molecular mechanisms involved in sleep and opioid withdrawal, craving and relapse.; and 3) Develop an understanding of the hypocretin (orexin) system in opiate addiction..

SUMMARY:

Substance use disorders (SUDs) and sleep disorders are intricately interconnected. Exposure to addictive substances evoke disturbances in sleep homeostasis, while sleep disturbances can increase the risk of development and severity of SUDs. Acute substance use disrupts sleep parameters such as latency, duration, quality and architecture of sleep. With chronic use, sleep disruptions intensify and withdrawal from substance use is often associated with chronic insomnia that enhances impulsivity and craving, increasing the propensity to relapse. Conversely, disruption in sleep homeostasis may increase drug intake, craving and the susceptibility to relapse to SUDs. This bidirectional relationship between sleep and SUDs has been demonstrated with a variety of substances with known addictive liabilities. While the relationship between SUDs and sleep is well known to be complex and bidirectional, less is known about the neurobiological mechanisms that underlie the intersection between sleep and SUDs. There are several brain regions and neurotransmitter substrates that underlie the regulation of arousal and sleep homeostasis, as well as motivation and reward. Locus coeruleus noradrenergic neurons, serotonergic neurons in the raphe, basal forebrain cholinergic neurons, midbrain cholinergic neurons, hypothalamic hypocretin (orexin) – ergic neurons, the endocannabinoid, the histaminergic systems and their projections regulate

arousal and sleep while also having known roles in reward-related behaviors. This panel brings together diverse expertise highlighting advances in understanding how discrete molecular targets, neural circuits and/or neuropeptidergic systems mechanistically intersect to create an inter-relationship between sleep and SUDs. Firstly, Dr. Yanhua Huang will discuss work identifying specific sleep signatures and their causal link to drug craving and seeking behaviors using an operant rodent self-administration model. Secondly, Dr Ryan Logan will present recent work using human postmortem tissues from people with opioid use disorder and describe molecular alterations upon exposure to opiates, as well as novel molecular mechanisms involved in sleep and opioid withdrawal, craving and relapse. Finally, Dr. Jerome Siegel will discuss the role of lateral hypothalamic hypocretin (orexin) neurons in opiate use disorder.

New and Improved! The ABPN Continuing Certification Program

Chairs: Robert Joseph Boland, M.D., Christopher R. Thomas, M.D.

Moderator: Catherine C. Crone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate the rationale behind continuing education; 2) Describe the ABPN Continuing Certification process, including the pilot process; and 3) Describe best practices for lifelong learning.

SUMMARY:

Continuing Certification (CC, formerly called Maintenance of Certification, or MOC) is a staple of all medical specialties. However, it continues to cause controversy and elicit emotions among many psychiatrists. Most professionals agree with the underlying rationale that once we finish our formal training, we should demonstrate that we are continuing to practice life-long learning. The devil is, however, in the details – for CC to be useful, the process should be relevant and meaningful to a psychiatrist's practice. The American Board of Psychiatry and Neurology (ABPN) is finishing a pilot program of an alternative approach to the Part 3

(10-year exam) portion of CC using a journal article-based assessment option. The pilot began in 2019. In this workshop, we will describe the pilot process and update participants on the results of the pilot. We will then discuss our ongoing plans, including how this alternative approach to CC will be implemented for all diplomates as well as incorporate subspecialty training into the process. We will also review recent updates to CC intended to make the process more accessible and educational for participants.

New Frontiers Targeting Neural Circuit Function to Develop Noninvasive Brain Stimulation Treatment Strategies for Substance Use Disorders

Chair: John Fedota, Ph.D.

Presenters: Khaled Moussawi, M.D., Ph.D., Travis Baker, Elizabeth West, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe state-of-the-art assessments of neurostimulation effects relevant to SUD; 2) Identify new circuit targets and stimulation protocols modulating SUD-relevant cognitive constructs; and 3) Appreciate how a better neurobiological understanding of SUD informs neuromodulation parameters.

SUMMARY:

Recent advances in our understanding of the neurobiological underpinnings of substance use disorders (SUD) and the effects of non-invasive brain stimulation (NIBS) open new avenues for improving the efficacy of treatment protocols. Identifying and quantifying neural circuits and proximal functions can define new targets for NIBS, tailor NIBS protocols for specific circuits and dysfunction, and more objectively measure the efficacy and outcome of NIBS. These advances add both to our understanding of the dysfunctions of SUD and the mechanisms of action of NIBS. In this symposium, a collection of early career scientists currently funded by NIDA will present findings of: new NIBS targets based on a lesion associated addiction remission brain network that aligns with existing circuit-based models of addiction and observed neuroimaging evidence (Dr. Moussawi); novel NIBS methods to restore flexible behavior and neuronal signaling in a

pre-clinical model of cocaine use disorder (Dr. West); recovery of reward function associated with the mid cingulate cortex and basal ganglia as indexed by electrophysiological measures in human problematic substance users (Dr. Baker).

Physician Depression and Burnout: An Organizational Problem in Need of Health Care System and Organizational Solutions

Chair: Constance Guille, M.D.

Presenters: Srijan Sen, M.D., Ph.D., Elena Frank, Ph.D., Rashi Aggarwal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the rationale for a tiered public health approach to addressing burnout and depression within healthcare organizations including primary, secondary, and tertiary interventions.; 2) Identify factors that have been shown to increase the risk for burnout and depressive symptoms among physicians to inform the development of preventative interventions.; 3) Effectively articulate the business case for and efficacy of organizational intervention to reduction burnout and depressive symptoms among healthcare professionals.; 4) Identify gender disparities among physicians and describe system level approaches to mitigating these differences.; and 5) Utilize the APA tool kit for effectively advocating for workplace improvements that reduce burnout and improve physician well-being..

SUMMARY:

Physician burnout, a work-related syndrome involving emotional exhaustion, depersonalization and a sense of reduced personal accomplishment, is prevalent and negatively affecting the health and lives of physicians, patients and healthcare systems and organizations. COVID-19 has further fractured the public health crisis of physician burnout, and the extend of COVID-19's consequences on burnout is yet to be fully realized. Action and a clear path forward to the successful development, adoption and implementation of organizational and system level interventions are greatly needed to alleviate the public health burden of physician burnout. Effective solutions to alleviating burnout need to

align with the organizational and system drivers of physician burnout. Excessive workloads, untenable patient-staffing ratios, long work hours, inefficient workflows, administrative and clerical burdens, work-home-family conflicts, lack of physicians input or control with respect to issues affecting their work and their patient's lives, lack of organizational support structures and poor leadership culture, need to be addressed to eradicate physician burnout. (1) System-level disparities faced by minority and underrepresented groups also play a role with higher rates of burnout commonly reported among female and younger physicians. (2) Interventions solely focused on alleviating symptoms of burnout among individuals will only temporarily alleviate suffering, at best. This symposium will provide the overarching framework for addressing burnout produced by healthcare organizations including a tiered public health approach including primary, secondary, and tertiary interventions. (3) Presenters will review the evidence supporting the organizational and individual drivers of burnout and depression among physicians to inform the development of interventions to mitigate the risk and burden of burnout and depression among physicians. (4,5) Presenters will discuss the efficacy of system level interventions shown to improve burnout and physician satisfaction as well as the business case to be made to healthcare organizations to adopt and support these interventions. (6) System-level disparities faced by minority and underrepresented groups will be reviewed as well as system level approaches to mitigate disparities will be discussed. (7,8) A tool kit developed by the APA Committee on Burnout and Well-Being will be presented including content and resources for participants to use when advocating for workplace improvements within their healthcare organizations and institutions.

Project I See Me__ : Mental Health Literacy Through Entertainment

Chair: Deepak Penesetti, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate knowledge of current psychiatry into discussions with patients; 2) Apply quality improvement strategies to improve clinical

care; 3) Provide culturally competent care for diverse populations; and 4) Identify barriers to care, including health service delivery issues.

SUMMARY:

GOAL: How do we help those who don't make it to our offices? **DESCRIPTION:** In this interactive and entertaining session, Dr. Deep Penesetti MD will show (not just tell) the power of mental health literacy through entertainment while revealing its clinical basis in Play Therapy. He will share his and his team's findings while developing Project I See Me __, an event series bringing world-class storytellers from Hollywood and mental health professionals together to help disseminate mental health literacy to our communities at a time when we've never needed it more. **BACKGROUND:** As professionals trained in working with the mind, we are our best when we can enter through the heart. The entertainment industry could be the unexpected and much needed public health partner to launch a therapeutic resource at scale. The power of entertainment allows us to talk about our lives indirectly in the way play therapy allows us to care for the mental health of children – characters resonate with us, and their stories help us process our own journeys. **CALL TO ACTION:** Our communities need psychiatrists to take the lead in guiding the mental health conversation that is already taking place outside of our offices. If we don't, others who may not be qualified will be at the helm posing significant public health risks. The stories are already out there, but the psychiatrists are not.

Promoting Diversity, Equity, and Inclusion: Mentoring Trainees Underrepresented in Medicine to Ensure Success and Belonging

Chair: Constance E. Dunlap, M.D.

Presenters: Dhruv R. Gupta, M.D., M.S., Sadé Diahann Frazier, D.O., M.S.

Discussant: Ranna Parekh, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the barriers faced by trainees who are underrepresented in medicine (URiM), including racial, ethnic, sexual, and gender

minority groups, in receiving effective mentorship.; 2) Identify institutional challenges that limit development of effective mentorship programs for URiMs.; 3) Discuss strategies to integrate a framework for effective mentorship for URiM trainees in an effort to promote diversity and inclusion.; and 4) Highlight the importance of effective mentorship including cross cultural training for all faculty to provide successful mentorship to URiM trainees..

SUMMARY:

While effective mentorship is critical for the professional development and success of trainees in medicine, URiM trainees often lack adequate opportunities for mentorship relationships. This can arise from bias, systemic discrimination, lack of support, and is exacerbated by a lack of URiM faculty role models. Further, establishing such programs is challenging when there is a dearth of mentors from backgrounds similar to those of mentees, often leading mentees to feel uncomfortable in their mentoring relationships and highlighting the need for developing cross-cultural mentoring programs. Working to mitigate these barriers and promoting comprehensive mentorship programs is a strategy widely proposed to help overcome the barriers faced by URiM trainees. Through this workshop, we hope to identify barriers in establishing effective mentorship programs for URiM trainees, discuss its overarching consequences (e.g., imposter syndrome, feelings of social isolation, limited opportunities for workforce diversity, among others), and present strategies to provide mentorship for URiM trainee success. We will present a mentorship model which highlights the importance of: connecting URiM trainees to research and clinical mentors with shared interests, encouraging involvement in scholarly projects, liaising with leadership to provide positive feedback, and serving as a resource for trainees. Next, provided the relatively lower numbers of URiM faculty members, we will shift to a discussion on cross-cultural mentoring and faculty development, focusing on strategies for non-URiM faculty to mentor trainees culturally different from them. Mentorship relationships between non-URiM faculty members and URiM trainees must openly address social injustices, institutional racism, stereotypes, and bias with intent to acknowledge structural

inequities that lead to differential educational opportunities. In addition to circumventing the shortage of URiM mentors, cross-cultural mentorship promotes diversity by creating groups that are more culturally aware, innovative, and have improved outcomes. In part two, the audience will be engaged and participants divided into small groups, composed of trainees and faculty members. They will be provided cases consisting of mentorship scenarios and recommended discussion questions to promote dialogue on barriers faced by URiM trainees, impact it can have on their professional development, and strategies to effectively mentor them. Hereafter, we will engage group members in role-plays, with simulated opportunities to practice building a mentorship relationship between a non-URiM faculty member and a URiM trainee, followed by opportunities for feedback from group members. We will conclude by reconvening participants; we plan to elicit experiences for an active discussion on URiM trainee mentorship and robust strategies to promote equity, diversity, and inclusion within training programs.

Promoting Health Equity for Adults With Intellectual and Developmental Disabilities: The Integrated Mental Health Treatment Guidelines for Prescribers

Chair: Jennifer Lyn McLaren, M.D.

Presenters: Andrea Caoili, Joan Beasley

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that people with intellectual and developmental disabilities (IDD) and co-occurring mental health (MH) needs experience gaps in healthcare services more often than the general population; 2) Identify a specific resource aimed toward holistic, interdisciplinary, integrated care approaches that can address several issues that lead to mental healthcare disparities; and 3) Discuss best practices in caring for an individual with comorbid IDD and mental health diagnoses.

SUMMARY:

Individuals with Intellectual and Developmental Disabilities experience significant health inequities in medical and psychiatric care. Few prescribers receive

guidance on the unique needs of individuals with intellectual and developmental disabilities and mental health service experiences (IDD-MH). The Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities, funded with a grant from the WITH Foundation was developed in 2020 in response to the need for more information to improve practices in the mental health system. In this presentation, we will describe the development process for the Guidelines including focus groups, peer review, evaluation and revision, and dissemination. Treatment recipients, families, and prescribers were integral partners in the development of effective guidelines, and to assure prescribers are made aware of the impact that medical and psychosocial factors have on emotional well-being. We will present an overview of the Guidelines and its origins. The Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities offers prescribers resources to promote an interdisciplinary, inclusive, and culturally competent approach to mental health treatment for prescribers. This includes strategies outside of psychopharmacology and considerations for biopsychosocial assessment and treatment along with positive psychology and other therapeutic mental health practices. The Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities offers methods to help overcome disparities in prescriber knowledge and practices. The Guidelines are now readily available for prescribers. Our hope is to promote greater equity for adults with IDD and shift toward multisystem interventions.

Psychiatrist Beware! Using Landmark Cases to Lower Your Malpractice Risk

Chair: Kayla L. Fisher, M.D., J.D.

Presenters: Stephen Noffsinger, M.D., Sara Gilmer West, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide recent data regarding physician malpractice risk and outcomes; 2) Examine rulings from landmark cases on topics such as Informed Consent, Confidentiality and Privilege,

Duty to Protect and Right to Refuse Treatment; and 3) Discuss how the application of these cases can help avoid malpractice pitfalls.

SUMMARY:

A majority of U.S. physicians have been sued, and nearly half of them more than once. Malpractice suits can arise when least expected and often take a hefty toll on a physician's personal and professional life. Issues such as informed consent, duty to protect, right to refuse treatment, and confidentiality surface regularly in psychiatric malpractice cases. Knowledge of landmark cases can help avoid these malpractice pitfalls. Rulings by the U.S. Supreme Court, U.S. Court of Appeals, and State Supreme Courts on these issues provide important guidance for lowering a psychiatrist's malpractice risk. In this presentation, we will examine: 1) the relationship between informed consent and negligence; 2) informed consent issues related to involuntary commitment, incompetency, and voluntary hospitalization; 3) what actions violate confidentiality; 4) when privilege can be asserted; 5) the relationship between duty to protect and foreseeable victims, specific threat, and unidentified third parties; and 6) the relationship between involuntary hospitalization and the right to refuse treatment. This presentation will include applications from these Court rulings that provide a framework for best psychiatric practices.

Psychotherapy for Addiction in a COVID World: Theory and Practice

Presenters: Petros Levounis, M.D., M.A., James Sherer, M.D.

Moderators: Philip R. Muskin, M.D., M.A., Nancy Diazgranados, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify one fundamental theoretical underpinning for each one of the major addiction psychotherapies of 2022.; 2) Match psychotherapeutic with psychopharmacological interventions for optimal management of substance use and other addictive disorders.; and 3) Discuss pros and cons of emerging tele-health platforms and

new mobile applications used in conjunction with psychotherapies in addiction treatment..

SUMMARY:

Substance use disorders and the behavioral addictions have spiked during the COVID pandemic. Now more than ever, mental health providers are asked to assess for addiction and are expected to manage people’s problems with substances and addictive behaviors effectively. Along with the psychopharmacology for opioids, tobacco, and alcohol, psychotherapy has been shown to be the staple of safe and effective addiction treatments. Brief Intervention (BI), Cognitive Behavioral Therapy (CBT), Contingency Management (CM), group psychotherapy, mindfulness, Motivational interviewing (MI), and mutual-help facilitation are the primary psychotherapeutic modalities that treat addiction and bolster recovery. In this clinical update, we will provide an overview of the theory behind different psychotherapies for addiction, as well as give practical suggestions on how busy psychiatrists can implement these techniques in their own clinical work. Special emphasis will be given to the integration of different psychotherapies with the psychopharmacology of addiction and other co-occurring psychiatric disorders. BI, CBT, CM, groups, mindfulness, MI, and mutual-help programs can be paired with medication management for great outcomes. Furthermore, we will examine how these therapies may (or may not) lend themselves to tele-health in the COVID and, hopefully, post-COVID era. We will discuss tele-health platforms; new applications that are used in conjunction with psychotherapy to help patients on the road to recovery; and mobile applications that can assist with medication management. Technology may deliver much needed support for many patients during the pandemic—ironically, even for patients who suffer from one of the emerging technological addictions!

SAMHSA’s New Office of Recovery: Living Well in Recovery

Chair: Dona Dmitrovic, M.H.S.

Presenters: Dona Dmitrovic, M.H.S., Keris Myrick, M.B.A., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define what is meant by recovery; 2) Discuss the impact of policies and programs on the recovery process; 3) Examine how the COVID-19 PHE has impacted rates of substance misuse and mental health across the nation; 4) Discuss how the mental health, overdose crisis and the COVID-19 PHE impacts future interventions and work; and 5) Illustrate SAMHSA’s role in promoting substance use and mental health disorder identification, treatment, and recovery.

SUMMARY:

On September 30, 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the launch of its Office of Recovery. This office has been established to advance the agency’s commitment to, and support of, recovery for all Americans. SAMHSA has a long history of advancing Recovery Support dating back to the 1980s with the Community Support Program and the 1990s, when the first Recovery Community Support Programs were funded. Mental health recovery support began in 1977 with the initiation of the Community Support Program. Launched by NIMH, this initiative supported community living for people with serious mental illness including holistic, consumer-centered care that incorporated self-help approaches. Beginning in the 1980’s, NIMH and then SAMHSA began funding consumer-operated service programs and requiring consumer involvement in the planning, delivery and evaluation of services. SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. There are four major dimensions that support recovery: Health; Home; Purpose; and community. Cutting through these dimensions are the social determinants of health. The Social determinants of health (SDoH), defined as “the conditions in which people are born, grow, live, work and age, and which are shaped by the distribution of money, power and resources”, have a considerable influence on the health of the US population, and are thought to be the primary driver of health inequities. Many people in recovery have faced difficult SDoH, including Adverse Childhood Experiences (ACEs). Indeed, recent research

demonstrates that there is a direct correlation between ACEs and the initiation of SUDs later in life. Other contributing factors include low educational attainment, which is associated with substance misuse later in life, as well as a host of other medical and socio-economic difficulties. SAMHSA has established recovery support systems to promote partnering with people in recovery from mental and substance use disorders. This presentation will expand upon this and also the role of the Office of Recovery.

Sleep and Sleep Disordered Breathing Impact the Presentation, Diagnosis and Management of Psychiatric Disorders.

Presenter: Richard K. Bogan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand sleep circadian processes and the effect on sleep/wake processes.; 2) Recognize sleep homeostatic drive and the clinical impact of pathology.; 3) Define how sleep pathology is evaluated to include patient reported measures and other diagnostics.; 4) Recognize the impact of sleep disorders on evaluation and management of psychiatric disorders.; and 5) Translate sleep diagnostics and understanding into psychiatric disease management..

SUMMARY:

Most psychiatric disorders have associated sleep disturbance. Many psychiatric disorders are not adequately treated until the sleep pathology is corrected, particularly sleep disordered breathing. Untreated obstructive sleep apnea often inhibits or delays response to therapy for depression. Sleep is a fundamental homeostatic drive. Circadian physiology protects sleep/wake stability. This physiologic stability protects us; enabling us to survive, exist and flourish. Impairment of quantity, quality and continuity of sleep has dramatic impact on normal physiologic processes including alertness, mood, executive function and coping skills. Anytime someone has impairment in energy, mood, executive cognitive function, attention as well as sleepiness, a clinician should query as to sleep processes and pathology. The clinician should

explore and recognize the impact of sleep processes and pathology on the underlying clinical disease process; as well as define diagnostic and treatment intervention to optimize disease management. This discussion focuses on the importance of sleep; recognizing sleep pathology, how to define the abnormality and what to do. Of importance is the impact of obesity and snoring on sleep. Seventy percent of patients with sleep disorders presenting for polysomnography traditionally have sleep disordered breathing. This discussion will focus on basic sleep physiology, the impact of pathology and how do we quantify the abnormality. Questions to be considered include the following: How do we recognize the influence of sleep pathology? What validated patient reported measures guide us to recognition the associated sleep disorders? How do we proceed with diagnostics to define sleep pathology and its influence? What action do we take to improve patient management?

Social Determinants of Substance Use Disorders During COVID Time

Chair: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the current state of the opioid crisis in the U.S.; 2) Appreciate the added social challenges facing those with substance use disorders during the COVID-19 pandemic; and 3) Better understand some of the unique social determinants facing those with substance use disorders during the COVID-19 pandemic.

SUMMARY:

The alarming escalation of drug use and overdose deaths in the United States reached an all-time high last year with the CDC reporting more than 100,000 overdose deaths between April 2020 and April 2021. Although the propensity to use drugs has strong biological, genetic, and developmental underpinnings, the interactions with environmental factors in a range of social domains profoundly impact an individual's risk for drug taking, their propensity to seek treatment for their drug use, and their tendency to relapse. The current drug crisis has been further heightened by the COVID-19 pandemic

and the associated social and structural challenges faced by those with substance use disorders—many of which are indirect. They arise from such factors as housing instability and incarceration, as well as reduced access to health care and recovery support services. A high percentage of individuals with SUD experience homelessness, and vice versa, which further increases their risk of infection when living in homeless shelters. The same is true of incarceration. More than half of U.S. prisoners have SUD, and prison populations are at great risk for disease transmission during epidemics. This presentation will highlight how NIH researchers are using scientific advances to address the opioid crisis amidst the COVID pandemic, which includes the development of new medications and formulations to help treat opioid use disorders and overdoses; prevention strategies to mitigate an individual's vulnerability to addiction; and implementation science to guide optimal deployment of therapeutic interventions including the use of telehealth in diverse settings (healthcare, justice setting, rural communities). Exacerbation of healthcare disparities from COVID-19 driven by social and economic factors that place certain groups at increased risks for both SUD as well as risk and adverse outcomes from COVID-19 will be addressed and mitigation strategies discussed.

Social Media and Psychiatry: Using Lessons Learned From Virtual Recruitment to Improve and Expand Your Online Presence

Chair: Daniel E. Gih, M.D.

Presenters: Gabrielle Elizabeth Hodgins, M.D., Simone Ariel Bernstein, M.D., Samir Johnny Abu-Hamad, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to explore ways residency programs have grown their digital presence and formulate resident-led recruitment initiatives.; 2) At the conclusion of this session, the participant will be able to synthesize new data about the use of virtual residency recruitment initiatives and their impact on psychiatry applicants.; 3) At the conclusion of this session, the participant will be able to construct resident-driven virtual recruitment

efforts to enhance a program's culture and promote diversity.; and 4) At the conclusion of this session, the participant will be applying the lessons learned from virtual recruitment to maximize their own online presence..

SUMMARY:

The 2020-2021 residency recruitment season was turned on its head by COVID-19. At the recommendation of the Association of Directors of Medical Student Education in Psychiatry and the American Association of Directors of Psychiatric Residency Training, recruitment moved to a virtual format for 2020-2021 and 2021-2022.^{1,2} The corresponding transition to virtual recruitment led to a massive shift in the use of digital platforms by programs, and oftentimes, these were resident-led efforts.³ In our increasingly digitized health care system and the growing influence of social media, future use of social media will continue as a business and recruitment tool. The lessons learned through two seasons of virtual recruitment provide critical insights regarding the use of social media platforms not only for residency recruitment but also for providers looking to attract future employees and patients.⁴ During this workshop, we will first provide an overview of social media use by residency programs. We will explore recruitment initiatives prior to the pandemic and highlight novel research data that quantifies the increase in social media use by programs that occurred during the pandemic. From data collected in March 2021, of the 109 psychiatry residency programs with Instagram accounts, 99 (90.8%) were created in 2020 amid the pandemic. Next, survey-generated data regarding applicants' perception of social media use by training programs will be presented and discussed. This data will be further stratified by demographics in order to demonstrate the impact of social media use on efforts to increase diversity in the workforce. Throughout the workshop, we will facilitate small group discussions of attendee perceptions of social media posts, how social media use can be improved to attract a diverse group of trainees or future employees, and ways in which providers can expand their online presence. The session will end with a summary of the information presented and a question-and-answer session, including a take-home guide highlighting how we can utilize these tools to

attract and recruit a diverse group of trainees, future employees, or patients.

Supporting ECPs and RFMs in Their Careers and Beyond

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

Presenters: Elie Aoun, M.D., Sanya A. Virani, M.D., M.P.H., Urooj Yazdani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; and 3) Describe the utility of psychotherapeutic and pharmacological treatment options.

SUMMARY:

This session is open to APA members who are residents or early career psychiatrists. In a small group discussion with APA CEO and Medical Director Saul Levin, attendees will have an opportunity to discuss challenges faced by residents and early career psychiatrists in their clinical setting and to brainstorm ways in which the APA might be able to assist. Attendees will hear from the ECP and RFM trustees to the APA Board on their experiences. Topics for discussion include the future of psychiatric care, challenges related to career advancement, workforce development, and promoting equal representation of minority ECPs and RFMs in leadership roles. PRESENTER UPDATE: Urooj Yazdani, M.D. will also present.

The Biological Underpinnings of Schizophrenia: From the Genome to the Connectome

Introduction: Lama Bazzi, M.D.

Presenter: Anil Malhotra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to discuss environmental and biological risk factors for schizophrenia.; 2) At the conclusion of this session, the participant will be able to understand the recent data from genetic studies detecting genes that influence risk for schizophrenia.; and 3) At the

conclusion of this session, the participant will be able to discuss new data from brain imaging studies on the neural circuitry of schizophrenia..

SUMMARY:

Schizophrenia is a chronic psychiatric disorder that includes positive symptoms such as hallucinations, delusions, and formal thought disorder, negative symptoms such as amotivation and alogia, and cognitive impairment. The disorder is found worldwide, with a prevalence from 0.4-~1% of the general population, and accounts for an ever-increasing amount of disability, as well as morbidity and mortality. Multiple factors increase risk for the disorder including social factors such as urbanicity and parental deprivation, exposure to infectious agents and famine, prenatal and obstetrical complications, childhood trauma and substance abuse, amongst others. Treatment is primarily with antipsychotic drugs that work via dopamine receptor blockade, which are primarily effective for the positive symptoms, but have diminished efficacy for negative symptoms and cognitive impairment and may result in adverse effects such as neuromotor abnormalities and metabolic disturbances. In this presentation, we will first review these data on schizophrenia, and then discuss new results from current research that focus on genetic and brain imaging methods that provide new clues to the biological underpinnings of this devastating and disabling disorder. Initial evidence for genetic factors influencing risk for schizophrenia is based upon twin studies demonstrating greater concordance for schizophrenia in monozygotic twins versus dizygotic twins, as well as multi-generations family studies. Initial genetic linkage studies largely failed to reliably detect any genes of major effect, but more recent association studies with increasingly comprehensive and cost-effective genotyping methods have now led to the detection of hundreds of risk loci. Moreover, it is increasingly recognized that schizophrenia is a polygenic disorder, with perhaps tens of thousands of individual loci imparting some influence on risk, and polygenic risk scores derived from these studies provide new insights into illness susceptibility, the overlap between psychiatric disorders, and the relationship of genetic risk to treatment response and other clinical manifestations of illness. Brain imaging studies initially focused on structural brain

changes associated with illness, with consistent reports of ventricular enlargement and cortical thinning in patients with schizophrenia. More recent studies assess the relationship of neural circuitry to illness risk by measuring the functional connectivity between brain regions as assessed with magnetic resonance imaging (MRI). These studies increasingly implicate cortico-striatal connectivity dysfunction in schizophrenia, as well as suggest that amelioration of these disturbances may mediate the effects of antipsychotic drug treatment in a significant portion of patients. These data suggest that there may be detectable MRI biomarkers in treatment response and provide empiric support for the development of new non-dopaminergic treatments of schizophrenia.

The Dimensions of Personality

Chair: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the template of the Alternative DSM-5 Model for Personality Disorders (AMPD); 2) Compare the AMPD with the proposed model for personality disorders for ICD-11; 3) Utilize the AMPD in clinical settings to judge its clinical utility; and 4) Identify the continuum between well-functioning personality styles and personality disorders.

SUMMARY:

A broad consensus has developed that personality pathology is best conceptualized dimensionally, rather than as a set of discrete, categorical disorders. The Alternative Model for Personality Disorders (AMPD), in Section III of DSM-5, represents a step in the dimensional direction. The AMPD has now been studied extensively, confirming its validity and clinical utility, work that will be briefly summarized. As well, the recently published Structured Clinical Interview for the Alternative Model for Personality Disorders (SCID-AMPD) will be described. Internationally, a major revision of the Personality Disorders section of ICD-11 has been developed, to be implemented in Europe in 2022. The ICD-11 model adopts a more definitive dimensional approach, yet there are striking similarities between the AMPD and the ICD-11 model, which will be

described. Finally, an educational web-based personality assessment system will be briefly reviewed.

The Neurobiology of Alcohol Use Disorder: A Heuristic Framework for Diagnosis and Treatment

Chair: George F. Koob, Ph.D.

Presenter: Frances Rudnick Levin, M.D.

Moderators: Philip R. Muskin, M.D., M.A., Nancy Diazgranados, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Comprehend the neurobiology of Alcohol Use Disorder; 2) Understand the role of emotional and physical pain among those with AUD; 3) Be aware of the advantages and disadvantages of FDA-approved pharmacologic interventions for Alcohol Use Disorder & Assess for psychiatric comorbidities in the context of ongoing alcohol use disorder; and 4) Implement therapeutic interventions for comorbid psychiatric and substance use disorders among those with an alcohol use disorder with cognizance of how the addiction cycle may impact treatment efficacy.

SUMMARY:

Alcohol use disorder (AUD) is a chronically relapsing disorder that is characterized by a compulsion to seek and take alcohol, loss of control in limiting intake, and emergence of a negative emotional state (e.g., hypohedonia, dysphoria, anxiety, hyperalgesia, irritability, and sleep disturbances, defined as “hyperkatifeia”) when access to the drug is prevented. AUD can be framed as a three-stage cycle—binge/intoxication, withdrawal/ negative affect, and preoccupation/anticipation that has heuristic value for translating the brain changes associated with AUD to the clinical domain. Here, dysregulation occurs in three functional domains that reflect the three stages of the addiction cycle: incentive salience/pathological habits in the binge/intoxication stage, negative emotional states in the withdrawal/negative affect stage, and executive function deficits in the preoccupation/anticipation stage. These three domains and stages are hypothesized to be mediated by three major neurocircuitry elements:

basal ganglia, extended amygdala, and prefrontal cortex, respectively, and an individual can enter the addiction cycle at any of these three stages. Among such multiple sources of motivational dysregulation, one, gaining significant traction, is negative reinforcement driven by the emotional pain of alcohol withdrawal and protracted abstinence. Negative reinforcement is defined as alcohol taking that alleviates the negative emotional state or hyperkatifeia that is created by drug abstinence. Compelling evidence exists to argue that hyperkatifeia triggered by acute excessive alcohol intake, is sensitized during the development of compulsive alcohol taking with repeated withdrawal, persists into protracted abstinence, and contributes to the development and persistence of compulsive alcohol seeking. Hyperkatifeia that drives negative reinforcement is hypothesized to derive from loss of function of key neurochemical circuits within the brain reward systems (dopamine and opioid peptide) in the basal ganglia and gain of function of the brain stress systems (corticotropin-releasing factor, dynorphin, norepinephrine, hypocretin, vasopressin, glucocorticoids and neuroimmune factors) in the extended amygdala. Significant overlap in the engagement in AUD of neural circuits mediating emotional pain and physical pain may provide insight into the development of medications and other treatments to reverse the allostatic changes to reward and stress circuits that drive and perpetuate AUD. Breaking this cycle is possible through the use of FDA-approved medications and other promising therapeutic agents. These interventions have distinct advantages for certain patient groups. Moreover, treatment of comorbid psychiatric disorders, often pre-existing or worsened by this addiction cycle, may be amenable to targeted pharmacologic strategies. A case presentation will elucidate potential treatment strategies for individuals with AUD and co-occurring psychiatric disorders.

The Rainbow Nation

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

Presenters: Sebolelo Letshego Seape, M.B.B.S.,

Mvuyiso Talatala, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Social determinants of mental Health • Mental wellbeing is largely shaped by the social, economic, physical and environmental factors. • Correction is through political action; 2) A brief history of The Repressive years of Apartheid Legislation • Legislation that upheld White Supremacy, abused Black people and prohibited blacks from having a reasonable quality of life; 3) The Truth and Reconciliation Commission • To Promote national Unity and Reconciliation in a traumatised population; 4) Qualities of a leader • “As I walked out the door towards the gate that would lead to my freedom, I knew if I didn’t leave my bitterness and hatred behind, I’d still be in prison,”; and 5) The 4th South African Constitution • Human Rights based constitutional order and the social determinants of mental health.

SUMMARY:

The laws of Apartheid South Africa were severely repressive and were formulated to oppress people of Colour and in particular, the black people. It was within the law to physically, emotionally, psychologically and economically abuse Black people, deny them human rights, appropriate education, health care, justice, jobs and render them stateless. Since at least 1943 Nelson Mandela entered the political scene as a youth leader of the African National Congress and through 27 years of incarceration, he represented freedom, equality, and a better life for all. The Truth and Reconciliation Commission and the adoption of the new constitution in 1996 by South Africa are some of the major events under Mandela’s government that earned South Africa a good standing on human rights in the world. It is the rights enshrined in this constitution and the supremacy of the constitution that protect vulnerable population groups including people with mental illness. These rights were protected by the Constitutional Court during the era of AIDS denialism and were further entrenched during the Life Esidimeni Tragedy where patients with severe mental illness and intellectual disability where patient care was neglected by the government. This tragedy resulted in the death of over 140 patients (Makgoba 2018). This presentation will give a background to the Mandela years to show

how the respect for human rights, dignity and its entrenchment into law has yielded protective mechanisms for the mental health of South Africans years after Mandela was no longer in power.

The Status of Laboratory Testing to Predict Antidepressant Response: Problems and Promises

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand the scientific principles that underlie genetic testing in medicine.; 2) At the conclusion of this session, the participant will be able to understand the current status of pharmacogenomics testing in predicting treatment response in psychiatry.; and 3) At the conclusion of this session, the participant will be able to understand the future of personalized medicine in psychiatry..

SUMMARY:

Ever since the development of the first two classes of antidepressant medications, tricyclics and monoamine oxidase inhibitors, psychiatrists have wished for development of predictors of response. This is of great clinical importance because the longer patients remain depressed, the greater the risk of a poor outcome including suicide and illicit substance abuse and alcohol abuse. Of course, there are now multiple classes of antidepressants and considerable pharmacological differences between the members of the different classes and even among those within a class, e.g. SSRIs. In the past several years much attention has focused on development of laboratory tests to predict response to antidepressants-both their therapeutic effects and their side effects. The use of pharmacogenomic testing has received considerable attention in recent years. In spite of a focus on both genetic polymorphisms in candidate genes believed to be involved in the mechanism of action of antidepressants or the pathophysiology of depression, i.e the serotonin transporter and genetic variations in cytochrome P450 isoenzymes that are responsible for the metabolism of antidepressants (presumably impacting on blood levels), the

randomized clinical trials that have been conducted have uniformly failed to show any value of pharmacogenomic testing. Primary outcome measures have failed to separate in the GUIDED study, in a replication study conducted at Mass General Hospital and now more recently in a Mayo Clinic study of adolescent depression. Multiple reports by commercial vendors of these pharmacogenomic test batteries of secondary outcome measures cannot hide the collective failure of these three randomized controlled trials. It is certainly possible and even likely that as additional genetic polymorphisms, based on recent GWAS studies, are included and the populations studied more homogeneous, there will be a role for pharmacogenomic testing in psychiatry. Other potential tests including EEG and functional magnetic resonance imaging studies have shown promise in early studies of antidepressant response prediction. In conclusion, the question of To Test or Not to Test using pharmacogenomics to predict antidepressant response is a resounding NO.

The Structural Determinants of Mental Health: Clinical Care, Education and Research

Chair: Dolores Malaspina, M.D., M.S.

Presenters: Kimberly Gordon-Achebe, M.D., Lisa Fortuna, M.D., M.Div., M.P.H., Francis Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) list structural and individual social determinants of mental health; 2) Describe the relationship between racism and social determinants of mental health; 3) list changes needed in clinical coding to address social determinants of mental health; and 4) Describe why SDofMH should inform clinical treatment plans.

SUMMARY:

The increased focus on social determinants of health by the WHO and the CDC presented a springboard for psychiatry to emphasize the social determinants of mental health (SDOMH), which was catapulted into the spotlight by the current national public health crisis as the enormous impact of socially driven health disparities was recognized. Individual clinicians, academic departments, and healthcare

organizations are at last contemplating strategies to dismantle health inequities. Knowledge on SDOMH can be employed to improve the health of the population, reduce the risks for psychiatric illness and advance clinical care to optimize treatment response and quality of life for individual patients. While prevention necessarily involves policy changes and public sector interventions, there is a pressing need to address SDOMH at the clinical interface. Current research is defining and standardizing assessment tools and examining the medical – psychiatric comorbidities associated with SDOMH as proinflammatory exposures requiring collaborative care. Trainees and clinicians need to learn how to assess patient exposures to SDOMH and understand the influence of these determinants on clinical presentations and treatments. Optimal outcomes may require interventions to address current needs for food, housing, transportation, safety and social isolation. Understandably, the largest impact for addressing SDOMH will be in child psychiatric approaches. Some training programs have developed curriculum on SDOMH for child and adolescent psychiatry (CAP) training, but strategies are also needed that incorporate social justice and anti-racism. Because of a lack of transparency about diversity, equity, and inclusion (DEI) processes and implementation efforts across institutions, there are discordant developmental approaches to building stronger child and adolescent psychiatry curricula among program directors that address social justice issues. Specifically antiracist approaches are needed to addressing the SDOMH in children and adolescents to achieve health equity for Black, Indigenous and Persons of Color (BIPOC). This change in practice may require changes in medical coding and systems of care, as will be presented, and in re-conceptualizing several aspects of cultural assessments.

The Theory of Opioid Use Disorder (OUD)

Presenters: Wilson M. Compton, M.D., Edward V. Nunes, M.D.

Moderators: Philip R. Muskin, M.D., M.A., Nancy Diazgranados, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how opioids produce their effects on the brain and body; 2) Appreciate the growing individual and public health burdens of OUD; 3) Understand the current range of effective available treatments and ongoing efforts to develop even more; 4) Understand the evidence from large clinical trials about the effectiveness of medications for treatment of opioid use disorder—methadone vs buprenorphine vs naltrexone; and 5) Understand the basics of prescribing medications for opioid use disorder and patient management.

SUMMARY:

Opioids, a class of drugs that includes heroin, synthetic opioids like fentanyl, and pain relievers legally available by prescription, such as oxycodone, and hydrocodone, exert their effects by attaching to opiate receptors found in the brain and many other organs. These drugs block the transmission of pain messages through peripheral and central effects, cause pleasurable sensations by activating brain reward regions including the brain dopamine reward pathway and regulate respiration by its effects in brain stem breathing centers. When used as indicated, opioids can be therapeutically very useful such as when used for severe pain conditions including cancer pain or to facilitate anesthesia among others. Non-medical use, in contrast, often results in physical dependence and addiction and can lead to overdose deaths from respiratory depression. After repeated opioid use, tolerance often develops, necessitating progressively higher doses to achieve the desired drug effect. The individual and public health burdens of OUD in recent years are staggering with >100,000 opioid overdose deaths annually. OUD is a chronic, relapsing, treatable disorder which is best understood as a biopsychosocial disorder in which genetic factors, exposure to adverse childhood experiences, mental disorders, and accessibility of drugs in the environment influence the extent of exposure and the opportunity for drug use. Over the past several decades, a range of treatments including medications and behavioral therapies have been developed which are effective at helping patients stop using opioids and achieve recovery. And, on the horizon, there is ongoing research to

develop anti-opioid immunotherapies, new medication, and neuromodulation techniques to treat OUD. Three medications are currently available for treatment of opioid use disorder, all acting at opioid receptors, with diverse mechanisms—methadone, a full opioid agonist; buprenorphine, a high-affinity partial agonist; and naltrexone, a high-affinity antagonist available as an extended-release injection. Clinical trials among patients presenting with active heroin or other opioid use show that 40% to 75% of patients will be retained in treatment 3 to 6 months after treatment entry with opioid use reduced or eliminated. This is remarkable effectiveness in a patient population where the placebo response rate is very low. Yet, most people with opioid use disorder are not receiving medication. Barriers to more widespread use of these medications include stigma around substance use disorders and around medication treatments, variable adherence by patients to taking the medications, limited funding for treatment, and lack of willingness or knowledge on the part of prescribers and health systems to get involved. Progress is being made on each of these fronts with strategies including anti-stigma public health messaging, development of treatment systems, and education and mentoring of psychiatrists and other physicians.
PRESENTER UPDATE: Wilson M. Compton, M.D. will replace Nora D. Volkow, M.D.

The Voices of Spirit and the Voices of Madness

Presenter: Tanya Marie Luhrmann, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand that not all voice-hearing events are necessarily the product of psychosis; 2) To understand that culture may affect the experience of both clinical and non-clinical voices; and 3) To understand that absorption and cultivation may affect the experience of voices.

SUMMARY:

They are strange experiences—a voice whispered on the wind, a god who speaks from on high—but far more common than we think. At the beginning of most great religions lies a voice. Who hears such voices? I have spoken to hundreds of people, in

many countries, who have heard voices, some only once, some more often. Most of these people are not psychiatrically ill. Some are. In this talk I will discuss what we know about the difference between mad voices and sane voices, and what traits and practices and cultural ideas make sane voices more likely. I will also talk about the evidence that the way we think about voices changes our experience of them—and may soften the impact of psychosis.

Tricks of the Trade: Editors' Advice on How to Get Published

Chair: Soren D. Ostergaard, M.D., Ph.D.

Presenters: Anthony Joseph Rothschild, M.D., Lisa Dixon, M.D., Soren D. Ostergaard, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine the correct order of authors on a manuscript and choose a good target journal; 2) Identify the best submission types for different manuscripts; and 3) Respond more convincingly to comments from peer reviewers.

SUMMARY:

Publishing is a fundamental part of (psychiatric) research, but conducting good research is not enough to get published. Indeed, the publication process is a discipline of its own, which is unfortunately not taught in medical schools nor in postgraduate clinical/research training. Further, the challenges and opportunities of publication extend beyond research to other types of scholarly writing. Therefore, the aim of this session is to provide the participants with some of the tricks of the publication trade. The three speakers have experience both as publishing researchers and as editors for internationally renowned journals in the field of psychiatry. During the session, the speakers will engage with the audience and address some of the common challenges encountered during the peer review and publication process. First, Dr. Anthony J. Rothschild (Editor-in-Chief of *Journal of Clinical Psychopharmacology*) will touch upon a sensitive and critical topic, namely the order of authors on a manuscript. Furthermore, he will give advice on how to choose a target journal. Second, Dr. Lisa Dixon (Editor-in-Chief of *Psychiatric Services*)

will discuss the differences between various submission types and how to choose the right one for a given manuscript. Third, Dr. Søren Dinesen Østergaard (Deputy Editor of *Acta Psychiatrica Scandinavica*) will share his experience on how to respond to the comments raised by peer reviewers. Also, he will provide examples of the rare situations in which appealing a rejection may be considered. Finally, 25 minutes is allocated for a Q&A during which the speakers will take questions and discuss with the audience. The aim is to have a very interactive session.

Updates From the Council on Psychiatry and the Law

Chair: Debra A. Pinals, M.D.

Presenters: Carl Erik Fisher, M.D., Reena Kapoor, M.D., Elizabeth Ford, M.D., Marvin Swartz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of the Council of Psychiatry and the Law and the Committee on Judicial Action for APA; 2) Describe areas of focus of the Council pertinent to practicing psychiatrists;; and 3) Discuss policy implications at the interface of Law and Psychiatry based on topics presented.

SUMMARY:

This workshop will provide members with an overview of the Council on Psychiatry and Law development of APA Resource Documents and policy in the form of Position Statements. The goal of the workshop is to provide members an update on recent and ongoing issues that the Council is addressing. This workshop will provide the members with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Pinals will provide an overview of the process and discuss a potential resource document on the issue of prosecution of psychiatric patients. Dr. Swartz will review a recently updated position statement pertaining to college mental health. Dr. Ford will review recent resources and positions from the correctional psychiatry task force. Dr. Fisher will discuss a recently drafted resource document on safe consumption facilities. Recent legal cases taken up by the Committee on Judicial Action will be

reviewed by Dr. Kapoor. In each area, the Council will elicit feedback from members regarding the important policy issues including diversity and engage participants to consider new areas of interest for the Council. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

Will Technology Transform Psychotherapy? Promises and Perils of Digital Psychotherapies and Direct Current Brain Stimulation

Chair: Dilip V. Jeste, M.D.

Presenters: Kara Bagot, Tarek Rajji, M.D., John Torous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply validated criteria for diagnosis of schizophrenia, depression, substance use disorders, and mild cognitive impairment remotely; 2) Provide certain digital behavioral interventions to mentally ill patients from different age groups; and 3) Understand psychobiology underlying the use of transcranial Direct Current Stimulation in persons with depression or mild cognitive impairment.

SUMMARY:

Traditionally, psychotherapy has involved in-person interactions between care-recipients and their therapists. Yet, recent advances in technology along with the Covid-19-associated social distancing, have hastened a rapid growth of electronic psychotherapies administered remotely. Concurrent developments in neuroscience have enabled direct current brain stimulation to enhance neuroplasticity even in older adults. This Symposium will present a balanced view of the promises and perils of technology-facilitated advances in digital psychotherapies and direct neurostimulation for people with mental illnesses across the lifespan. Bagot will provide an overview of modes of delivery and effectiveness of mobile and digital health interventions for adolescents with mental illnesses such as substance use disorders. Nearly 75% of psychiatric illnesses emerge before age 25. Notably, 95% of adolescents in the US engage with mobile and digital technologies via smartphone, and use

them to access health-related information and care. Digital mediums help reduce common barriers in accessing mental healthcare and improve engagement and retention in treatment. Certain digital interventions have been found to be acceptable and efficacious among vulnerable youth, although there are risks of overuse. Torous will explore digital phenotyping at the level of sensors, data science, and healthcare, presenting its risks, benefits, and potential. Specific examples include relapse prediction in psychosis and customizing clinical care for patients with depression. As digital health technologies expand in scope and availability, the need to tailor them to patients' real time needs increases. This talk will focus on how new data streams from commercial devices can help inform or hurt care, with examples from research studies, clinical care, and novel devices. Rajji will discuss recent advances in combining transcranial Direct Current Stimulation (tDCS) with cognitive remediation to enhance prefrontal cortical function in older people at risk of developing dementia. He will also present on novel neurophysiological measures that index prefrontal cortical function and could serve as a target to engage using tDCS with or without cognitive remediation. The prefrontal cortex is thought to support, via its connections, compensatory mechanisms that help in delaying or preventing cognitive decline in high-risk conditions like major depression and mild cognitive impairment. Consistent with the 2021-22 Presidential Theme, Jeste, who Chairs the APA Presidential Task Force on Social Determinants of Mental Health, will discuss how the technology-based interventions can help people with mental illnesses, especially those coming from diverse marginalized populations. There will be ample opportunities for Q&A and general discussion with the audience throughout this Symposium.

Tuesday, May 24, 2022

Adapting Evaluation and Treatment of ADHD for High IQ Kids and Adults on the Autism Spectrum

Chair: Thomas E. Brown, Ph.D.

Presenters: Ryan J. Kennedy, D.N.P., N.P., Elizabeth A. Laugeson, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) describe unique challenges of those with combined ADHD/ASD and their families.; 2) select and; 3) suggest and provide effective psychosocial interventions to support patients with ADHD/ASD, their parents, and other family members; and 4) describe important similarities and differences between ADHD and Autism Spectrum Disorder.

SUMMARY:

CDC estimates indicate that 1 in 54 children in the U.S. is diagnosed as being on the autism spectrum. While most on that spectrum suffer from intellectual disability or borderline cognitive abilities, 44% on this spectrum have average or above average IQ. Those with relatively high IQ face many unique challenges in their schooling, social interactions, and employment. Moreover, about 3/4 of clinically-referred persons with Autism Spectrum Disorder (ASD) also suffer from significant ADHD-related impairments. Objective of this general session is to provide clinicians with information and strategies to improve clinical understanding, treatment, and support for patients with ADHD/ASD and their families. Methods will include lectures including relevant research data, a variety of case examples and outcomes from various interventions utilized with high IQ patients with ADHD/ASD and their families. Numerous successes and some failures will be reported. Presentations will cover: 1. Review of similarities and differences between ADHD and ASD, review of recent research on genetic heritability as well as quantitative and qualitative similarities and differences. 2. Adaptations of evaluation and treatment approaches for higher IQ children, adolescents and adults with both ADHD and ASD. Case examples will be used to highlight strengths and difficulties of those with high IQ as well as adaptations to help assessment and to sustain effective treatment for executive function impairments related to ADHD. 3. Selection and "fine-tuning" of medications for those with relatively high IQ, ADHD and ASD. Emphasis will be on "sensitive body chemistry" found in many with combined ADHD and ASD and on common comorbidities. Examples of dosing strategies and adaptations for medication will be provided. 4. Strategies for

psychosocial support of high IQ children and adolescents with ADHD and their families. The PEERS program developed at UCLA for social skills training of teens and young adults will be described as well as case vignettes for addressing family dynamics and parent-child and sibling conflicts in daily life.

Adapting to a Dynamic Landscape: Robust Strategies for Incorporating Social Determinants of Mental Health Into Psychiatric Practices in the Military

Chair: Jerry Trotter, M.D.

Presenters: Madeline B. Teisberg, D.O., Ravi B.

Desilva, M.D., David Asher Nissan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss and compare the impact of the social determinants of mental health on mental healthcare delivered in multiple and varied locations within the United States Navy; 2) Illustrate how the guiding principles of embedded behavioral health improve care by addressing stigma and barriers that might otherwise exist due to ethnicity, socioeconomic class, sexual orientation; 3) Discuss the varied approaches to improving Diversity, Equity and Inclusion within mental health care, identifying practices applicable to other communities or locations; and 4) Propose further initiatives for the improvement of current community-based practices to further address stigma, increase access to care and improve Diversity, Equity and Inclusion efforts.

SUMMARY:

Military psychiatry has shifted towards an embedded model that 'brings mental healthcare' closer to the patient to decrease barriers, reduce stigma, and improve collaboration. The military encompasses a diverse population with different cultures, ethnicities, nationalities, and socio-economic backgrounds. The institutional need of maintaining the military forces relative to the diversity of this population instills the importance of incorporating social determinants of mental health into healthcare practices. Interventions with these considerations are often generalizable to the non-military population, which is the focus of this

session. Participants will be taken on a journey to Pacific, aboard naval vessels, and embedded with military units that highlight interventions aimed to foster more equitable and inclusive care. Our first presentation takes place in Sasebo, an austere environment for mental health care, several hours and a plane ride from the nearest possible inpatient psychiatry bed. Where after recognizing barriers in travel and access to virtual encounters, mental health care moved onboard Navy ships to improve patient access. Our second presentation is in Yokosuka, where there is a larger and more dynamic military presence necessitated changes to care engagement to ensure equitable access. Here, providers collaborated with primary care and a wide variety of community supports, to proactively identify needs, reduce stigma and enhance care coordination. Our final presentation is in San Diego at a virtual intensive outpatient program where the DSM-5's Cultural Formulation Interview was integrated into the patient care evaluations, resulting in the facilitation of care both during individual encounters and in group settings. The inclusion of this cultural formulation also assisted with improving the patient's progression through the program and in their return to work by integrating the concepts into how they related to others. This session will be interactive, giving participants an opportunity to respond to real-time questions that facilitate self-reflection on their management practices that incorporated social determinants to enhance care equity and outcomes. Participants will also be able to interact with each other in small groups to discuss their experiences. Lastly, participants have the opportunity to discuss with the panel the application of these interventions to their clinical scenarios. Maintaining the health and well-being of our patients is a holistic process, often necessitating robust and dynamic intervention plans to mitigate barriers to care and enhance outcomes. Being mindful of the special considerations for each patient to optimize their care plan is critical in the goal to give hope and alleviate suffering. Through these presentations, we hope to facilitate increased awareness of the effects of social determinants of health and ways to improve equitable care.

Addressing the Physical Health Needs of Patients With SMI: Emerging Roles for Psychiatrists

Chair: Benjamin G. Druss, M.D.

Presenters: Matthew Louis Goldman, M.D., M.S., Joseph John Parks, M.D., Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Utilize a framework for improving integration for patients with serious mental illness; 2) Understand new policy developments and service delivery models for the physical health care in populations with serious mental illness; and 3) Learn skills for addressing patients' physical health needs in mental health settings.

SUMMARY:

Patients with serious mental illnesses have higher rates of medical morbidity and die 10-20 years earlier than the general population. This symposium will provide an updated view of the clinical and policy landscape on this topic, highlighting emerging roles for psychiatrists in addressing this health disparity. First, we will present a framework that psychiatrists can use for better integrating physical health, mental health, and social services in their patients. Second, we will describe new models of service delivery including Certified Community Behavioral Health Centers and Health Homes, and how they will both facilitate and necessitate better integration of services for individuals with SMI. Finally, we will review APA's newly updated Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness, and how it can help you to address your patients' whole-person needs.

Advancing Health Equity Through Crisis Services: Focus on Data and Quality

Chair: Sivakumar Shanmuga Sundaram, M.D.

Presenters: Matthew Louis Goldman, M.D., M.S., Margaret E. Balfour, M.D., Ph.D.

Discussant: Debra A. Pinals, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate the current state of

knowledge on what constitutes high-quality and equitable mental health crisis services.; 2) Apply implementation science principles to select research methods that incorporate the social determinants of mental health into crisis service evaluation.; 3) Identify strengths and limitations of various strategies for quality measurement in crisis services.; and 4) Advocate for meaningful program evaluation and data collection within mental health systems..

SUMMARY:

Amidst growing consensus about the potential harms of exposure to law enforcement for minoritized individuals in mental health crisis,1 crisis services have increasingly become a focus of attention for advancing equity and antiracism within psychiatry. Additionally, healthcare system pressures such as limited access to care, emergency department boarding of psychiatric patients, and inadequate inpatient psychiatric bed capacity have aligned with national initiatives such as the highly anticipated 9-8-8 crisis line to increase attention on crisis services.2 Crisis response programs that serve as alternatives to traditional police response have drawn widespread attention and sparked major implementation efforts, such as the introduction of the Street Crisis Response Team (SCRT) in San Francisco in December 2020.3 However, in the absence of conclusive, high-quality evidence on effective crisis intervention,4 public fervor for new programs may obscure meaningful ongoing challenges in defining, implementing, and evaluating high-quality crisis services. In this session, emerging leaders and seasoned experts in crisis research and program implementation will equip participants to address the challenges of establishing effective crisis services with a focus on health equity and quality improvement. We will summarize the current landscape of crisis services research, highlighting gaps in identifying best practices and in accessing meaningful data to inform quality and equity aims. Next, using the example of an ongoing evaluation of San Francisco's SCRT, we will review research methods from the discipline of implementation science that can help address the unique challenges of crisis services research. In particular, we will describe how high-quality crisis services research should extend beyond conventional metrics (such as emergency service reutilization) to include measures

related to social determinants of mental health (such as linkage to housing and jail diversion) and qualitative data that illuminate how patterns of service utilization depend on social determinants (such as phone access). Finally, we will discuss how to develop and refine meaningful quality measures for crisis services that can be used in research as well as program evaluation and continuous quality improvement activities.⁵ Participants in this session will have the opportunity to practice applying implementation science principles to hypothetical evaluations of their own health systems and to engage with the panelists in a Q&A focusing on how psychiatrists can shape policymaking regarding crisis service implementation and evaluation.

Advancing Psychiatry Through Diversity, Equity, and Inclusion: APAF SAMHSA Minority Fellowship Program

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify existing and emerging mental health disparities within underserved communities and among marginalized populations; 2) Discuss evidence-based practices and supporting strategies in diversity, equity, & inclusion (DEI) and how they can be applied to Psychiatry; 3) Describe ongoing research conducted by APAF SAMHSA MFP Fellows and early-career psychiatrists; and 4) Facilitate networking opportunities for fellows, general members, and leaders within the APA.

SUMMARY:

This session will highlight the research and community-based projects of fellows in the APAF SAMHSA Minority Fellowship Program (MFP). To fulfill the requirements of this federally funded program, each fellow has been tasked with developing a unique and innovative project aimed at addressing mental health disparities and substance abuse disorders in either underserved communities or among marginalized populations. In keeping with the theme of Social Determinants of Mental Health (SDOMH), these talks will address a variety of topics including ensuring mental health equity in clinical practice, addressing health disparities through policies, systems, and environmental change, and

increasing the uptake of psychiatric and other mental health services among historically underrepresented groups. Participants in this session will have the opportunity to engage with meeting attendees and panelists in individualized talks focusing on how early-career professionals can continue to advance psychiatry through the implementation of diversity, equity, and inclusion initiatives.

This session will consist of six presentations:

- 1) Development of a Culturally Sensitive Asian American/Pacific Islander Curriculum for Child Psychiatry Trainees

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2) Imposter Syndrome Among Minority Medical Students Who Are Underrepresented in Medicine

3) A Systematic Review of Using Virtual and Augmented Reality for the Diagnosis and Treatment of Psychotic Disorders

4) Psychiatric Needs and Community Perspectives of Mental Health Care on Guam, USA

5) Inclusion of Peer Specialists to Strengthen Resident Training in Recovery-Oriented Care: Results From a Pilot Study

6) AHAM (Arya Hindus for Awareness of Mental Health): Awareness, Education and Inclusivity around Indian American Mental Health: In Context

No. 1

Development of a Culturally Sensitive Asian American/Pacific Islander Curriculum for Child Psychiatry Trainees

Presenter: Crystal Han, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain factors contributing to the limited number of culturally sensitive providers for AAPI youth; 2) Understand the implementation of a culturally sensitive curriculum on AAPI mental health for CAP fellows; and 3) Describe the survey responses to the novel AAPI curriculum and identify strengths and areas for future study.

SUMMARY:

The Asian American and Pacific Islander (AAPI) population is the fastest growing minority group in the US, have higher rates of depression/suicide attempts but are among the least likely to receive

treatment, in part due to lack of culturally sensitive providers. The ACGME requires training programs to develop curricula that reflect the needs of their communities, particularly in racial minorities. AAPI individuals represent 5.3% of Maryland residents, but few training programs, including the University of Maryland, have reported curricula specifically on AAPI culture, needs and treatment. Learning objectives from this curriculum to fill this gap in education include: defining cultural identity, cultural humility, and specific challenges and guidance in treating AAPI families. In the past year, 5 guest lectures were given to 14 child psychiatry fellows at the University of Maryland on these themes. All fellows were based in Baltimore and guest lecturers with expertise in these fields spoke virtually from various institutes/private practice locations across the US. Lectures varied between 1-2 hours in a lecture format that included interactive discussion. Participants provided survey feedback on 5 questions. Responses reflected that the series deepened their understanding of the issues facing AAPI families, and recommended that this lecture series be repeated for future trainees. Specific feedback reported that this information was important to personal/professional understanding of the AAPI community and was lacking in their prior training. Due to a lack in standardized curriculum on culturally sensitive psychiatry, there is a significant dearth in providers/mentors with AAPI-specific knowledge. Training psychiatrists in structural competency and cultural humility is more predictive of positive patient outcomes than demographic of the provider themselves. Future lectures at this program will include how to engage AAPI communities in treatment and case consultation. Broader future goals would include standardizing and more widespread implementation of similar AAPI curricula across programs.

No. 2

Imposter Syndrome Among Minority Medical Students Who Are Underrepresented in Medicine

Presenter: Francois Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain what imposter

syndrome is.; 2) Compare differences in imposter syndrome among UiM and non-UiM medical students at a PWI and an HBCU.; 3) List examples of how discrimination from peers and faculty affect UiM medical students.; and 4) Discuss how institutions can be more supportive of professional development for medical students..

SUMMARY:

Purpose: Impostor syndrome is highly prevalent in medical professionals, particularly racial/ethnic minorities. However, little is known about the prevalence of impostor syndrome among medical trainees who are underrepresented in medicine (UiM). Even less is known about the experiences of UiM students at predominantly white institutions (PWIs) and historically black colleges/universities (HBCUs) relative to their non-UiM peers. The purpose of this study was to investigate differences in impostor syndrome among UiM and non-UiM medical students at a PWI and an HBCU. **Method:** Medical students (N = 284) at a PWI (N = 187) and an HBCU (N = 97) completed an anonymous, online survey. The response rate was 22% and 25% at the PWI and HBCU, respectively. Students provided sociodemographic information and completed a measure of impostor syndrome. We conducted a series of chi-square tests of independence, independent samples t-tests, and a stepwise linear regression to test the main aim of the study. **Results:** Overall, 97% of students reported moderate to intense feelings of impostor syndrome. UiM students at the PWI reported higher levels of impostor syndrome (M = 65.54, SD = 11.75) than UiM students at the HBCU (M = 58.52, SD=12.86). Further, UiM students at the PWI were 2.6 more likely than chance to report intense IS while UiM students at the HBCU were 2.6 times less likely than chance to report intense feelings of IS. Lastly, after adjusting for race, UiM status, first-generation status, and other sociodemographic factors, students at the PWI still reported higher levels of impostor syndrome than their peers at the HBCU. **Conclusions:** The environmental context in which medical students inhabit may contribute to insecurities about their intellectual abilities, adjusting for critical sociodemographic factors. Efforts to provide supportive professional development for medical students are warranted.

No. 3

A Systematic Review of Using Virtual and Augmented Reality for the Diagnosis and Treatment of Psychotic Disorders

Presenter: Lucy Lan, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the current applications of virtual reality to the diagnosis and treatment of psychotic disorders; 2) Learn that the addition of VR therapies and rehabilitation methods to treatment-as-usual (medication, psychotherapy, social skills training) can be more effective; and 3) Learn about the feasibility, safety, and acceptability of VR to patients.

SUMMARY:

Objective: Immersive virtual reality (VR) and augmented reality (AR) have the potential to improve the treatment and diagnosis of individuals experiencing psychosis. Although commonly used in creative industries, emerging evidence reveals that VR is a valuable tool to potentially improve clinical outcomes, including medication adherence, motivation, and rehabilitation. However, the effectiveness and future directions of this novel intervention requires further study. The aim of this review is to address the gap of knowledge in AR/VR research and provide insight into the effective clinical procedures for physician practice. **Methods:** 2069 studies involving AR/VR as a diagnostic and treatment option were reviewed. **Results:** Of the initial 2069 articles, 23 original articles were eligible for inclusion. One study applied VR to the diagnosis of schizophrenia. Most studies demonstrated that the addition of VR therapies and rehabilitation methods to treatment-as-usual (medication, psychotherapy, social skills training) was more effective than traditional methods alone in treating psychosis disorders. Studies also support the feasibility, safety, and acceptability of VR to patients. No articles using AR as a diagnostic or treatment option were found. **Conclusions:** VR may be effective in diagnosing and treating individuals experiencing psychosis. **Keywords:** Virtual Reality; Psychosis; Treatment; Diagnosis; Immersive

No. 4

Psychiatric Needs and Community Perspectives of Mental Health Care on Guam, USA

Presenter: Rajkaran Sachdej, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to recognize and appreciate the distinct cultural heritage of Guam with a population of unique health and psychiatric concerns.; 2) Participants will be able to identify the needs of mental health providers on Guam to enhance mental healthcare delivery as well as appreciate community perspectives.; 3) Participants will be able to determine ways in which this novel data for Pacific Islander mental health can be operationalized for clinical enhancements.; and 4) Participants will be able to discuss how the Guamanian history and identity within America has impeded adequate mental healthcare delivery..

SUMMARY:

Guam, an American territory with a rich past and distinct cultural heritage, has been historically overlooked and has a strained healthcare system. There have been few attempts to determine the state of psychiatric healthcare delivery and the barriers to optimal care. The showcased study is part of an American Psychiatric Association (APA) Substance Abuse and Mental Health Services Administration (SAMHSA) Fellowship to be completed in April 2022. The study aims to better understand the current state of mental health care and awareness on Guam as well as to identify needs, as seen by local mental health providers, to enhance mental health care. This will be done using quantitative survey data from mental health providers and gathering anecdotal data from interviews with locals. The poster will feature the results of the exploratory surveys as well as note social barriers to care as gathered by discussions with Guamanian community members. While Pacific Islander mental health remains poorly showcased, the intent of this research is not only to highlight the needs of an overlooked community in America but to also provide crucial mental health statistics for Pacific Islander mental health and pave the way for

further, locally driven mental health care enhancements. More importantly, the hope of this research is to spark needed discussion around Guamanian and Pacific Islander identity in America and its relation to mental health.

No. 5

Inclusion of Peer Specialists to Strengthen Resident Training in Recovery-Oriented Care: Results From a Pilot Study

Presenter: Pranav Aurora, M.D., M.Sc.

Co-Author: Arkaprava Deb

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain key concepts of recovery-oriented care; 2) Describe the unique skills of peer support and peer specialists; 3) Appreciate the evidence base for peer support and peer specialists; and 4) Understand the importance for psychiatry residents to collaborate with peer specialists.

SUMMARY:

Background: Far too many patients with serious mental illness (SMI) report negative experiences of care that lead to dissatisfaction with the mental health system or disengagement altogether. As part of the broader patient-centered and disability justice movements, people with SMI have long advocated to be better represented in the clinical and policy decisions about themselves. Peer specialists are people with lived experience of mental illness in advanced stages of recovery that receive training to support others with SMI through shared understanding, respect, and mutual empowerment. The next generation of psychiatrists must be prepared to collaborate with peer specialists, not only because it is evidence-based but also because peer specialists are increasingly recognized as essential members of the interdisciplinary team. However, there is no ACGME requirement for psychiatry residents to learn principles of recovery-oriented care or about the role of peer specialists. In fact, commonly cited barriers to the successful implementation of peer specialists include the lack of a clear understanding of their role and an organizational climate that adequately supports

their needs. **Objectives:** To fill this gap, we developed a curriculum for residents to be introduced to recovery-oriented care with the guidance of peer specialists from Kings County Hospital, our home institution, and Fountain House, an international leader in the clubhouse model of peer support. **Methods:** To test the feasibility of the curriculum, we conducted a pilot study of two, two-hour sessions during evening hours after work over the course of one month. Five residents volunteered and three peer specialists were recruited. Quantitative evaluations and qualitative feedback from this pilot cohort are reported here. A two-tailed t-test was used to analyze changes in residents' responses before and after the intervention. **Results:** Residents reported a significant increase in confidence about practicing recovery-oriented care. While not rising to the level of statistical significance, residents also reported sizable increases in their interest and confidence in collaborating with peer specialists. Overall, all five residents would recommend this course to another resident and believed that this course should be integrated into the residency curriculum. Peer specialists in this program reported an improved understanding of the role of psychiatry residents along with greater interest and confidence in collaborating with psychiatry residents. They also rated the course highly and all three peer specialists would recommend participation in a program like this to their peer specialist colleagues. **Conclusions:** This pilot study demonstrates the feasibility of an educational intervention to improve psychiatry residents' knowledge, interest, and confidence in collaborating with peer specialists. The program was well-rated by both residents and peer specialists.

No. 6

AHAM (Arya Hindus for Awareness of Mental Health): Awareness, Education and Inclusivity around Indian American Mental Health: In Context

Presenter: Shuchi Khosla, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Enumerate the major topics of mental health interest among the Indian American Population; 2) Understand a culturally inclusive

methodology for provision of mental health among the Indian American community; 3) Evaluate a model of Mental Health education delivery that can be replicated to other cultural/ spiritual communities; and 4) Evaluate the efficacy of the intervention in improvement of understanding of mental health of Indian Americans.

SUMMARY:

Background: AHAM, a Sanskrit word for a description of one's true inner self and an acronym for Arya Hindus for Awareness of Mental Health. An idea that was born out of the analysis of data reflecting a higher risk of suicide among Indian immigrant populations, and of personal experiences growing up in small town India. The project was presented to the over 400 Indian Americans at the Arya Mahasammelan, November 2020. The outpouring of positive responses from the attendees including small dollar donations to express their support brought the attention that project needed. This led to the birth of AHAM—a partnership between Michigan State University and Arya Pratinidhi Sabha America, funded by a grant from SAMHSA via a fellowship awarded by the APAF **Goals & Objectives:** Based on principles of Arya Samaj (not dissimilar to Unitarianism), aims of the project were- **1. Awareness-** Promoting among all Indian Americans awareness of mental health and substance use issues within the community. **2. Education-** Designing and disseminating culturally acceptable literature on mental health within the Indian American community. **3. Inclusivity-** Providing a platform for discussions of challenges faced by Hindu Americans facing the burden of intersectionality, mental health and substance use. **Methods:** The project started with collecting survey data from within the community and presenting it back with the assessment of need. A jot-form survey was sent out asking 1000 Indian American Families with what they thought were the most important mental health topics for them. Upon data analysis, top six topics were chosen and made the focus of the project. Next was the recruitment of six priests/religious—vedic scholars of Arya Samaj of Indian origin who would be willing to participate in monthly group discussions- one topic every month. This was followed by the recruitment of six non-psychiatric physicians of Indian origin who would be

willing to participate in monthly group discussions—one topic every month Every month two separate group discussions were held on a qualitative research model—One with the religious leaders and another with the physicians. Pre & Post Survey with regards to the contribution of the discussion to the participants understanding of mental health was collected. After completion of the group discussions, there was held a Webinar on the topic discussed. The 60- minute webinar had three presenters—A religious scholar, A non-psychiatric physician and an APA psychiatrist—each speaking for 8-10 minutes. The forum was then opened for questions from the community participants for 30 minutes. Pre & Post survey with regards to the contribution of the discussion to the participants understanding of mental health was collected. **Results:** Awaited as the project is ongoing **Conclusion:** Indian American mental health is an underserved area in psychiatry. Initiatives contextualizing mental health in a cultural context are much needed.

Alive and Thriving: Supporting Physicians With Disabilities

Chair: Ludmila B. De Faria, M.D.

Presenters: Jacqueline A. Hobbs, M.D., Kent Mathias, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review changes in prevalence of disability among physicians and its effect on workforce diversity and patient care; 2) Discuss relevant privacy and other regulatory issues for physicians and trainees disclosing disabilities; 3) Review the latest data on substance use disorders and suicide in physicians and psychiatrists including major risk factors; 4) Recognize substance use disorders, burnout, and suicide risk in colleagues and trainees; and 5) Practice physician and trainee substance use disorders, and suicide recognition and referral via case review.

SUMMARY:

Despite the possible stigma associated with disclosing a disability, a recent survey indicates that the number of medical students who report having a disability (physical, sensory, learning, psychological,

chronic health condition) rose 69% 2016-2019, suggesting either more existing students disclosing a disability and/or better reporting. This number is likely to increase further as more medical schools and training programs improve accessibility. Having more medical students and trainees with all categories of disabilities can have a positive influence on the future physician workforce, including increasing diversity, reducing stigma and stereotypes about people with disabilities, and informing patient care. Physicians with disabilities provide unique perspectives that can translate to better and innovative patient care. Mental health issues, including substance use disorders (SUD), depression, burnout, and suicide risk merit special attention. Despite wide prevalence (depression or depressive symptoms range from 20.9% to 43.2%, SUD from 10 to 15%, and suicide rates 1.4-2.3 higher than the general population), some experts believe the number is even higher given the “code of silence” that exists in medicine. This has allowed sick friends, colleagues, or mentors to suffer out of fear of disciplinary action or harm to their professional reputation, ignoring the potential benefits of early interventions. Not only have medical systems been slow to respond to the growing mental health crisis, but physicians themselves are hesitant to engage in mental health treatment, creating a vicious cycle. The most common reasons reported by physicians as to why they began using alcohol/drugs were to relieve stress and physical/emotional pain. Emerging evidence suggests physician burnout is also a significant factor in SUD development. This is concerning given the events over the last couple of years with the COVID-19 pandemic, social injustice, and increased incidence of burnout among physicians. Furthermore, it is well known that SUDs among physicians is associated with a higher rate of suicide. Physicians have one of the highest rates of suicide among any profession globally, with a 40% higher rate of suicide for male physicians compared to male peers, and approximately a 130% higher rate of suicide among female physicians compared to women in the general population. Facilitating access to care for physician colleagues, including trainees, and monitoring upon return to work is critical to save lives and maintain patient safety. Session presenters have significant experience working with psychiatrists and trainees with disabilities affecting

work and training. Case review and discussion with presenters and colleagues will allow participants to enhance their confidence in dealing with these complicated situations and balancing open dialogue and privacy.

“Am I an Imposter?” the Imposter Syndrome: A Myth or Reality

Chair: Tanuja Gandhi, M.D.

Presenters: Cheryl D. Wills, M.D., Shireen F. Cama, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Enhance understanding about the challenges faced by women psychiatrists in the context of feeling like an imposter in professional environments; 2) Create a safe space for discussion about imposter syndrome, an important but often uncomfortable discussion to have; 3) Examine and discuss the factors that contribute to the imposter feeling for women trainees and psychiatrists; and 4) Highlight available resources, opportunities and supports for the professional growth of women psychiatrists.

SUMMARY:

Background: First described in 1978, the impostor syndrome has gradually gained recognition as a phenomenon that is experienced by physicians. It is described as a pattern of thought including feeling of inadequacy, an inability to accept one’s success or level of competence often leading to the feeling of being a fraud or an imposter. This syndrome, which can occur in physicians, is associated with low self-esteem and higher rates of burnout. There is limited literature examining its impact on women psychiatrists. To address the impact of this phenomenon, it is important to understand it’s presentation and factors leading to a feeling of imposterism on women trainees and psychiatrists from diverse racial, cultural and ethnic backgrounds and in diverse clinical and academic settings. It is only by understanding the phenomenon that we can effectively identify, create, and provide resources to support women psychiatrists struggling with this experience. This presentation aims to create a safe space to have this discussion. **Methods:** This session

will be in the format of an interactive panel discussion with individual presentations of 15min each by Dr. Cheryl Wills, Dr. Shireen Cama and Dr. Tanuja Gandhi. This will be followed by a small group discussion if possible or alternatively hypothetical scenario based discussions. The panelists will help examine and reflect on professional and personal challenges faced by women trainees and psychiatrists in their career path using their own unique experiences. Together, the panel helps examine the myriad of challenges women psychiatrists deal with and its contribution to feeling like an imposter. We examine the complexities associated with an imposter syndrome and ways to address some of these challenges through support and mentorship. **Results:** This presentation will enhance participants' understanding of imposter syndrome, factors that precipitate this phenomenon and its impact on the well-being of women physicians from diverse cultural, racial and ethnic backgrounds. This presentation is geared towards creating a space for this discussion, for attendees to reflect on their professional and personal experience and to discuss ways to support women psychiatrists experiencing this phenomenon. **Conclusion:** The Imposter Syndrome is an internal experience often leading to a feeling of being a fraud or an imposter. This feeling of inadequacy can lead to low self-esteem and can be linked to burn out. It is important to discuss the experience of imposterism to improve physician engagement, functioning and well-being in academic and institutional environments. It is also important to identify and address the systemic challenges that contribute to this phenomenon and interventions to address it both from a personal and systemic standpoint.

Assessment and Management of Behavioral and Psychological Symptoms of Dementia

Presenters: Rajesh R. Tampi, M.D., M.S., Helen C. Kales, M.D.

Moderator: Art C. Walaszek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discussion of the epidemiology and neurobiology of individuals with behavioral and psychological symptoms of dementia; 2) Describe

the assessment of individuals with behavioral and psychological symptoms of dementia; 3) Elaborate on the evidence-based management of individuals with behavioral and psychological symptoms of dementia; and 4) Summarize the controversies in the treatment of individuals with behavioral and psychological symptoms of dementia.

SUMMARY:

Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. In this symposium, we will first describe the discuss the epidemiology and neurobiology of individuals with BPSD. Then we will describe the assessment of individuals with BPSD. This will be followed by an elaboration on the evidence-based management of individuals with BPSD. Finally, we will conclude with a review on the controversies in the management of individuals with BPSD. Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse

effects. In this symposium, we will first describe the discuss the epidemiology and neurobiology of individuals with BPSD. Then we will describe the assessment of individuals with BPSD. This will be followed by an elaboration on the evidence-based management of individuals with BPSD. Finally, we will conclude with a review on the controversies in the management of individuals with BPSD.

Assessment and Management of Memory Complaints in Older Adults

Presenters: Susan W. Lehmann, M.D., Brent P.

Forester, M.D., M.Sc.

Moderator: Art C. Walaszek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify key differences between cognitive changes associated with normal aging and those that may signal a cognitive disorder; 2) Discuss the appropriate office work-up of subjective cognitive complaints; 3) Describe differences in presentation between common types of dementia (major neurocognitive disorders); 4) Discuss the FDA-approved pharmacologic agents available for treatment of cognitive symptoms in dementia; and 5) Describe evidence-based strategies for maintaining brain health and preventing cognitive decline.

SUMMARY:

Currently, over 6 million Americans have Alzheimer's disease and other dementias and the number is expected to double by 2050. It is estimated that an additional 5 million Americans have mild neurocognitive impairment. With the aging of the population, psychiatrists are likely to see more older patients who are concerned about their memory. Subjective memory decline may be an early sign of a serious cognitive disorder, but may also occur due to other conditions. Teasing out the underlying causes of memory concerns can be challenging, and requires a multi-step assessment. In this session, geriatric psychiatrists, Dr. Susan Lehmann and Dr. Brent Forester will discuss the office approach to the assessment of memory complaints in older adults. Dr. Lehmann will discuss ways that psychiatrists can differentiate normal changes in memory with aging

from those seen in mild neurocognitive impairment and in late life depression and other psychiatric disorders, such as late-life depression. She will review the appropriate office work-up of cognitive complaints, including cognitive and laboratory testing to rule out "treatable" causes. Dr. Lehmann will also discuss the differential diagnosis of memory complaints, focusing on how to distinguish memory concerns due to psychiatric disorders from the most common major neurocognitive disorders. Dr. Forester will discuss how understanding the underlying pathology of Alzheimer's Disease and other dementias is leading to better treatment strategies. He will review current best practices for the pharmacologic treatment of cognitive impairment in dementia. Dr. Forester will also discuss practical strategies for clinicians to share with patients to maintain good brain health and prevent cognitive decline.

Benzodiazepines: A Debate

Presenters: Donovan Todd Maust, M.D., M.S., O.

Joseph Bienvenu, M.D., Ph.D., Edward Silberman, M.D., Ilse R. Wiechers, M.D., M.H.S., M.P.P.

Moderators: Ron M. Winchel, M.D., Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) make a more informed decisions about if, when and how to prescribe benzodiazepines appropriately.; 2) recognize that benzodiazepines may present risks that are specific to various patient subpopulations.; 3) evaluate various clinical scenarios that make benzodiazepine prescription a reasonable clinical choice.; and 4) analyze benzodiazepine prescriptions based solely on medical considerations, uninfluenced by "benzodiazepine counter-transference"..

SUMMARY:

Ironically, the choice to prescribe benzodiazepines is often fraught with anxiety for the prescribing physician. This debate is intended to air the pros and cons of benzodiazepine medications and to help address physician anxiety attendant to their prescription. Cognitive side effects, risk of falls, and possible abuse are serious problems. But high

probability of rapid relief and potentially unique capacities in regard to anxious depression and Panic Disorder are not nothing. If we accept side effects and appropriate precautions with other drugs for the sake of their benefits, are we applying the same standard when we think of benzodiazepines? SSRI antidepressants might elicit withdrawal upon rapid discontinuation? Does the need to taper automatically denote “addictiveness”? Steroids need to be tapered. Steroids can cause behavioral side effects and increase the risk of hip fracture. They require special monitoring and an awareness of contraindications - but do physicians shrink from their use? Is there any medical setting in which steroids are banned? We should certainly be circumspect about prescribing benzodiazepines to the elderly, the cognitively impaired, or those at elevated risk for substance abuse. But has that bled over into our thinking in other circumstances - making us overly cautious and at times failing to provide succor? What about non-drug abusing patients in midlife? However, should we not be chastened by the problem of patients who were started on benzodiazepines when younger, but continued them into an age of heightened risk? Does the history of uneven - and at times over-zealous - punitive enforcement by monitoring agencies lurk in our minds, discouraging use in proper circumstances? Do benzodiazepines lose efficacy over time? Is it inevitable that maintaining symptom relief will require subsequent dose increases? Are views of benzodiazepines contaminated by its association with opiate abuse? Are they innocent bystanders to the opiate crisis? Or do they contribute meaningfully to opiate-associated morbidity and mortality? We might ask how has the cultural history of anxiolytic medication in the 20th century affects the way we think of benzodiazepines now. The iconic image of anxiety in 1950s America was the hard-working, square jawed man who wore anxiety as a badge of nose-to-the-grindstone honor. By the 1960s and 1970s the face of anxiety - as portrayed in advertisements and cultural memes - was the stressed housewife who required “mother’s little helpers” to survive the ennui of household drudgery. Does historical gendering of anxiety affect the way we think of anxiety (and its treatment) now? We may not be able to address all these concerns in this debate. But at its conclusion we will all be more

informed and less anxious when considering benzodiazepines. PRESENTER UPDATE: Oscar J. Bienvenu, M.D. will also present.

Beyond the Affordable Care Act: Why Policy is Imperative in Advancing Mental Health Equity

Chair: Regina S. James, M.D.

Presenters: Omar Escontrías, Dr.P.H., M.P.H., Gabriel Escontrías Jr., Ed.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify barriers to care, including health service delivery issues; 2) Provide culturally competent care for diverse populations; and 3) Apply quality improvement strategies to improve clinical care.

SUMMARY:

Although the Patient Protection and Affordable Care Act made great strides in closing gaps in health care coverage and access, there remains mental health disparities that need to be addressed. As policymakers face substantial amount of pressure to support mental health legislation at the state and federal levels, grassroots advocacy plays an important role in the public policymaking process in alleviating mental health disparities and achieving mental health equity. This session will explore James E. Anderson’s framework of the public policymaking process. Specifically, it will provide case examples of grassroots initiatives aimed at advancing mental health equity through the five key policy processes of: formation, formulation, adoption, implementation, and evaluation.

Clinical Update: Borderline Personality Disorder Management

Presenters: Katharine J. Nelson, M.D., Lois W. Choi-Kain, M.D.

Moderator: Robert Joseph Boland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe advances in tailoring care for BPD with briefer treatments and stepped care; 2) Describe principle driven strategies for case management using good psychiatric management

(GPM); 3) Describe clinical strategies for adjunctive, off-label, and rational pharmacological treatment of BPD; and 4) Design comprehensive and patient-centered management plans to meet the recovery needs of patients living with BPD.

SUMMARY:

Drs. Choi-Kain and Nelson are presenting this session. "Borderline Personality Disorder Management" in the new APA Annual Meeting Clinical Updates track. During this session moderated by Dr. Robert Boland, Dr. Choi-Kain will focus on the short-term psychological treatment of people with borderline personality disorder (BPD) and Dr. Nelson will focus on adjunctive pharmacological management strategies. This session will use this new format to provide clinicians with practical, evidence-based tools they can take home and use right away in their practices. BPD is common, associated with substantial morbidity, mortality, and functional impairment. At one point in history, BPD was considered to be relatively stable across the course of one's lifespan. However, paradigm-shifting research over the past forty years has led to an evolution in our conceptualization of BPD. Numerous proven psychological treatments have been developed, including mentalization-based treatment (MBT), dialectical behavioral therapy (DBT), transference focused psychotherapy (TFP), and general psychiatric management (GPM); however, the availability for these treatments are limited by their intensity and duration. Briefer stepwise interventions may broaden access to reasonable care while tailoring combinations of approaches to each patient's profile of symptoms, stage of illness, co-occurring disorders, and treatment goals. While psychotherapy is the primary recommended treatment for people with BPD, and there is no Federal Drug Administration approved medication indicated for BPD, early evidence may serve as a basis for adjunctive, off-label pharmacotherapy to target primary symptom domains. This session will provide conceptual frameworks and tools to support clinicians seeking to provide comprehensive, data driven, and patient-centered management strategies for their patients with BPD.

Data Science Tools to Predict, Prevent, and Treat Substance Use Disorders

Chairs: Susan N. Wright, Ph.D., Janet Kuramoto-Crawford, Ph.D., M.H.S.

Presenters: Brenda Curtis, Ph.D., M.S.P.H., Brandon D. L. Marshall, Ph.D., Jinbo Bi, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Become familiar with data science tools applied to research on substance use, abuse, and disorders and related conditions; 2) Learn how data science tools can provide actionable insights for prevention and services for substance use disorders and related conditions; and 3) Understand how NIDA intramural and extramural research programs support research on substance use, and disorders and related conditions that leverages data science tools.

SUMMARY:

The continuous collection of large volumes of various types of data is highlighting many opportunities for measuring, analyzing, and documenting individual and population health using "big data" approaches. These approaches lead to new technologies that can improve decision-making at both the individual and community level. This symposium will explore the opportunities and challenges that come with leveraging big data sets and artificial intelligence/machine learning (AI/ML) approaches to gain new knowledge about substance use disorders and related conditions.

Does My Patient Really Have Bipolar Disorder? An Experiential Workshop.

Chair: Marsal Sanches, M.D., Ph.D.

Presenters: Vineeth John, M.D., M.B.A., Cristian Zeni, Sabrina Correa Da Costa

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the challenges involved in the proper diagnosis of bipolar disorder and the therapeutic and prognostic implications of the inaccurate diagnosis; 2) Understand the main heuristics and cognitive processes associated with the misdiagnosis of bipolar disorder; 3) Discuss

strategies aiming at improving the diagnostic accuracy of bipolar disorder; and 4) Critically analyze practical examples involving different clinical situations mistakenly diagnosed as bipolar disorder.

SUMMARY:

Bipolar Disorder (BD) is typically characterized by recurrent periods of depression, alternating with episodes of elated mood (mania or hypomania). Despite the existence of well-described criteria for the diagnosis of this condition, the diagnosis of BD is, often, difficult. Available literature has largely focused on the underdiagnosis of BD. Nevertheless, over the last few decades, with BD being incorporated by culture and concepts involving “soft” presentations of BD becoming progressively more popular among clinicians and the general public, concerns have been raised about the potential risks associated with the overdiagnosis of BD. Psychiatrists have an urgent need for a better characterization of the diagnostic strategies involved in the identification of bipolar patients, aiming at improving the diagnostic accuracy of this condition. This workshop will focus on providing the practicing psychiatrist with key elements necessary for the correct identification of BD patients. Critical aspects of the clinical history and mental status exam will be discussed, with a particular emphasis on atypical presentations of BD and their differential diagnosis with other conditions, such as major depressive disorder, borderline personality disorder, attention-deficit and hyperactivity disorder (ADHD), and substance-induced mood disorder. The different cognitive errors that may lead to the misdiagnosis of BD will be critically addressed. Clinical vignettes will be utilized to illustrate the diagnostic difficulties involved in the correct identification of BD patients and to engage the audience in interactive discussions and diagnostic exercises. Moreover, recent research studies directed to refining and incrementing the diagnosis of BD will be discussed. Finally, proposed practical algorithms aiming at improving the diagnostic precision of BD will be presented.

Educating 21st Century Trainees in the Bio-Psycho-Social Model of Care

Chair: Robert Mark Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe a data-driven methodology to teach bio- psycho-social formulation and treatment planning to trainees.; 2) Describe structural competency and list three experiential methods to teach this competency to trainees.; and 3) Describe three interventions to utilize this competency in the biological perspective, the psychological perspective and the social perspective..

SUMMARY:

The Bio-Psycho-Social model provides trainees with a method to understand their patients from differing perspectives and apply knowledge from each perspective to their formulation and treatment of patients. Educators must ensure that as knowledge about our field advances, those advances are reflected in the way we teach our trainees. Recent advances in neuroscience and psychopharmacology have significantly changed the approach to teaching the biological perspective. Recent social movements have also underscored the importance of understanding how oppressive social forces like racism, sexism and homophobia affect our patient’s social function and mental wellbeing. However, it is less clear how to teach trainees about those social forces or how to integrate the effect of those social forces into the bio-psycho-social perspective. This lecture will explicate a data-driven model to teach the bio-psycho-social model, provide examples of innovative methods to teach trainees about the effects of oppressive social forces, and consider new methods to structure incorporation of this data into the traditional bio-psycho-social dataset for patient formulation and treatment planning purposes.

Emergency Psychiatric Care for Transgender Patients: Demographics, New Data, and Clinical Approaches

Chair: Laura S. Erickson-Schroth, M.D.

Presenters: Patrick Haenlein, M.D., Ruth McCann

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate familiarity with

common acute psychiatric symptoms in the transgender community; 2) Understand barriers to gender-affirming care faced by patients in the psychiatric ER; and 3) Provide basic elements of gender-affirming psychiatric emergency care.

SUMMARY:

Our goals in this session are to: 1) Provide background information regarding emergency psychiatric symptoms in the transgender and gender nonconforming (TGNC) community, 2) Share new data from our research on TGNC emergency psychiatric care, and 3) Provide concrete steps that psychiatrists can take to provide gender-affirming care in the ER setting. Approximately 0.6% of adults in the United States identify as TGNC.^{1,10} Compared with the general population, TGNC individuals are at increased risk for psychiatric symptoms, including depression, anxiety, and substance use disorders.^{1,2} Alarming, the lifetime prevalence of suicidal ideation among TGNC individuals is thought to be as high as 83%, and the lifetime prevalence of suicide attempts in this population is ~40% (compared to ~4.6% in the overall population).^{2,8} While TGNC patients appear to be at increased risk of acute psychiatric symptoms, few studies have examined the demographics, symptoms, and/or experiences of TGNC patients presenting for emergency psychiatric care.^{3,5,10} Concerningly, data suggests that most emergency room physicians lack basic knowledge of how to provide gender-affirming care.¹⁰ In addition to describing existing data regarding acute psychiatric symptoms in TGNC patients, we will summarize new data from a 7-year retrospective case-control study, in which we performed a chart review of each TGNC patient who presented to a Manhattan psychiatric ER between 2012-2019. We will describe the most common presenting symptoms in this cohort, as well as demographics (including housing, trauma history, and race/ethnicity), and the frequency of pronoun discordance in the EMR. We will then argue for the importance of providing any psychiatrist practicing in an ER setting with basic education regarding: gender and gender diversity, gender-affirming medications and surgeries, and stressors faced by the TGNC community (including racism, poverty, assault, and lack of access to care).^{4,8} We will then posit several key components of gender-affirming emergency

psychiatric care, including: use of appropriate language and terminologies, use of appropriate questions to elicit information related to gender, availability of gender-neutral spaces (bathrooms, hospital rooms), maintenance of respect/privacy around gender, and knowledge of local aftercare resources.^{5,9} We will then provide interactive case examples in which participants will work in small groups to identify obstacles to gender-affirming care, practice asking gender-affirming questions and making appropriate interventions, and practice providing brief education to colleagues. Finally, we will open up for group discussion regarding additional measures that practitioners and healthcare systems can take to provide more gender-affirming care. We will also share information regarding existing educational resources that participants can access after the session.⁹

Essential Psychopharmacology: What Is “Essential” About Psychopharmacology in the Post-COVID, Inclusive 21st Century?

Chair: Stephen Michael Stahl, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To review what is classical; 2) To propose how best to master this expertise; and 3) To discuss how access to these treatments are not equitable and how to improve this.

SUMMARY:

What is "essential" psychopharmacology? With about 200 psychotropic drugs to treat 157 DSM5 disorders having collectively 79 symptom profiles, psychopharmacology traditionally - including multiple editions of my own textbooks over the past 25 years - targets the symptoms of an individual who has a given disorder for treatment. Often, the long term challenge becomes what to do when the first agent does not work completely or is not tolerated. The approach to teaching this is to master this material and then integrate it into one's clinical practice. Principles of adult education tell us that in order to adapt and improve diagnosing and prescribing behaviors, new materials must be mastered to the level that the individual is confident with that information, usually >70% retention. The

most efficient way to get to this level is to repeat materials as small multiples and to do it in different ways, namely visually with graphics if available since most are visual learners, certainly with text, and traditionally with lectures. The same materials repeated in interesting and different forms will most efficiently lead to mastery, confidence and rapid integration into clinical practice. Although these principles are well known and used by teachers and students alike, the practice of psychopharmacology is evolving to take account of how mental illness has changed due to the COVID pandemic, namely with an explosion of substance abuse, suicide, major depressive episodes, and anxiety disorders to name a few. The need for treatment has never been greater. But just as we are seeing increased demand for psychiatric and psychopharmacological services, we are coming to understand the lack of equity in delivering these services. For example, the use of clozapine and long acting injectables is different in people of color when there is no justification of this. Also, a population that has very problematic access to care and is disproportionately people of color, are those with serious mental illnesses referred to the criminal justice system. In our state hospitals, those arrested and found incompetent to stand trial are not just disproportionately people of color, but also homeless, without any treatment for at least the prior 6 months, and a median of 15 prior arrests. What good are antipsychotics if there is inadequate access to them? One solution that is promising is "diversion" programming, where arrested patients are rapidly transferred from jail to hospitals or outpatient programs for competency restoration, housing and long term medications. Additional programs are needed to attain necessary access to mental health services and for equity of psychopharmacologic treatment, a new dimension to what we should include in the concept of "essential" psychopharmacology.

Fostering Mentorship Among LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer) Aspiring Psychiatrists

Chair: Petros Levounis, M.D., M.A.

Presenters: Chaden Noureddine, Nathen Spitz, B.A., Allison Rhodes

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the lack of and need for identity-based mentors in psychiatry among LGBTQ+ medical students.; 2) Define multiple examples of positive, enriching mentorship experiences in psychiatry among LGBTQ+ medical students.; 3) Formulate actions to find mentors and to foster suitable mentorship relationships.; and 4) Summarize what makes for a positive mentorship experience in psychiatry among LGBTQIA+ medical students..

SUMMARY:

Medical students are at increasing risks of burnout, depression, and anxiety (1). LGBTQ+ identified students, specifically, are at increased risks of isolation, discrimination, and mental wellness challenges compared to their non-LGBTQ+ counterparts (2). LGBTQ+ identified medical students are exposed to additional long-term stress due to stigma associated with their sexual orientation and gender identity (3). This additional stress can impact students' burnout and attrition rates (3). Mentorship can be extremely beneficial to students, especially when mentors and mentees share similar identities. Additionally, mentorship has been proven to have a positive impact on both the professional and personal well-being of LGBTQ+ medical students. This workshop focuses on mentorship needs and the impact it can have on LGBTQ+ medical students pursuing psychiatry. It will feature a panel of medical students and residents who will share why mentorship is important, the various ways that a successful mentorship relationship can operate, and their experiences in seeking and maintaining those relationships. In a time when medical students' exposure and ease of networking with psychiatrists from across North America has drastically increased, a more traditional mentor-mentee relationship may appear antiquated. This shift in the ease and immediacy of access to mentors long-distance, may leave students feeling less sure about how to initiate and maintain a more personalized, longitudinal relationship. This workshop aims to provide LGBTQ+ identified students and psychiatry mentors with a toolkit on how to initiate as well as foster an enriching and sustainable mentorship experience. Throughout a

portion of the workshop, the panelists hope to empower audience members and share, in a moderated as well as an open-format question and answer format, specific issues, concerns, or advice on their experience with mentorship. Our panel is excited to share why, what, and how LGBTQIA+ medical students can find benefit and meaning in a sustained meaningful relationship with mentors.

Getting to Justice: Building an Equitable, Diverse, and Inclusive (EDI) Health Care System for All

Chair: Eric R. Williams, M.D.

Presenters: William McDade, M.D., Regina S. James, M.D., Aletha Maybank, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop a shared understanding of the concepts of equity, diversity, inclusion and belonging; 2) Give two examples of successful EDI initiatives at the Undergraduate, Graduate and Post-Graduate medical educational levels; and 3) Identify three potential ways to incorporate EDI approaches in their institution.

SUMMARY:

A more equitable health care system requires us to center, embed and integrate equity, diversity, inclusion (EDI) in all aspects of our work and institutions. A focus on EDI enables organizations to not only perform better on quality, financial, and other measures (Hunt 2015), but also to create environments where all employees can bring their full selves to work and feel that they belong. However, despite valiant efforts nationwide, substantial inequities and structural racism persist both in patient care as well as in the composition and advancement of the healthcare work force (Stanford 2020). To achieve sustained systemic change, we must focus on institutional capacity for EDI. There have been equity strategies implemented to address inequities and build equitable, diverse, and inclusive cultures across different educational and workplace settings. In this session, we will draw on the expertise of an esteemed panel of national leaders in EDI for their innovation in this arena. Dr. William McDade, the Diversity, Equity, and Inclusion Officer for the Accreditation Council for Graduate

Medical Education (ACGME) will highlight priorities at the GME level that will lead to workforce and workplace equity and the creation of more inclusive learning environments. Dr. Aletha Maybank, the chief health equity officer and senior vice president for the American Medical Association (AMA) will detail how the AMA Center for Health Equity has embedded health equity across the AMA. Finally, Dr. Regina James, the American Psychiatric Association's (APA) Chief of Division of Diversity and Health Equity (DDHE) will outline the DDHE's vision and strategic plan to promote EDI efforts in the APA. The task ahead in dismantling structural racism is difficult and will require sustained examination, revision, and investment (Vela 2021). By leveraging the shared wisdom of EDI leaders who are paving the way, this session will provide a roadmap for creating a more just and equitable health care system for all.

Global Mental Health: Its Meaning Has Changed

Chair: Vivian Pender, M.D.

Presenters: James Lamont Griffith, M.D., Francine Cournos, M.D., Brandon Alan Kohrt, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate current aspects of global mental health (GMH) that indicate its maturation as a discipline of study and practice; 2) Discuss how maturation of GMH as a discipline has changed the role and required competencies for psychiatrists in GMH services delivery; 3) Discuss how maturation of GMH as a discipline is re-defining training objectives in psychiatry residency and fellowship curricula; 4) Discuss models of GMH services delivery that potentially can be utilized for low-income, underserved, or remote U.S. populations; and 5) Utilize digital technology to conduct GMH training and competency-based assessment of learning.

SUMMARY:

The 2007 *Lancet* global mental health (GMH) series of articles became a call to action that caught the imagination of psychiatry residents. Their idealism, compassion, and altruism motivated a desire for careers that could promote mental health in the world's regions of greatest need. U.S. psychiatry

residencies began piloting elective GMH training experiences, new curricula, and GMH residency tracks, most of which focused upon in-person training experiences in low- and middle-income countries. By 2021, however, GMH had matured as a discipline focused on equitable mental health services delivery using methods validated by research. Roles for psychiatrists in GMH projects shifted from direct care to teaching, supervision, and case consultation. Psychiatry residents needed additional competencies in specific skill sets in order to fill meaningful roles in GMH research and clinical projects. Availability of remote teleconferencing and COVID travel restrictions curtailed international travel that had been the core of many residency GMH electives. Finally, task shifting/task sharing strategies used to train mental health workers for services delivery in low- and middle-income countries began finding applications in underserved U.S. populations. Such changes have argued for greater consistency in GMH training across residencies, organizing training around core commitments to equitable mental health services, evidence-based practices, and human rights, while local resources and populations might create variations in GMH curricula from one residency to the next. In this presentation, we illustrate how the maturation of GMH as a discipline and these changing circumstances are reshaping the meaning of GMH in psychiatry residency training. Key topics to be discussed and illustrated include: (1) Distinguishing learning objectives for residency education from those for PGY-V GMH fellowships; (2) Creating GMH residency rotations that enable residents to achieve competency in skill sets for GMH research and clinical projects, such as Problem-Management Plus (PM+) Therapy, Psychological First Aid, the WHO EQUIP and ENACT tools, and teaching MhGAP to primary care clinicians; (3) Bringing GMH strategies and methods to low-income, under-served, or remote U.S. populations.

I Never Heard of That: A Clinical Review of Several Lesser Known Eating Disorders and Other Frequently Described Subclinical Patterns of Eating Behavior

Chair: Evelyn Attia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Integrate knowledge of current psychiatry into discussions with patients.; and 3) Identify barriers to care, including health service delivery issues..

SUMMARY:

Clinical presentations to mental health providers increasingly include individuals with eating and body shape and weight concerns. In fact, the COVID-19 pandemic has seen a dramatic rise in numbers of individuals seeking mental health care for eating disorders, likely reflecting an impact of the stressors of lock-down and other features of the pandemic upon vulnerable individuals. While most providers recognize the classic symptoms of anorexia nervosa and bulimia nervosa, some of the more recent diagnostic labels in DSM5's Feeding and Eating Disorders category, such as avoidant-restrictive food intake disorder (ARFID), are lesser known. In addition, popular media has labeled other eating fads and newer practices involving eating behavior that do not appear in DSM5 or the academic literature. Labels such as "orthorexia" and "bigorexia" have received recent media attention, leading patients to ask their clinicians about these and other related conditions, without there being much information about how best to assess and manage these problems. This session will review definitions of the less well known eating disorders and other popularized labels used to describe problem eating patterns. The session will describe methods for assessing these conditions and provide recommendations for management. Where there is little or no evidence for specific treatment approaches, possible adaptations of treatments that work for other eating disorders will be discussed. The session will include time for audience comments and questions in order to facilitate case-based learning.

Leadership as a Social Determinant of Wellness: Lessons for Physician-Leaders From the U.S. Army Leadership Doctrine

Chair: Rohul Amin, M.D.

Presenters: Aniceto Navarro, M.D., Shannon Ford, M.D., Rohul Amin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) describe leadership behaviors that impact long-term wellness of workers.; 2) demonstrate three reasons for the disproportionate negative impact of toxic organizational climate on minorities; 3) demonstrate three domains of the US Army leadership doctrine; 4) identify three mental models from the US Army planning process that can be used by physician-leaders for effectively leading their healthcare delivery organizations; and 5) summarize frameworks from the US Army leadership doctrine to help enhance organizational diversity, equity, and inclusivity mission.

SUMMARY:

Physician-led hospitals outperform those led by non-physicians. This includes a 25% higher overall quality scores. A boss' technical competence also affects employees and is one of the strongest predictors of an employee's job satisfaction. While a physician may be "expert-leaders", most medical training time is consumed by medical knowledge and technical skills acquisition. Therefore, with the absence of focused leadership training, most physicians are "heroic lone healers" who tend to underperform in team-based roles. Another old profession—the profession of arms relies on the hierarchy of its rank structures, professional development, and talent management. This process takes a novice Lieutenant and develops them to eventually lead as a Colonel or General. True to this theme, the United States Army's leadership doctrine has been iteratively shaped to reflect the values of expertise and teamwork. The way employees are led impacts their long-term health. Some of the drivers are a lack of control, poor social support, and longer hours worked. This demand-resource mismatch tends to be worst in lower-wage jobs. Minority groups are disproportionately impacted by these suboptimal work environments. However, skilled leaders can help mitigate these occupational hazards in those whom they lead. Research supports prevention and mitigation strategies a leader can take to improve these health outcomes. Therefore, leadership is

indeed a social determinant of health. In this highly interactive workshop, we attempt to provide physician-leadership skills based on the US Army's leadership doctrine. These leadership and management mental models from the US Army can help physician-leaders in their day-to-day job. We also share concepts of ethical leadership that emphasize eustress over distress to improve organizational climate and ultimately long-term health outcomes of the employees. We emphasize addressing the diversity, equity, and inclusivity of an organization based on leadership decisions and policies. The stress mitigation strategies are derived from the Army's Combat and Operational Stress Control (COSC), and work psychology principles. The workshop is taught by three US Army psychiatrists and officers, and graduates of the Army's Command and General Staff College (CGSC) leadership course; with experience in executive/administrative settings (AN), departmental and clinical settings (SF), and operational and academic (RA) settings. Learners will be provided Army leadership mental models in didactics and then asked to practice these skills in pair-groups using vignettes. PollEveryWhere tool will be used for engagement. Deliverables, including a Current Operational Picture (COP) template, project management template, and copies of the US Army's leadership doctrine will be provided. Further self-directed leadership development recommendations will also be provided.

LGBTQ in a Minority Culture of Psychiatry and Leadership

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

Presenters: Dinesh Bhugra, M.D., Kenneth Bryan Ashley, M.D., Sarah C. Noble, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; and 3) Describe the utility of psychotherapeutic and pharmacological treatment options.

SUMMARY:

Minority voices often have difficulty being heard in psychiatric leadership and advocating for minority

patients is more challenging when those patients are not well represented in positions of authority. This session will examine the role of culture, authority, and leadership within medicine from an LGBTQ lens and explore strategies for enhancing the voices of minorities within psychiatry so that all patients can receive comprehensive, quality mental health treatment.

Manifestations, Assessment, and Diagnosis of Borderline Personality Disorder

Presenter: Andrew E. Skodol, M.D.

Moderator: Robert Joseph Boland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize the manifestations of borderline personality disorder from the perspectives of DSM-5 Section II and the Alternative DSM-5 Model for Personality Disorders (AMPD).; 2) understand the parameters of personality pathology that distinguish personality traits from personality disorders.; and 3) understand that the criteria for borderline personality disorder in DSM-5 Section II and in the AMPD tap similar realms of psychopathology and are highly correlated..

SUMMARY:

The manifestations of borderline personality disorder (BPD) can be seen through the lenses of both the DSM-5 Section II personality disorder (PD) classification and the Alternative DSM-5 Model for Personality Disorders (AMPD). PDs in Section II are defined as patterns of “inner experience and behavior” manifested by characteristic patterns of cognition, affectivity, interpersonal functioning, and impulse control. In the AMPD, PDs are defined by impairments in personality (self, interpersonal) functioning and by pathological personality traits. Cognitive, interpersonal, affective, and impulse control features of BPD, and their embodiments in the AMPD, follow. Individuals with BPD are characterized by dramatic shifts in their views toward people with whom they are intensely involved, leading them to overidealize others at one point and then to devalue them at another point when feeling disappointed, neglected, or uncared for. These shifts emanate from disturbances in

mental representations of self and others, with markedly impoverished, poorly developed, and unstable self-images, and with interpersonal relationships that are unstable and conflicted as individuals alternate between overinvolvement with others and withdrawal. Separation insecurity is a relevant AMPD trait. Individuals with BPD experience extreme emotional lability and intensely dysphoric emotions – depression, anxiety, irritability, or hostility – or chronic emptiness. Emotional lability, depressivity, anxiousness, and hostility are four pathological personality traits from the Negative Affectivity trait domain in the AMPD rendition of BPD. Problems with impulse control are myriad, including indiscriminate sex, substance abuse, binge eating, self-injurious behavior, and suicide attempts. AMPD traits that predispose to these behaviors include impulsivity and risk taking from the Disinhibition trait domain. For a diagnosis of BPD, personality pathology has to be pervasive, i.e., general tendencies or proclivities toward thinking, feeling, and behaving in particular ways, evident in many contexts. BPD pathology is inflexible in that a narrow repertoire of responses is repeated even in the face of evidence that a behavior is inappropriate or not working. BPD pathology is “relatively stable,” although fluctuations in some manifestations, i.e., symptomatic behaviors or impairments in personality functioning, may occur, while other aspects, such as pathological personality traits, are more stable. Gender and age are also considerations. Although BPD is thought to be more common in woman than in men, this may be the result of sampling or diagnostic biases in clinical settings. Although the onset of BPD has traditionally been considered to be in adolescence or early adulthood, the onset may be earlier in childhood. The criteria for BPD in Section II and in the AMPD are based on different models of personality pathology, but they tap similar realms of psychopathology and are highly correlated.

Meaning-Making, Transformation, and Structural Racism: Global Lessons Learned From the COVID-19 Pandemic

Chairs: Sheila M. Loboprabhu, M.D., Steven Moffic, M.D.

Presenters: Ahmed Hankir, Thema Bryant-Davis, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To define racism, including individual and systemic forms of racism.; 2) To describe the physical and mental health consequences of racism.; 3) To explain the intersection of religion, race, and anti-racism.; 4) To identify effective clinical and community approaches, including both current and future possibilities, to combat racism.; and 5) To describe an innovative interfaith and interracial initiative to combat racism in the psychiatric profession..

SUMMARY:

The destructive power of the COVID-19 pandemic has been exacerbated by underlying structural racism and resultant inequities. These became apparent with disproportionately severe illness and death in communities of color and indigenous communities. There are worldwide calls for individual examination of biases, and for major societal changes. "Meaning-making" is the process by which people interpret situations, events, objects, or discourses, in light of previous knowledge and experiences. Dr. William Breitbart refers to meaning-making when discussing the experiences of cancer survivors. Dr. Victor Frankl discusses meaning-making as a concentration camp survivor during the Holocaust. "Transformation" is a dramatic, extreme, and radical change in form or appearance. Examinations of individual and systemic attitudes towards BIPOCs (Black and Indigenous Persons of Color), and LGBTQI+ communities have shown need for such transformations to right centuries of wrongs for those subjected to racial inequities, hate crimes, and major transgressions. In this session, ethnically diverse presenters from four major faiths who have presented in APA symposia and published extensively on racism, prejudice, mental health, trauma, loneliness, burnout and the elderly will discuss the trauma of racism and its impact on mental health and access to care. Understanding patient experiences, applying meaning-making, and examining effective transformative approaches will guide a framework of thinking for major national change, starting at grass-roots level. Dr Thema Bryant-Davis is Professor of Psychology at

Pepperdine University, and ordained elder in the African Methodist Episcopal Church. She served as American Psychological Association representative to the United Nations, including at the UN World Conference against Racism and published a key framework to treat survivors of racial trauma. Dr. Ahmed Hankir is Academic Clinical Fellow in Adult Psychiatry at Institute of Psychiatry Psychology and Neuroscience, King's College London, Senior Research Fellow in Association with Cambridge University, and Lead for Public Engagement and Education at the W.H.O. Collaborating Centre for Mental Health, Disabilities and Human Rights at Nottingham University. Dr. Sheila LoboPrabhu is Professor of Psychiatry at Baylor College of Medicine, and staff psychiatrist for older adults at Michael E. DeBakey VA Medical Center, Houston, with expertise on loneliness, burnout, and cultural psychiatry. Dr. Steven Moffic retired from his tenured Psychiatry Professorship at Medical College of Wisconsin in 2012. He assembled the 'Seven Psychiatrists Against Racism' (SPAR) who wrote a cover story "Dismantle Racism in Psychiatry and Society" in Psychiatric Times. He leads advocacy movements on climate instability, burnout, Islamophobia, and Anti-Semitism. Dr. Moffic received the Hero of Public Psychiatry Designation by the APA Assembly, 2002 and APA Administrative Psychiatry Award, 2016.

Medical Education Scholarship: Finding Your Niche
Chair: Paul Haidet, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Choose an area of their work in which to engage in meaningful scholarship; 2) Construct a focused, answerable scholarly question; and 3) Make a plan for gathering a team to work on the question.

SUMMARY:

Many educators find themselves in positions in academic medicine that are heavy on clinical duties, administrative tasks, and primary teaching, but leave little to no time or mentoring for scholarly pursuits. This unfortunate situation can, over time, can foster disillusionment and burnout, especially when

institutional expectations for scholarly outputs are not met. In this workshop, we will talk about educational scholarship as not a separate or extra task to add to an already full workload, but rather, as something that can be done in the process of typical educational activities, such as teaching in clinical environments or preparing sessions for the classroom. In other words, scholarship can be successfully achieved when educators "make it count twice" with their educational activities. We will practice with some of the core skills needed to make it count twice, including developing an important and focused research question, designing data collection strategies, and communicating findings. We will model ideal real-world practices by having participants work in teams to achieve shared goals.

Microaggressions in South Asian Americans: Mental Health Consequences and Community Strategies

Chair: Ranna Parekh, M.D., M.P.H.

Presenters: Dhruv R. Gupta, M.D., M.S., Karuna Poddar, M.D., Manan Shah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review evidence-based literature on Asian-American hate, prejudice, and microaggressions.; 2) Assess the various forms of microaggressions—microinsults, microassaults, and microinvalidations—experienced by South Asian populations living in the United States.; 3) Demonstrate health and mental health consequences of microaggressions.; and 4) Discuss effective strategies for South Asian communities to overcome prejudice..

SUMMARY:

Asians were the fastest-growing racial or ethnic group in the United States (US) from 2000-2019 and currently account for 19.9 million Americans. Asians, particularly East Asian and South Asian Americans are known to be at high risk of prejudice and microaggressions in multiple community settings. South Asians are more likely to report racial discrimination in institutional settings and interpersonal settings than East Asians and White Americans. First coined in 1970 by Dr Chester Pierce

for the African American population, the term microaggressions has expanded to include other minority populations. This presentation will examine the existing bias against Asian and South Asian American populations; special focus will be placed on local community members, members of professional organizations, health care workers, and persons with any existing mental health issues. Although the direct impact of anti-Asian hate has been highlighted and exacerbated during the COVID-19 pandemic, subtle prejudice against Asian and South Asian Americans has always existed. Asian Americans frequently face unique challenges such as the model minority myth and the spokesperson phenomenon; both of these can affect self-esteem and lead to symptoms of anxiety, depression, and other mental health-related sequelae or consequences. Given the continually increasing presence of Asians in the US, it must be considered imperative to educate health care providers of discrimination risks and impacts within the South Asian population. Given the dearth of resources on the mental health impacts of microaggressions specific to South Asians, the presenters will review and extrapolate existing literature regarding the health and mental health effects of microaggressions among minority communities broadly. The prevalence of microaggressions and prejudice among Asians and South Asians may be a social determinant of mental health, as seen in other minority populations. The goal is to increase awareness among mental health providers to help incorporate the effects of microaggressions in assessments and treatment planning for this population, similar to their approach for other vulnerable groups. We will walk through the process of evaluation and assessment of microaggressions against South Asians and explore areas of future research and "clinical assessment." As a conclusion to the presentation, we would like to facilitate a discussion on solutions. Some talking points for this session will include the idea of leveraging the strengths and resilience of the South Asian family and community, starting from a smaller scale within the family unit and then extending to a larger scale outside the family unit to include cultural community centers, religious organizations, and other community groups. This discussion will also focus on strategies to counter microaggressions for

recipients, as well as allies, on an individual and community level.

Mitigating Maternal Melancholy

Introduction: Catherine C. Crone, M.D.

Presenter: Katherine Leah Wisner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the benefits and harms of pharmacotherapy for mood disorders in pregnancy.; 2) Identify the pharmacokinetic changes associated with pregnancy and the effect on dose requirements.; 3) Design dose management strategies for pregnant women treated with psychotropics.; and 4) Access resources for information about drug and environmental exposures in pregnant and lactating women..

SUMMARY:

Nowhere in medicine is the need for personalization of care so crucial than during pregnancy--personalization of the treatment with consideration of pregnancy physiology and the woman's capacity to provide sustenance for the growing fetus and newborn. Major Depressive Disorder (MDD) is associated with physiological alterations and psychosocial sequelae that negatively impact pregnancy outcomes independent of antidepressant exposure. MDD is associated with poor nutrition, obesity, smoking, substance use, trauma, poverty, and an elevated risk for preterm birth and small for gestational age. With increased recognition of the risks of MDD, SSRI are frequently prescribed to pregnant women. The interpretation of studies examining the risks of psychotropic drug use is complicated by the fact that the mother and fetus are also affected by the sequelae of maternal MDD and often other exposures, which are confounding variables in observational studies. Few studies have evaluated the benefit of psychotropic drug treatment that justifies the risk. The pharmacokinetics of antidepressants, lithium, lamotrigine and atypical antipsychotics change across pregnancy, which often results in progressively lower plasma drug concentrations. The altered dose requirements of pregnancy are the result of plasma volume expansion; reduction in

plasma protein (albumin) levels that leads to decreased drug binding; enhanced hepatic blood flow and increased glomerular filtration rate and renal excretion. Steroid hormone effects on cytochrome activities cause an increase in the activities of cytochrome P450 (CYP) 2A6, 2B6, 2C9, 2D6, and 3A4/5, while the activities of CYP1A2 and 2C19 decrease. The rates at which these changes in activity occurs varies across CYP enzyme systems. A consequence of failing to treat optimally is reduced efficacy and the ongoing burdens of mental illness. Optimization of SSRI dosing during pregnancy dictates several treatment goals: 1) the drug must be at the optimal dose; that is, the dose that produces the best response with tolerable side effects; 2) a measure of symptoms must be repeated and adjustments to maintain antidepressant efficacy may be required; 3) the resolution of pregnancy at birth also requires dose adjustment in accord with the woman's transition to the non-pregnant, breastfeeding state. The treatment courses of pregnant women with unipolar depression and bipolar disorder will be described to illustrate strategies for management based on research findings for the drug management of psychotropic medication during pregnancy. Data from the author's recent study of the pharmacokinetics and pharmacogenomics of SSRI will be included to support management strategies and treatment recommendations.

NAMI's First Book: *You Are Not Alone* Book Presentation and Discussion

Chair: Kenneth Duckworth, M.D.

Presenters: Christine Crawford, M.D., M.P.H., Daniel H. Gillison Jr., Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe NAMI's free education programs for their patients and for their families; 2) Appreciate the experience of shame, help seeking and engaging in care from a diverse group of people with a range of diagnoses, and how a book of first person accounts can reduce stigma; 3) Appreciate the psychiatric and non-psychiatric tools people used get to a better place in relation to their psychiatric illness; 4) Understand the diversity of

family perspectives on supporting themselves and their family member, and the challenges families face; and 5) Appreciate the most common questions families and individuals have at NAMI, and how the answers in the book are organized to address those questions.

SUMMARY:

NAMI's first book *You Are Not Alone* is being published in September of 2022. Ken is the author; the copyright belongs to NAMI. All proceeds from all sales for all editions go to NAMI. Pre orders are up on amazon and Barnes and Nobles. Bulk discounts are available. This is a practical guidebook written for the public. It has value for community psychiatrists, primary care physicians and mental health educators. It is designed to be relatable, approachable and non-technical. The book includes first person expertise from a diverse group of 130 first person and family interviews with people who self-identify as living with a mental illness or loving them. Both individuals and family members use their names to reduce shame so often associated with psychiatric illness. The individuals discuss in their own words many topics such as what barriers they overcame, what helped them, what they have learned, how culture has influenced their journey and how they define recovery and give back to others. book matches that first person perspective with 35 research and recovery experts answering common and important questions I get as the NAMI chief medical officer. se range from recovery tools like what is WRAP? by Mary Ellen Copeland and How do I create a crisis plan? by Jackie Feldman, to when to get help e.g. what is normal adolescent behavior and when to do I need an assessment for my teen? by Dr Christine Crawford. questions also cover more medical questions: Do I have to take these meds forever? by Andy Nirenberg and psychotherapy questions like What is CBT ? by Judith Beck. The book also describes all free NAMI programming from family support to peer to peer to school education that is available across the country in person and virtually. All interviewees signed publisher consent forms and reviewed and approved their quotes in the book. These are not my patients, but rather a community of people in and out of NAMI who want to tell their story to help others. Zando Projects is the publisher and designed the interview consent

form. All interviews were transcribed to improve accuracy and the interviewees were offered the option to review and edit their transcript. The book has been resold in the UK and Doug Turkington is the co-author there. NAMI leaders will be distributing a brochure of the book in the session.

Neuroimmune Imaging in Major Depressive Disorder

Introduction: Catherine C. Crone, M.D.

Presenter: Jennifer Marie Coughlin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Present the value of understanding the neuroimmune contribution to Major Depressive Disorder (MDD); 2) Discuss existing and emerging neuroimaging tools; and 3) Introduce novel approaches to probe the neuroimmune contribution to MDD.

SUMMARY:

For too many patients with Major Depressive Disorder, finding a beneficial antidepressant regimen requires several, serial medication trials, and some patients prove treatment-resistant. Dr. Coughlin's work aims to use molecular imaging with positron emission tomography (PET) to elucidate the underlying molecular factors that contribute to depressive symptoms and treatment response. This presentation will focus on the study of microglia, the resident immune cells in the brain, using PET neuroimaging with radiotracers developed to probe the neuroimmune microenvironment. Dr. Coughlin will present PET-based research strategies that build on findings from study of the 18 kDa translocator protein on activated microglia in treatment-resistant Major Depressive Disorder. She will also present data that demonstrate how study of microglia in the living human brain may inform use of existing and emerging therapeutic interventions targeting microglia in treatment-resistant Major Depressive Disorder.

Neuropsychiatric and Neurological Complications of COVID-19

Chair: Avindra Nath, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the neuropsychiatric manifestations of COVID-19; 2) Understand the neuropathological findings and underlying mechanisms; and 3) Understand ongoing research on the long-term complications of the infection.

SUMMARY:

COVID-19 is a pandemic of magnanimous proportions that humans have faced in modern times. It has impacted every aspect of society and killed nearly a million people in United States alone. Neuropsychiatric complications are the most devastating manifestations of SARS-CoV-2 infection. With nearly 30% people complaining of a wide variety of symptoms at 6-12 months post-infection, termed, Long-COVID, this is likely to have major socio-economic consequences. We are ill prepared to handle these millions of individuals with neuropsychiatric complaints. It is critical that we understand the underlying pathophysiological manifestations, study their pathophysiology and initiate clinical studies in interdisciplinary clinics and conduct clinical trials as early as possible. I will discuss the acute, subacute and chronic manifestations of the infection. I will show autopsy findings and discuss the role of the virus, the neuroinflammatory cascade and vascular injury in mediating these effects. I will also define the biotypes of Long-COVID with a particular emphasis on the mood and cognitive dysfunction. Lastly, I will discuss ongoing clinical studies at NIH in these patients.

Orchestrating Change: Screening of Award-Winning Documentary About Erasing Mental Health Stigma Through Music

Presenters: Margie Friedman, Barbara Multer-Wellin

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Design group programs echoing Me2/Orchestra's transformative model designed to help eliminate mental health stigma and promote recovery through inclusion, acceptance, and mutual support; 2) Explore how any community or

organization can use the Me2/Orchestra model to create successful, inclusive, and stigma-free environments; 3) Demonstrate how music, arts, and other group activities can be as pathways for people living with mental illness to find purpose, avoid isolation, reconnect with community and experience recovery; 4) Discuss how people living with and without mental illness diagnoses working together can challenge society's preconceived notions of what it means to live with a mental illness; and 5) Playing orchestral music is a shared experience but any group can define goals to work together, breakdown barriers and connect members with community.

SUMMARY:

Orchestrating Change is the award-winning documentary film that tells the inspiring story of the only orchestra in the world created by and for people living with mental illness and those who support them. The mission of Me2/Orchestra is to erase mental health stigma one concert at a time. Its groundbreaking, transformative model is truly changing the lives of these musicians by providing purpose, connection, and community. Too often, those diagnosed with mental illness feel isolated and alone and may even suffer from self-stigma. Others fail to seek treatment for fear of societal stigma. Me2/'s "No Stigma Zone" policy, starting with a sign stating exactly that on the rehearsal room door, breaks down barriers by creating an environment where acceptance is the norm. The orchestra members, about half of whom live with mental health diagnoses and half do not, are able to create beautiful music together knowing they will always be supported and encouraged. With compelling characters, striking animation, beautiful music, even humor, *Orchestrating Change* addresses many of the myths about mental illness perpetuated by the media by showing what living with a mental illness is really like. Audiences are challenged to reconsider their preconceived notions. For those living with a diagnosis, it is empowering. Me2/ Music Director and Conductor, Ronald Braunstein was on a trajectory to being one of the world's leading conductors. A graduate of Juilliard, he was the first American to win the prestigious International von Karajan Conducting Competition. Soon after, he was conducting major symphonies including the Berlin Philharmonic and the San Francisco Symphony. But

once he made his diagnosis of bipolar disorder public, his once meteoric career plummeted. He was shunned by the classical music community. After years of struggle on the bipolar cycle, in 2011 he founded Me2/Orchestra in Burlington, Vermont along with new wife, Caroline Whiddon, an orchestra administrator. A second orchestra in Boston, MA soon followed. *Orchestrating Change* follows Braunstein and several of the musicians over two years, capturing their accomplishments and obstacles including, hospitalizations. The film culminates in a joyous concert with both orchestras at the last major venue where Braunstein had conducted professionally. It is a triumph for Braunstein and the musicians and a revelation for the audience who will never look at people living with mental illness the same way again. The film is the winner of the 2021 Austen Riggs Erikson Prize for Excellence in Mental Health Media. Braunstein and Whiddon's goal is to create Me2/Orchestras throughout the country. There are currently a Me2/Orchestra in Manchester (NH) and an ensemble in Portland (OR). A Me2/Los Angeles is in the works. They hope other organizations, including those outside the music world, will employ their stigma-free model to help erase the misconceptions and stigmas surrounding mental illness.

Patient Suicide in Residency Training: The Ripple Effect

Chair: Marguerite Reid Schneider, M.D., Ph.D.

Presenters: Sidney Zisook, Deepak Prabhakar, M.D., M.P.H., Rachel Christine Conrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand experiences of psychiatry trainees who have experienced the suicide of a patient; 2) Provide compassionate witnessing for psychiatry trainees who share their personal experiences with the suicide of a patient; 3) Identify challenges in providing support for psychiatry trainees after experiencing a patient; and 4) Provide a forum for discussion of patient suicide in psychiatry and medical training environments.

SUMMARY:

While the likelihood that a psychiatrist will experience a patient suicide during their career varies greatly by clinical setting, patient volume and patient population, studies estimates that anywhere from 20-68% of psychiatrists will lose a patient to suicide during their career. A significant number of trainees will experience patient suicide during their training, yet discussions about their experience remains rare in training programs and scant in published literature. Across fields of medicine, residents report feeling unprepared to manage their own feelings about death. Prior research suggests that receiving emotional support is the most important coping mechanism for trainees who are recovering from a patient's death, but, unfortunately, most trainees report that they have coped in isolation and that their emotional needs were unmet. Most residents and many faculty report feeling unprepared to help trainees cope with a patient's death. The silence of peers and mentors following the suicide of a patient may be due to uncomfortable feelings that occur after a patient dies by suicide. Feelings of shame, loss, fear, confusion and helplessness may arise in the trainee who cared for the patient as well as their peers, supervisors, program directors and hospital leadership. These feelings may lead others to distance the trainee after the death, and thus leave the trainee to experience this loss in isolation. As avoiding discussions of patient suicide may interfere with trainees' ability to cope with this traumatic event, psychiatry training programs need to prepare future psychiatrists for the potential experience of losing a patient to suicide and actively support their residents through this difficult experience when it occurs. A video titled "Collateral Damage: The Impact of Patient Suicide on the Psychiatrist" was developed as a discussion stimulus for psychiatry trainees, faculty, and practicing psychiatrists to explore the experience of losing a patient to suicide. A study by Prabhakar et. al. examined the impact of using this video in combination with support systems within residency training programs. His study showed an increased awareness of issues related to patient suicide in residents who underwent the training and highlighted potential benefits of its broader implementation. With that in mind, this session features residents (in real time) and faculty

(via selected vignettes from *Collateral Damages*) openly discussing their personal experiences with losing a patient to suicide, discusses ways these types of testimonies can be used in residency training and other educational programs and provides ample opportunity for audience participation.

Persons With Serious Mental Illness With Criminal System Involvement: An Overview and Guide for Practitioners

Chair: Debra A. Pinals, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List three risk factors related to arrest for persons with serious mental illnesses and three means to minimize that risk through proactive care; 2) Describe specific adult criminal legal system pathways to improve care of persons with SMI through linkages to local resources; and 3) Apply at least two strategies that clinicians can use in working with individuals with criminal justice involvement to ensure ongoing support for their mental health and legal rights.

SUMMARY:

Individuals with serious mental illness (SMI) are at increased risk for arrest and incarceration, but often for more minor crimes. Once they are involved in the criminal system, they face numerous challenges including additional stigma. They may also exhibit behaviors that were adaptive in correctional settings but become maladaptive in other settings. Many of these persons have histories of trauma and their exposure to criminal justice processes can be further traumatizing. Individuals with serious mental illness, especially those arrested for more minor crimes, are often routed through forensic competence to stand trial evaluation and treatment processes. Some will have co-occurring antisocial personality features that the mental health treatment provider may feel ill-equipped to support. Individuals with SMI in the criminal justice system often have co-occurring substance use disorders and medical conditions that compound their complexity. For clinicians, these features in their patient populations can present numerous challenges. In addition, clinicians may

have limited knowledge or familiarity with the criminal system to know how best to help individuals in their care with these histories. As patients move from arrest to court proceedings to jail or prison and release, there may be opportunities to foster continuity of care and attention to aspects of their lives that can reduce their risks of further involvement in the criminal system. This session will provide an overview of the interaction of serious mental illness and the risk of criminal involvement and will provide practical information for practitioners to better serve their clients. There will be opportunity for questions and answers and curbside consultation.

Perspectives on the Understanding and Assessment of Imminent Suicide Risk

Chair: Megan Rogers, Ph.D.

Presenters: Lanny Berman, Ph.D., Kristin J. Fredriksen, M.D., Igor I. Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify gaps in clinicians' and researchers' knowledge about imminent suicide risk.; 2) Describe the five components of the Suicide Crisis Syndrome.; and 3) List factors that have been linked to increased risk for suicidal behavior after inpatient psychiatric hospitalization and describe their applicability to suicide risk assessment and management..

SUMMARY:

Suicide accounts for the lives of over 47,000 individuals in the United States each year; however, little is understood about factors that predict short-term, or imminent, suicide risk (i.e., within hours to days). Indeed, differing perspectives exist regarding whether and how clinician determination of imminent suicide risk can and should be conducted. One perspective, highlighted by our colleague, the late Robert I. Simon, is that the demand imposed upon clinicians to determine a patient's imminent risk of suicide "imposes an illusory time frame on an unpredictable act." Dr. Alan Berman will elaborate on this viewpoint, highlighting that (1) no operational definition of "imminent" exists in the suicidology literature, and that (2) clinicians lack

both the tools and empirical findings to support anything more than a “gut call” or intuitive judgement of a patient’s imminent risk for suicide. With this background, Dr. Berman will review what is known and not yet known, as well as what is needed to be sufficient enough to inform the assessment and formulation of imminent suicide risk. A differing perspective is that clinical tools and syndromes have been developed that inform the prediction and prevention of imminent suicide risk. In particular, Dr. Igor Galynker will make the case for the Suicide Crisis Syndrome (SCS), an acute, cognitive-affective, pre-suicidal state that is theorized to precede imminent suicidal behavior. The SCS is characterized by five empirically-supported symptom domains that cohere as a unidimensional syndrome without relying on the assessment of suicidal ideation. Dr. Galynker will provide evidence for the utility of including the SCS in the DSM-5 as a suicide-specific diagnostic category and for its widespread use in suicide risk assessment and prevention in acute clinical settings. Finally, Dr. Kristin Fredriksen will highlight the necessity of identifying factors that predict suicide risk during and following inpatient psychiatric treatment through a prospective cohort study of 7,000 consecutively admitted patients that examined predictors of death by suicide (inpatient and post-discharge) within a week of admission. Following the presentation of these three perspectives, participants will have the opportunity to ask questions and process specific examples with the speakers, who include two psychiatrists and a clinical psychologist with extensive experience with both clinical practice and research in high-risk populations. Overall, this interactive discussion on imminent suicide risk, led by multiple experts in the field of suicide research and prevention, will provide insights to participants on best practices and future directions for the assessment and management of imminent suicide risk.

Pharmacogenetics: Clinical Applications and Cases Across the Lifespan

Chair: Daniel J. Mueller, M.D.

Presenters: Chad Bousman, Ph.D., Helen Lavretsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the expert groups that develop pharmacogenetic dosing guidelines; 2) Describe the current evidence for pharmacogenetic testing across the lifespan; and 3) Identify clinical situations where pharmacogenetic testing should be considered.

SUMMARY:

The implementation of pharmacogenetics into practice is supported by dosing guidelines developed by expert groups such as the Clinical Pharmacogenetics Implementation Consortium, the Dutch Pharmacogenetics Working Group, and the FDA. Pharmacogenetic-based dosing guidelines endorsed by these expert groups cover most antidepressants (i.e., selective serotonin reuptake inhibitors, tricyclics), several antipsychotics (i.e. aripiprazole, quetiapine, risperidone, zuclopenthixol), anticonvulsants (i.e., carbamazepine, oxcarbazepine, phenytoin), anxiolytics (i.e., clobazam, diazepam), and ADHD medications (i.e., amphetamine, atomoxetine). However, many providers of psychiatric care are not familiar with these guidelines, unsure about the evidence from which these guidelines were developed or are uncertain about when and for whom these guidelines should be employed. As such the aims of this symposium are to: (1) raise awareness of the current guidelines, (2) provide an overview of the pharmacogenetic evidence associated with commonly used medications in psychiatry, and (3) present unpublished and published studies and clinical cases that highlight the utility of pharmacogenetic information in delivering psychiatric care across the lifespan. These aims will be accomplished via a series of talks by experts involved in the development and implementation of dosing guidelines relevant to psychiatry. The symposium will begin with Dr. Chad Bousman, who will provide the rationale behind pharmacogenetics and deliver an overview of the pharmacogenetic guidelines available for commonly used medications in psychiatry. He will also share clinical application and case examples with a focus on the child and adolescent psychiatry care setting. Dr. Daniel Mueller will then provide a summary of the antidepressant pharmacogenetic trials and highlight

existing recommendations in adults. In addition, he will present results from his own studies and case reports from more than 12,000 patients undergoing pharmacogenetic testing in his institution. Finally, Dr. Helen Lavretsky will focus on late-life mental health. She will present a published case highlighting the potential utility of pharmacogenetic testing in late-life depression and will also share results of a recent survey that assessed the perspectives on pharmacogenetic testing among members of the American Association of Geriatric Psychiatry.

Physical Exercise: How Can We Prescribe It?

Chair: Anna Szczegielniak, M.D., Ph.D., M.Sc.

Presenters: Ruta Karaliuniene, M.D., Victor Pereira-Sanchez, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss positive effects of physical exercises on general mental health as well as reduction and remission of symptoms of different disorders from biological, psychological and social perspective.; 2) Address the lack of physical exercises programs within the health facilities and varied health services in the community.; 3) Identify specific resources and existing solutions tailored to the needs of patients.; and 4) Discuss the role of psychiatric trainees and specialists in shaping holistic yet accessible approaches for mental health programs and services..

SUMMARY:

We believe that the access to holistic treatment programs, despite the increasing knowledge on the importance of using non-pharmacological therapy, including exercise or cognitive training, for the prognosis and quality of life in mental disorders, is still significantly limited across the globe. There is also a lack of solutions for patients after the end of the treatment process, which would be an element of preventive measures, and would be available outside the basic structures of the health care system. We want to discuss the gaps and possible solutions of addressing this issue with a focus on physical exercises. Physiotherapeutic activities seem to be an omitted, albeit an important element of the treatment and rehabilitation process of patients for

whom symptoms related to lowering mood, drive, memory and concentration disorders or night sleep disorders prevent proper functioning in everyday life. Especially in the time of COVID-19 epidemic we should be looking for accessible, individually-tailored, easy to organize and effective therapies that would allow patients to have more control over their rehabilitation process. Structural and functional changes in the central nervous system under the influence of exercise benefit both from a biological, psychological and social perspective. The studies published so far seem to confirm that, inter alia, physical exercise understood as planned, ordered and repetitive activity reduces the severity of depression (including symptoms such as depressed mood, disturbed circadian rhythms, appetite disorders), while giving a greater chance of achieving full remission and reducing the risk of relapse. There are also reports indicating a positive effect of treatment in the case of addictions, anxiety disorders or schizophrenia. Still, even with growing number of research supporting inclusion of physical exercises in the treatment and as a preventive matter, it is usually overlooked in the medical recommendations leaving patients with general suggestion to “be fit”. Through this interactive session we aim to assess different approaches to the use of physical exercises in the rehabilitation process of patients across regions and discuss possible solutions for existing gaps. We believe that exchange of different experiences and programs may widen the perspective and allow to focus on physical activity in more adequate manner. Exercising is healthy, but do we now know to “prescribe” it? We hope to answer this question during the session.

Pipe Dreams: The Role of Sleep in the Etiology and Treatment of Substance Use Disorders

Chair: Tanya Ramey, M.D., Ph.D.

Presenters: Kelly Dunn, Ph.D., Deepak D'Souza, M.D., Albert Arias, M.D.

Discussant: Evan Herrmann, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the interrelationship of sleep impairment and drug abuse; 2) Know that there are shared

neurobiological mechanisms, contributing to increased initiation and maintenance of problematic substance use and poor treatment outcomes; 3) See the disrupted sleep as a recalcitrant symptom of drug withdrawal syndromes.; 4) Know recent advancements in research and novel drug development in this area; and 5) See sleep disturbance as an important therapeutic target for new medications development in addiction.

SUMMARY:

Sleep dysregulation is present in the clinical picture of Substance Use Disorders (SUDs), where its symptoms are a part of the withdrawal syndrome, contribute to the loss of control in substance use, and speed up the relapse, leading to poor treatment outcomes. To date, very little attention has been given to the increased incidence of sleep abnormalities in SUDs. This session will provide an overview of the role of sleep in the etiology, clinical presentation and treatment options of SUDs, highlighting two promising new pharmacotherapies that utilize sleep as a therapeutic target. There will be three primary presentations by NIDA-funded clinical investigators summarizing data from projects in DTMC's Clinical Research Grants Branch portfolio. Two members of this Branch will serve as the Chair and the Discussant. The Discussant will present a brief synthetic summary of the Session highlighting key take-home points and future directions. Upon completion of this session, the target audience will have a fundamental understanding of some recent research advances in the role of sleep in the etiology and treatment of SUDs. The talk of our first presenter, Kelly Dunn, Ph.D., will address disrupted sleep as significantly associated with many aspects of substance use disorder. The degree to which sleep and symptoms of substance misuse interact is not yet thoroughly understood. There has also been growing interest in the orexin peptide neurotransmitter system and its role in the pathophysiology of addictive disorders. Recent developments have put the focus on "dual orexin antagonist" compounds that seem to have perhaps the most potentially beneficial effects in some addictive disorders. The talk of our second presenter Albert Arias, M.D., will include the review of preclinical and translational studies implicating orexinergic involvement in different aspects of the

addiction process and will review ongoing clinical trials in humans. D. Cyril D'Souza, M.D., will then discuss the data on the effects of the FAAH-inhibitor PF-04457845 on sleep that were characterized in a double-blind, placebo-controlled, parallel-group phase 2a single-site study in cannabis dependent males. There will be a summary presentation by the Discussant Evan Herrmann, Ph.D., and the panel-led Q&A that will conclude the session.

Predatory Publishing: How to Navigate the Perils and Pitfalls of Academic Publishing

Chair: Josepha A. Cheong, M.D.

Presenters: Michelle Leonard, M.A., Suzanne Stapleton, M.S., Terry K. Selfe, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize and define the characteristics of predatory journals; 2) Recognize and identify characteristics of ethical, non-predatory journals; 3) Identify reasons why individuals justify publishing in a predatory journal; 4) Determine whether a fee charge for publishing is a legitimate or fraudulent practice; and 5) Identify resources and tactics to counter predatory publishing practices.

SUMMARY:

"Publish or Perish" has long been the lament of academicians through the centuries. Within academic medicine and graduate medical education, "academic productivity" and "scholarly work" have become the often repeated buzz words in the assessment of the quality of a training program and academic departments. Often, the primary currency of a faculty or resident's academic productivity is measured in the quality and number of publications. Over the past 15-20 years, there has been a significant increase in the overall number of scientific journals, including predatory journals. Distinguishing between predatory and legitimate journals has grown increasingly difficult. On a very basic level, publishing in predatory journals can harm authors with exorbitant publishing fees, damage to reputation of academic credibility, and potential loss of intellectual property. This workshop will provide an overview of the development and current state of predatory publishing and its effect

on academic productivity. The presenters will also review several resources that can assist an author in confirming the legitimacy of a publication. Through the use of polling, case discussions and didactics, the workshop will provide participants with the training to be able to identify predatory publishing practices. In addition, participants will learn of several key steps in how to avoid falling prey to predatory journals. Participants are encouraged to bring forward examples or experiences that they may have had with predatory publishing practices.

Psychiatric Neuroscience: A Reckoning

Chair: Ashley E. Walker, M.D.

Presenters: David Ross, M.D., Ph.D., Joseph Cooper

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the relevance of new findings in neuroscience to clinical care and to the future of psychiatry; 2) Summarize core concepts relating to the neurobiology of psychiatric illness; and 3) Apply cutting-edge neuroscience to clinical scenarios.

SUMMARY:

The United States is in the midst of social reckonings relating to both systemic racism and the long-term impact of COVID. Both issues have brought drastic changes to our lives via their direct sequelae, social upheaval, and cascading effects on a wide range of health outcomes. We've seen a continued spike in deaths related to opioid use disorder; biological effects of ongoing racial and historical trauma; and the results of forced social isolation. The National Neuroscience Curriculum Initiative (NNCI) has developed a series of brief talks and interactive exercises focused on recent advances in neuroscience that also address these primary concerns on the minds of patients and society. These activities will help busy clinicians keep pace with clinically relevant updates around the neurobiological basis of psychiatric illness by distilling complex topics down to their core concepts and bringing them to life through narrative approaches. In this session participants will be introduced to cutting-edge topics with particular relevance to this unique moment in history.

Psychiatry in the Courts: APA Confronts Legal Issues of Concern to the Field

Chair: Reena Kapoor, M.D.

Presenters: Maya Prabhu, M.D., LL.B., Marvin Swartz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process by which APA becomes involved as a "friend of the court" in major legal cases.; 2) Review the courts' decisions and APA's positions on access to abortion.; 3) Review the courts' decisions and APA's positions on insurance coverage for mental health and substance use disorders.; and 4) Review the courts' decisions and APA's positions on discrimination against transgender individuals..

SUMMARY:

The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and it makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year and to provide their input concerning APA's role in these cases. Three cases will be summarized and the issues they raise will be addressed: 1) *Corbitt v. Taylor* involves the right of transgender individuals to obtain drivers licenses consistent with their gender identity; 2) *Wit v. United Behavioral Health* involves coverage of treatment for mental health and substance use disorders by employer-sponsored insurance plans; 3) *Planned Parenthood v. Philip* and *Sistersong v. Kemp* involve access to abortion and government interference in medical decisions. Since new cases are likely to arise before the annual meeting, the Committee may substitute a current issue on its agenda for one of these cases. Feedback from the participants in the workshop will be encouraged.

Psychiatry in the Syndemic: Leadership for the Third Revolution

Introduction: Michael F. Myers, M.D.

Presenter: Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the critical issues that impact psychiatric leadership in the 21st century; 2) Identify effective strategies for addressing leadership challenges for psychiatry and developing networks to support learners at all levels to promote advancement and reduce burnout; 3) Increase understanding of how institutions maintain structural barriers to diversity and inclusion in training and health equity; and 4) Increase awareness of need for training to assist with challenging personal and professional issues in the psychiatric workforce.

SUMMARY:

Psychiatric leadership during the syndemic of the early 21st century will require a significant change to achieve the desired system change. Alternative approaches to training, clinical care and research are required if we are to achieve the goals that we have committed to: addressing health inequities, creating a diverse and welcoming medical culture, and incorporating strategies that position psychiatry to remove the institutionalized barriers in our systems and implement strategies that create more balanced, equitable, and welcoming environments in training and practice settings. With leadership and will, psychiatry can demonstrate to social justice–motivated medical students and residents that we will not abandon the commitments made during this time, remain deafeningly silent, or worse, gaslight them by suggesting that the person speaking out is the real problem. It is also clear that modifying medical and graduate medical education models and practices is not enough to produce the diverse mental health workforce needed for the 21st century. Future leaders will need to focus on redesigning educational models, including lifelong learning, if we are to achieve the changes we want in psychiatry. The lecture will describe strategies for making real change that includes policies to create transparent and accountable institutional systems. Examples of system barriers such as isolation, “minority tax”, unrealistic expectations for “super mentoring”, and intersectional identity issues (ie., race, gender, caregiver, etc.) will be discussed along with potential for burnout and moral injury.;

Recommendations for addressing and overcoming these issues will also be provided.

Psychopharmacology Master Class: The Art of Psychopharmacology

Chair: David L. Mintz, M.D.

Presenters: David L. Mintz, M.D., Carl Salzman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe some of the evidence base that suggests that how one prescribes may affect outcomes as much as what one prescribes; 2) Develop a patient-centered alliance that supports the patient’s ability to make healthy use of medications; and 3) Adapt prescribing behaviors to the specific need of the patient.

SUMMARY:

In this era of evidence-based psychiatric practice, it is important to recognize that there are evidence bases, too often overlooked, that provide guidance not about what to prescribe to optimize pharmacotherapy outcomes, but, rather, about how to prescribe. Indeed, for some of the most common conditions, the evidence suggests that psychosocial factors exert a larger influence on treatment outcome than do the actual medications. Mastery of these psychosocial factors in prescribing constitutes an important part of the art of psychopharmacology. In this session, some of that evidence base will be explored, addressing the science of the art of psychopharmacology. The importance of the doctor-patient relationship will be highlighted, as well as the importance of a patient-centered evaluation that considers who the patient is, and not just what the patient is. The presenters will show how a deeper understanding of the patient may help guide prescribing decisions in ways that facilitate the patient’s healthy use of treatment. The presentation will also explore some common errors in prescribing that, though sensible from the perspective of the standard of care, may undermine effective treatment.

Shrinking the Carbon Footprint of American Psychiatry: Meeting the Demands of Climate Change

Chair: Elizabeth Haase, M.D.

Presenters: Daniel Bernstein, M.A., M.S., Joshua Ross Wortzel, M.D., Elizabeth Haase, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) State how the carbon footprint generated by APA meetings can be reduced by varying where it is held and incorporating regional and hybrid meeting options; 2) Quantify the carbon footprint generated by residents traveling during the psychiatric residency interviews and describe how the Match process could be modified to mitigate these climate impacts; 3) Identify the most carbon-intensive elements of psychiatric practice and describe ways to reduce them through telepsychiatry and changes to outpatient office design and practice; and 4) Describe the benefits and risks of carbon-saving measures for psychiatry.

SUMMARY:

There is a growing appreciation that global warming will negatively affect human health, including mental health (1). Increased ambient heat is associated with the increased prevalence of many psychiatric disorders (2), and psychiatric patients are more prone to heat-related morbidity and mortality (3). Changing climates are contributing to the increased prevalence of nutritional deficiencies and infectious diseases with psychiatric sequelae (4). Increased frequency and severity of climate change-related natural disasters are leading to higher rates of acute stress and PTSD (5), and existential anxieties about the future of the environment, termed eco-anxiety, are becoming increasingly prevalent even among those who have not experienced such traumas (6). In August 2021, the United Nations' Intergovernmental Panel on Climate Change reported that, to prevent the worst-case projected models of climate change over this century, carbon production needs to be reduced dramatically within this decade (7). Currently, the health care system produces 8% of total US greenhouse gas emissions (8), which is larger than the total carbon footprint of many countries. This sizeable contribution to climate

change runs counter to physicians' Hippocratic oath to "do no harm" to patients, and there is a growing appreciation among medical associations that it is imperative that physicians take action to reduce their carbon footprints (9-11). In accordance with this, the APA has expressed its commitment to address the effects of climate change on mental health (12). The presenters of this general session will review the research they have conducted about how American psychiatry can significantly reduce its carbon footprint within this decade without compromising the quality, professional development, and collegial interactions that are central to medical and psychiatric progress. The data presented will include 1) an analysis of the carbon footprint of the APA Annual Meeting and how this can be dramatically reduced, 2) an analysis of the carbon footprint of the residency match process and how this can be dramatically reduced, and 3) an analysis of the carbon footprint of psychiatric clinical practice and how this can be reduced through use of telepsychiatry and infrastructural changes. The session will be interactive with real-time polling through use of Poll Everywhere, and the participants will walk away with practical knowledge for how they can reduce their carbon footprints and get involved with efforts to reduce the carbon footprint of American psychiatry. The session will conclude with a final large-group discussion during which participants can ask questions, offer opinions about this topic, and reflect together about how they are adapting to the stresses of climate change.

So Your Patient Asks You About Medical Cannabis and CBD... What Psychiatrists Should Know, Part 1

Chair: Henry Samuel Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review limitations on current scientific knowledge of marijuana; 2) Review history of marijuana in medicine; and 3) Review biochemistry of exogenous and endogenous cannabinoids and their unique biological actions, receptors, approved cannabinoid preparations, metabolism, and routes of administration.

SUMMARY:

Marijuana, according to the National Institute on Drug Abuse, is “the most commonly used illicit substance.” However, according to state—not federal—laws, medical marijuana is legal in 37 states and the District of Columbia. Eighteen states have also legalized recreational use of marijuana. As the legalizing of marijuana grows, more patients are turning to us, their doctors, for advice and information regarding marijuana’s risks and benefits. Some patients with medical/psychiatric illness use marijuana without knowledge of its effects. Patients deserve education from us based on scientific knowledge. However, despite research to the contrary, the U.S. government still considers marijuana a Schedule I substance “with no currently accepted medical use and a high potential for abuse.” The federal stance inhibits research on the science of marijuana and promotes attitudes toward marijuana’s risks and benefits that are not objective or scientifically based. We need to be able to counsel and educate our patients based on objective, scientific data. Too much is said with authority about medical aspects of marijuana—pro and con—that is misleading and deceptive. This course will teach the practitioner to understand the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. The faculty will review the 4,750-year-long history of cannabis use in medicine and the recent history of restrictions on research and use of cannabis in the U.S. We will discuss the cannabinoid system, CB1 and CB2 receptors, and their distribution and function, as well as the endogenous cannabinoids. We will cover cannabis’ routes of administration, bioavailability, distribution and elimination, and the unique actions of various cannabinoids

So Your Patient Asks You About Medical Cannabis and CBD... What Psychiatrists Should Know, Part 2

Chair: Henry Samuel Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review clinical research data on the effects of marijuana upon psychiatric and non psychiatric conditions and upon behaviors such as violence and its potential hazards.; 2) Discuss how to

address providers’ legal/ethical/documentation and history-taking issues and patients’ questions, concerns, and educational needs regarding marijuana use; and 3) Integrate knowledge of current psychiatry into discussions with patients..

SUMMARY:

We will present clinical research and its limitations on the effects of cannabis in psychiatric conditions, including anxiety, depression, psychosis, PTSD, and sleep, and its role in violence. We will also review clinical research on its effects in nonpsychiatric medicine, including its actions in inflammation, pain, spastic diseases, appetite loss, nausea, and epilepsy. We will present data on FDA-approved cannabinoids. The faculty will detail hazards of cannabis use, including use in pregnancy, addiction, accidents, cognitive deficits, withdrawal, heart and lung illnesses, reproductive effects, and other symptoms. We will describe the malpractice risks and legal restrictions and limitations on medical practitioners who may be asked by their patients to issue a “cannabis card.” We will discuss history-taking relevant to the use of cannabis. We will discuss ways to listen to and talk with patients who are considering using or are actively using cannabis for medical reasons, or who are using cannabis recreationally while in treatment for a psychiatric or other medical disorder. We will not address screening for or treatment of addiction.

Social Determinants of Mental Health: Clinical Assessment and Structurally Competent Treatment Interventions

Chair: Tresha Gibbs, M.D.

Presenters: Francis Lu, M.D., Steve Hyun Koh, M.D., Enrico Castillo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Specify the skills and practices psychiatrists should use to identify key social determinants of mental health in their clinical practice; 2) Discuss the rationale, benefits and challenges to utilizing Z codes and V codes in clinical practice to elevate social determinants; and 3) Understand structurally competent use of

community referral in the clinical practice to improve patient outcomes.

SUMMARY:

The APA Presidential Taskforce on Social Determinants of Mental Health (SDoMH) Clinical Workgroup is focused on the specific practices, skills and resources that psychiatrists and other mental health providers can utilize to identify, diagnose and address the needs of our patients. Utilizing a structurally competent approach, this session will highlight recommendations for psychiatrists to incorporate screening tools, billing and charting, diagnosis using V codes, community referral and multidisciplinary team advocacy. It will also engage attendees in a discussion of controversies and barriers to implementation of these elements in practice. There is ample evidence that negative SDoMH are critical predictive and perpetuating factors for mental illness. Also, certain positive social determinants promote healing and recovery. Yet, there is a practice gap in exactly how psychiatrists and other mental health professionals approach social determinants of mental health in screening, diagnosis and treatment planning to address patient needs. This session will cover the above areas of clinical practice and highlight examples across the life cycle, including adverse childhood experiences in youth and loneliness in older adults, among others. Efforts to screen for and identify social determinants of mental health can be patient centered, streamlined and aligned with patient's own goals for overall health. Existing validated instruments will be presented. Additionally, psychiatrists have the opportunity to utilize billing codes to capture their findings after screening for SDoMH. Available Z codes and V codes in the ICD 10 and DSM 5 TR describe social conditions but are not utilized routinely due to lack of billing incentives. Yet, they provide an opportunity to capture the social context and can potentially be utilized by healthcare systems to track patient needs and to allocate resources. Additionally, psychiatrists play a role in the care pathways that following a positive screening result. Thinking structurally, while this involves individual, organization and system actions, this presentation will walk attendees through the individual actions such as advocating for community based resources. Learners will recognize that despite inconsistencies

across health systems and state health departments in the degree to which patients can access community resources, psychiatrists play a key role in addressing certain SDoMH. Overall, this presentation will provide practical action items that can be utilized in clinical practice, will incorporate case vignettes to elevate key points and stimulate discussion among attendees. This session will give members an opportunity to share their ideas for ways for the APA as an organization can provide leadership in this area.

Somatic Symptom Disorder: Conceptual Models, Patient Engagement, and Treatment Approaches

Chair: Albert Yeung, M.D.

Presenters: Margaret C. Tuttle, M.D., Allan Abbass, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand Somatic Symptom Disorder (SSD) as defined by the DSM5.; 2) Understand contemporary conceptual models for SSD; 3) Explore ways to develop therapeutic alliance with patients around SSD diagnosis; 4) Describe evidence-based treatment approaches for SSD; and 5) Describe the team-based approach used in the Functional Neurological Disorders Clinic at the Massachusetts General Hospital.

SUMMARY:

As defined by DSM-5, somatic symptom disorder (SSD) is characterized by preoccupation with one or more distressing physical symptoms, resulting in disruption of daily life. A diagnosis of SSD does not preclude the existence of a co-occurring medical condition explaining the somatic symptom, nor does it preclude the possibility of finding a medical explanation for the symptom in the future. The focus is on whether there are "excessive" thoughts, feelings, or behaviors related to the somatic symptoms, rather than whether there is a medical diagnosis. The DSM-5 definition of SSD, however, is problematic for engaging patients in treatment. It contains words that can be perceived as judgmental or invalidating to patients, setting up resistance to treatment by a psychiatrist. SSD is also a condition that is poorly understood. As patients with SSD

concentrate on their somatic symptoms, many of them will seek help from primary care providers and medical specialists who may order extensive laboratory tests and imaging that result in negative findings, ultimately concluding the condition is “psychiatric.” A more contemporary conceptual model for SSD shows how physical and psychological states are intimately intertwined, and somatic symptoms can be understood in terms of neurophysiological pathways that become habitually activated by identifiable internal and external triggers. This will lead to a discussion of how to engage patients in treatment, which can be the most challenging phase of treatment. The words used to communicate the concept of SSD need to be clear, non-judgmental, compassionate, and culturally sensitive. In fact, the process of developing a therapeutic alliance begins in the diagnostic interview, when we can elicit the patient’s understanding of the meaning of the symptoms and possible directions for treatment. Case examples will be provided, and audience participation will be invited through instant polling technology (via cell phones) and through a small group exercise. The management of SSD requires a multifaceted approach tailored to the individual patient. The use of a biopsychosocial model with cultural sensitivity is more likely to succeed, rather than the use of a predominantly biological approach. Evidence based treatment provided by mental health care professionals include short-term psychodynamic psychotherapy, cognitive behavior therapy and mindfulness-based therapy. Effective pharmacological treatments include the use of antidepressants, with tricyclic antidepressants showing better outcomes than SSRI’s. Data from available studies on the use of other psychotropic medications for treatment of SSD will be discussed, though we will argue that non-pharmacological approaches are key to successful treatment of these conditions. We will describe one multidisciplinary team treatment approach currently being employed at the Functional Neurological Disorders (FND) Clinic at Massachusetts General Hospital.

Special APA CEO Breakfast Session: John Fryer 50th Anniversary Speech Award Celebration

Presenters: Jim Obergefell, Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide culturally competent care for diverse populations; 2) Identify barriers to care, including health service delivery issues; and 3) Apply quality improvement strategies to improve clinical care.

SUMMARY:

50 years ago, John Fryer, M.D., uttered the now infamous words at APA’s Annual Meeting: “I am a homosexual. I am a psychiatrist.” This watershed moment ultimately led to the removal of homosexuality from the DSM. At this session, APA CEO and Medical Director Saul Levin, M.D., M.P.A. will honor his memory and this moment with an interview with civil rights activist Jim Obergefell, the named plaintiff from the landmark marriage equality case Obergefell v. Hodges. Obergefell will be presented with the special John Fryer 50th Anniversary Award for his courage and conviction to equality for LGBTQI Americans, and will share his story.

Supporting Children in Education

Chair: Kristen E. Pearson, Ph.D.

Presenters: Monica Stevens, Corey Black

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) apply the necessary framework for navigating the educational system.; 2) describe and provide resources for educational rights, policies, and procedures to patients and families.; and 3) identify educational services and accommodations that may be helpful for patients and families..

SUMMARY:

Psychiatrists and other mental health professionals are often presented with the opportunity to advocate for children experiencing symptoms and behaviors that affect their educational performance. However, the educational system can be a difficult one to navigate. Understanding the general frameworks and access points, including families’ legal rights, educational policies and procedures, and what kinds of services and accommodations may be

helpful to address specific needs, are crucial. With this information, mental health professionals can be allies to patients and families and collaborators with schools to translate psychiatric need to educational support. This is especially true for the most vulnerable children who are at an increased risk for adverse educational outcomes, like poor achievement, school dropout, expulsion, and involvement in the juvenile justice system. Further, the COVID-19 pandemic has amplified the need for collaborative care between educators and mental health providers. The compounding impact of the pandemic will make collaborative work even more crucial in the years to come.

Supporting IMGs Throughout Their Careers

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

Presenter: Elie Aoun, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; and 3) Describe the utility of psychotherapeutic and pharmacological treatment options.

SUMMARY:

International Medical Graduates (IMGs) need support, particularly during this pandemic. IMGs are committing suicide at higher rates than ever before, and often do not receive the same resources as domestic psychiatrists, leading to disproportionate rates of burnout. In a small group discussion with APA CEO and Medical Director Saul Levin, IMGs will have an opportunity to discuss the unique challenges they face and brainstorm ways in which the APA might be able to assist.

Technology as a “Crystal Ball” to Predict Patient Aggression: Using AI to Mitigate Violence in an Academic Hospital Setting

Chair: Rajvee P. Vora, M.D.

Presenters: Kimberly Klipstein, Jennifer Finkel, Hameed Azeb Shahul

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the use of AI to predict diseases and behaviors using unstructured data and natural language processing; 2) Understand the need to predict patient aggression in psychiatric as well as non-psychiatric hospital settings; 3) Understand how different types of EMR data can be efficiently utilized to make patient and staff safety scalable; and 4) Learn how to create a clinical intervention team that can respond to AI based predictions.

SUMMARY:

Patient aggression is one of the most complex and dangerous occupational hazards in the healthcare environment. Aggression toward healthcare providers is especially pronounced, as The World Health Organization (WHO) reports that nearly a quarter of workplace violence occurs in healthcare settings, and health professionals are 16 times more likely to be attacked than workers in other industries. While aggression in patients with psychiatric diagnosis is a well-known phenomenon with an estimated presence in 20 per cent of psychiatric admissions, it is important to recognize that this behavior is not limited to acute psychiatric settings, and also occurs with high prevalence in the general hospital setting. A recent study of US hospitals reports an overall 12-month prevalence rate of 39% for aggressive and violent behavior against hospital workers, with mental health and behavioral issues as contributing factors in about 2/3rd of cases. In this context, it is critical to frame patient aggression as a behavioral emergency associated with a high risk of injury for both patients and healthcare professionals. Patient agitation and aggression can lead to physical and psychological suffering, not only for the patient, but also for staff who witness these incidents. In addition, patients with aggressive behavior are subjected to more restrictive interventions, have increased cost of care and higher resource utilization. Clearly, the current practice of assessing aggression in the healthcare setting is imperative to the health and safety of patients and staff. The Broset Violence Checklist (BVC) has been found to be highly reliable and easily implementable in predicting aggression and violence in patients with agitation. However, violence risk

assessment tools have limited prognostic value as they are rule-based engines with the golden time (time between initiation of aggression and intervention) close to zero. In effect, these scales identify aggression too late to have the most meaningful effect and a predictive tool with more “lead time” would be a novel approach leading to an initial treatment plan specifically targeting aggression at, or close to the time of the patient’s admission. Natural language processing (NLP) is a subfield of linguistics, computer science, and artificial intelligence that processes and analyzes large amounts of natural language data to “understand” the contents of documents. The technology can then accurately extract information and insights contained in the documents as well as categorize and organize the documents themselves. Using NLP, we processed our manually completed BVC screening and clinical notes accompanying that to create an algorithm using both structured and unstructured data to predict patient aggression. We have tested this algorithm to ensure sensitivity and specificity of the predictions and the potential to increase early intervention to aggression.

The Management of Adolescent-Onset Transgender Identity: Should “Best Practices” Change?

Chair: Stephen B. Levine, M.D.

Presenters: Kenneth Zucker, Ph.D., Sasha Ayad, L.P.C., Lisa Marchiano, L.I.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the dramatic increase in incidence of adolescent-onset trans identities particularly among previously gender typical girls and consider some of its psychosocial mechanisms; 2) Grasp the ethical significance of life altering interventions prior to scientifically establishing their long-term efficacy; 3) Provide a list of topics that any comprehensive evaluation of a trans-identified adolescent should address; and 4) Understand the engagement challenges of conducting psychotherapy with trans identified persons between the ages of 13 and 19 years of age.

SUMMARY:

In recent years a dramatic increase has occurred in the number of adolescents, particularly females, declaring some form of a transgender identity. Worried parents bring their teenage children to gender clinics or mental health professionals for evaluation and guidance. In Australia, Western Europe, and North American, mental health organizations have been recommending social transition, puberty blockers, cross-sex hormones, and breast or genital surgery. These interventions, all of which preceded evidence for their effectiveness, have become embroiled in what the media has termed a trans culture war. Its battles are being waged in federal, state, community, and juvenile courtrooms. In the arena of science, groups from the UK, Finland, and Sweden have failed to find strong evidence that hormonal interventions provide lastingly improved quality of life. Studies claiming that puberty blockers decrease suicidality and suicide and that gender conforming surgeries improve mental health have been refuted. The latter claim, published in the *Am. J. Psychiatry*, has been retracted. Advocates and skeptics agree that the mental health of transgender adults remains problematic in terms of depression, anxiety, substance abuse, suicide, and discrimination. Advocates of medical intervention for adolescents argue that societal acceptance of trans persons is improving so that the mental health of transgender communities will be better in the future. Skeptics point to reduced life expectancies, the large number of reports of de-transition, and the limitations of informed consent in this age group. This symposium will present the recent epidemiological trends in order to clarify the legitimacy of adolescent-onset trans identities. It will summarize the methodological limitations of existing studies and the guidelines that have led to the wave of medical and surgical interventions to diminish gender/sex incongruities. Long-term follow-up of the adolescent-onset patients treated in this manner is lacking. The high prevalence of mental health problems, the startling incidence of autism, and frequency of family dysfunction among these adolescents have implications for how the initial psychiatric evaluation process should be conducted. While there is no specific treatment for gender dysphoria, psychotherapy over time can address

social anxiety, depression, family and peer relationships, substance abuse, suicidality, and self-harm. The adolescent remains in charge of how personal identity is represented to the family, school, and the world. While there is only anecdotal evidence that young people may desist during psychotherapy or as they mature, long-term systematic follow-up of more conservative interventions is also lacking. Mental health professionals can benefit from an appreciation of the fact that there are currently no “best practices.” The phrase is a euphemism that belies the inherent uncertainty of what is best for the patient and family.

The Role of the Medical Director in the Current Health Care Landscape

Chair: Stephanie Le Melle, M.D., M.S.

Presenters: Maria Mirabela Bodic, M.D., Bianca Nguyen, Ludwing Alexis Florez Salamanca, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply the Systems-Based Practice model in conceptualizing the Medical Director role in a community behavioral healthcare system; 2) Think broadly about solving a systems’ problem - there is no one correct answer; and 3) Use the Systems-Based Practice model to understand organizations and solve systems’ problems.

SUMMARY:

Behavioral health agencies are traditionally run by an executive director/chief executive officer with training in business management and administration, but not necessarily in the clinical aspects of the services being provided (1). In 1997, Ranz et al surveyed public psychiatrists who began filling positions in administrative leadership, cataloguing tasks and assessing job satisfaction to further define and explore the role of agency or program medical director within organized mental health care delivery systems (2). Since then, research and focus on the role of medical director has been limited, despite major transformations that occurred in the decades since, which include the introduction of new funding and organizational structures, the

emerging ubiquity of task-shifting, and expansion of staffing models to include nurse practitioners, physician assistants and peers (3). Through the Public Psychiatry Alumni network, we have witnessed the ever-changing role of psychiatrists in administration and leadership amid countless transitions in healthcare funding and service delivery. We also recognize that during this time, there has been a dearth of forums available to psychiatric providers to explore and analyze the role of medical director, as well as provide support to one another. During the APA Annual meeting in the spring of 2021, Dr. Saul Levin held an open discussion for medical directors, out of which grew an emphasis on the need for additional resources and collaboration. Using the Four Factor model of Systems-Based Practice (4), we aim to use this workshop to answer the call for more activities geared towards medical directors and help them (and psychiatrists aspiring to be in this role), to better understand their position inside their organizations, the reporting structures and funding streams being used, and their formal and informal authority in implementing change. Through a hands-on, problem-solving exercise based on a vignette of a typical behavioral health agency, we will assist the audience in tackling real life issues such as staff turnover, training, clinical and operations supervision, clinician support, and addressing workplace culture.

Theory and Application of Psychodynamics of Psychopharmacology Within the 30 Minute “Med-Check” for Residents and Early Career Psychiatrists

Chair: David L. Mintz, M.D.

Presenters: Ali Ahsan Ali, M.D., Manal Farrukh Khan, M.D., Ian King, M.D., Dhruv R. Gupta, M.D., M.S., Raja Ramis Akhtar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize and understand the evidence base that supports psychosocial factors and social determinants as strong mediators of psychopharmacological treatment outcomes in psychiatric disorders.; 2) Identify the limitations of an “illness centered” perspective and understand the need for a “patient-centered” perspective in the

provision of psychopharmacological treatments.; 3) Appreciate the psychological and relational contributions to pharmacological “treatment resistance” and use psychodynamic principles to optimize pharmacotherapeutic adherence and response.; and 4) Identify and learn to operationalize the six technical principles of psychodynamic psychopharmacology in everyday clinical practice..

SUMMARY:

There is robust evidence indicating that psychosocial factors and therapeutic alliance have potent and specific therapeutic effects in the treatment of psychiatric disorders and are powerful moderators of successful pharmacotherapeutic outcomes. Research advances in neurosciences and time constraints have led to a predominantly biomedical model of illness conceptualization limiting the scope of psychiatric education and practice. Hence there is an emerging tendency to make applied psychopharmacology the primary bases of psychiatric treatment, restricting training and competency in psychotherapeutic modalities in psychiatry residency training programs and everyday clinical encounters. Specifically, there is a decreasing interest in clinical details of individual psychiatric patients, leading to impersonal, symptom-focused medication-check visits that have eroded the once indispensable – and still therapeutic – psychiatrist-patient relationship. Unfortunately, this has undermined the public perception of modern psychiatry and has also led to a 16-fold increase in the diagnosis of “treatment resistant disorders”, which further sheds light on the limitations of a purely biologic treatment model. Another consequence is that social determinants of mental health, which are taken as non-biological, are frequently overlooked. Psychodynamic and psychosocial interventions are efficacious biological contributors to treatment. Insofar, psychodynamic psychopharmacology is an emerging, integrative approach to treatment that explicitly recognizes and operationalizes powerful psychological and interpersonal factors to enhance pharmacotherapeutic outcomes, all the while working within the financial limitations, time-constraints and large caseloads of everyday clinical practice. Specifically, it aims to augment pharmacotherapeutic outcomes through avoiding

the mind-body split, knowing who the patient is, attending to patient’s ambivalence about loss of symptoms and countertherapeutic uses of medications, cultivating a therapeutic alliance and utilization of countertransference (The Six Technical Principles). In accordance with emerging evidence and training requirements of the Accreditation Council for Graduate Medical Education (ACGME), this workshop has been developed for residents, fellows, and early career psychiatrists with the goal of teaching clinicians how to clinically integrate psychosocial determinants and biomedical theories of treatment. The content of our workshop is grounded in evidence-based findings, and will actively engage participants in small and large groups.

Toward Precision Medicine in Psychiatry Using Pharmacogenomics

Presenter: Daniel J. Mueller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review evidence for actionable gene-drug pairs; 2) Review recommendations provided by expert panels and regulatory agencies; 3) Highlight implementation strategies of pharmacogenetics in clinical practice; and 4) Present patients' feedback following pharmacogenetics testing.

SUMMARY:

Psychiatric medications, and in particular antidepressants and antipsychotics, are essential components in treatment of most psychiatric disorders. Unfortunately, lengthy trials are often required before the optimum medication treatment is found. The underlying reasons for this large inter-individual variability in terms of treatment response are not fully understood. Important factors that influence drug dose, response and side effects include age, gender, patient compliance, clinical symptoms, co-morbidity, ancestry and genetic factors. In this context, first strategies using pharmacogenetic (PGx) information have shown promise to optimize medication treatment in clinical practice. This presentation targets researchers, trainees and clinicians and will provide them with

updates and state-of-the-art summaries of key concept and strategies of psychiatric PGx: 1) Review the evidence, clinical utility and publications including randomized clinical trials of distinct gene-drug pairs (e.g., CYP2C19 and escitalopram and CYP2D6 and aripiprazole); 2) discuss current expert recommendations (e.g., Clinical Pharmacogenomics Implementation Consortium) how applying PGx information in clinical practice 3) highlight ongoing implementation efforts in North-America and 4) provide feedback given by patients and physicians who chose to use PGx information and 5) provide a synopsis with practical guidelines for psychiatrists and clinicians. Time for discussion format will be provided to interact with the audience's questions, experiences and concerns related to psychiatric pharmacogenetics.

Treating Substance Use Disorders With Classical Psychedelics

Chair: Bryon Adinoff, M.D.

Presenters: Albert Garcia-Romeu, Peter Hendricks, Michael Bogenschutz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify substance use disorders that may benefit from the structured use of classic psychedelics.; 2) Evaluate evidence suggesting a therapeutic potential for classic psychedelics in SUD treatment.; 3) Identify possible biological and non-biological mediators/moderators of psilocybin's effectiveness.; and 4) Describe safe guidelines for the therapeutic use of classic psychedelics..

SUMMARY:

Research investigating psychedelic drugs as treatments for drug addiction began in the 1950s, but was terminated in the 1970s due to concerns of nonmedical use, a misunderstanding of the risks, and the political environment. In recent years, however, the interest in the potential of these drugs for the treatment of various psychiatric disorders has dramatically increased. The heightened awareness of the therapeutic potential of psychedelics has yielded several exciting new clinical studies, suggesting a novel approach for the treatment of

substance use disorders. This symposium will review recent and ongoing research by leaders in this emerging field. In their studies using the classic psychedelic psilocybin, the presenters will describe their paradigms, safety procedures, outcomes and potential mediators of effectiveness. Albert Garcia-Romeu will begin the session by providing a brief historical review of psychedelic use, including more recent studies in healthy volunteers. He will then present outcomes from a previous pilot study of psilocybin treatment of cigarette smoking (tobacco use disorder) and preliminary findings from an ongoing study comparing psilocybin with nicotine replacement treatment of cigarette smoking. He will also discuss issues surrounding participant diversity and inclusivity in psychedelic clinical trials more broadly, as well as the colonization of sacred indigenous practices. Peter Hendricks will present observations from a double-blind placebo-controlled trial of psilocybin in the treatment of cocaine use disorder, including recruitment, retention, and therapeutic considerations in a vulnerable population from the Deep South comprised predominantly of economically disadvantaged Blacks. Michael Bogenschutz will present findings from a recently completed double-blind study comparing psilocybin with diphenhydramine in the treatment of individuals with alcohol use disorder. The implications for future research with psilocybin and other psychedelics for the treatment of substance use disorders will also be discussed.

Understanding the Contribution of Stressful Life Events to Suicide Risk: What Do We Need to Look Out for?

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

Presenters: Megan Rogers, Ph.D., Lisa Cohen, Ph.D., Fredrik A. Walby, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relationship between stressful life events and the suicide crisis syndrome; 2) List the stressful life events most predictive of suicidal risk.; 3) Understand the effect of using different means of assessing stressful life events.; and 4) Understand how stressful life events

interface with other clinical features to raise the risk of suicide death..

SUMMARY:

Despite many decades of suicide research and prevention efforts, suicide remains a major health problem and one of the most frequent causes of death for middle aged and young adults (Heron, 2021). Stressful life events (SLEs) often serve as triggers for suicidal thoughts and behavior (Bagge et al, 2013) yet research into the specific characteristics of this relationship is surprisingly thin. The present symposium will present data from an international panel of researchers looking at the relationship between SLEs and suicide risk, considering the timing of SLEs, comparative risk of specific SLEs, predictive values of different assessment methods, and cross-cultural differences. As many SLEs involve social factors, such as romantic break ups, family conflicts, or the death of a loved one, this topic accords with the theme of the 2022 APA annual meeting, the social determinants of mental health. Dr. Megan Rogers will present data from the ISPARC study (N=5,528), an international on-line, community-based survey assessing the timing and nature of SLEs as correlates of suicidal ideation and the suicide crisis syndrome (SCS), an acute, negative affect state strongly associated with near-term suicidal risk (See Schuck et al, 2019). Data were collected across 10 countries during the COVID-19 pandemic: Brazil, Canada, Germany, India, Israel, Japan, Poland, Russia, South Korea, Turkey and the United States. Findings were strikingly consistent across cultures. Past week as opposed to past month SLEs had a high correlation with the SCS and a significant but weaker association with suicidal ideation. Interpersonal and identity-related SLEs were the strongest correlates. Dr. Lisa Cohen will present data from a large sample (N=1,058) of psychiatric inpatients and outpatients on the relationship between 22 specific SLEs and suicidal thoughts and behavior in the past month and 1-2 months after initial assessment. Different methods of assessment will also be compared, self-report vs. clinical ratings from the medical record. In this psychiatric sample, SLE's were common and overall amount of SLEs was predictive of imminent and near-term suicide risk. Rating method impacted the number of SLEs recorded, such that self-report measures produced an incidence of SLEs almost five

times higher than that produced by chart-based ratings. Nonetheless, chart-based SLEs may be more predictive of suicide risk. SLEs related to interpersonal rejection and loss, homelessness and academic failure seem to offer elevated risk. Finally, Dr. Fredrik Walby will present data of suicide deaths drawn from the Norwegian national registry. He will address the role of SLEs in the 3 months prior to death in conjunction with diagnosis, contact with clinician, SCS-like symptoms, and clinician judgment of short-term and long-term risk.

Who Is the Psychiatrist of the Future? Psychotherapeutic Expertise in Psychiatric Consultation to Integrated Care

Chair: David L. Mintz, M.D.

Presenters: Madeleine Elise Lansky, M.D., Sherry Katz-Bearnot, M.D., Elizabeth A. Greene, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the rationale for a biopsychosocial approach to psychiatric consultation on integrated care teams; 2) Offer case formulation as a trustworthy foundation on which appropriate and helpful psychiatric interventions can be structured, implemented and maintained; 3) Recognize and help manage countertransference constellations that can interfere with optimal functioning of integrated care teams; and 4) Explain at least two brief psychotherapeutic interventions that can be taught to and utilized by primary care clinicians.

SUMMARY:

New models of treatment bring new challenges and raise old questions. Integrated care models confront us with familiar questions about psychiatric identity. If psychiatry is seen primarily as a biomedical discipline, then the task of the psychiatrist who consults to the integrated care team is to provide diagnostic clarity and to offer recommendations about what treatments to prescribe. If, however, psychiatry is viewed as a biopsychosocial discipline and the psychiatrist integrates biomedical and psychotherapeutic skills, the task of consultation not only addresses biomedical needs, but also leverages psychiatric expertise regarding the patient's

experience of illness and relationship to care, in order to optimize outcomes. From this perspective, the psychiatrist is uniquely positioned, as a physician and therapist, to provide an “overall diagnosis” that helps the primary care team to understand and address dynamics that promote treatment-resistance. In other words, a consulting psychiatrist who integrates biopsychosocial/psychotherapeutic perspectives is able to guide the Team in understanding not only what treatments to offer, but also how to offer those treatments in ways that optimize patients’ abilities to make use of that care. In this presentation, we will review the history, theory, and evidence underlying biopsychosocial psychiatric consultation in integrated care. We will demonstrate how an understanding of the dynamics of treatment resistance can support the work of the primary care team with some of the most challenging patients, and will review some common dynamics underlying treatment-resistance. Such consultation can help front-line treaters identify and cope with countertransference, which has a range of benefits, including enhancing the treatment alliance, reducing irrational prescribing, and potentially reducing treater stress and burnout. We will also demonstrate how primary care teams can be educated to provide very basic psychotherapeutic interventions that remove resistances to the healthy use of treatment and enhance working alliances with the primary care team.

Why Didn't Y'all Just Evacuate? Examining the Effects of Systemic Racism and Social Disparities on Patients During the Pandemic and Natural Disasters

Chair: Rahn K. Bailey, M.D.

Presenters: Lee D. Michals, M.D., Jennifer Creedon, M.D., LaKisha Mamon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and identify examples of systemic racism within our institution, community and state.; 2) Propose ways to adapt our substance abuse treatment model to address disparities in both access to treatment an overall treatment outcomes.; 3) Understand unique needs and vulnerabilities of LGBTQ+ youth during and after disasters; 4) Recognize how structural racism

impacts underrepresented populations during and after disasters; and 5) Identify strategies for psychiatrists to promote awareness and advocate change in policies and systems to improve diversity, equity, and inclusion.

SUMMARY:

At LSU HSC New Orleans, we are working to identify and understand the effects of systemic racism as they affect access to care and overall treatment outcomes for our patients who are BIPOC and LGBTQ+. With the increased awareness of the association between the effects of systemic racism and substance misuse, there is an imperative for clinicians to adapt their treatment approach vulnerable populations. To improve treatment outcomes by implementing meaningful and effective solutions to systemic racism, this panel argues that the first step toward a more equitable future to reflect on how our own bias and prejudices contribute to disparities. Many clinicians who provide substance use treatment were educated in higher educational systems, potentially harboring racial bias. We will examine the downstream effects of physician bias specifically in times of crisis, and will focus on the impact disasters on access to care and health outcomes. Specific intersections need to be taken into account, as well. LGBTQ+ youth face higher rates of mental health challenges compared to their cisgender and heterosexual peers. One study by the Trevor Project, conducted just before the start of the COVID-19 pandemic, found that 40% of LGBTQ+ youth and half of transgender youth had considered suicide in the past 12 months. Multiple societal factors contribute to the discrepancy in psychiatric symptoms and diagnoses in this population, including discrimination, increased rates of homelessness, and poverty. These issues are made even more acute in the face of disasters, including hurricanes, wildfires, and pandemics. Despite known vulnerabilities, LGBTQ+ communities, particularly those of color, are often neglected in disaster planning and policies. This session will explore unique needs and challenges of LGBTQ+ youth during and after disasters, and discuss how psychiatrists can advocate within our systems to improve access and quality of care, during the most trying of times. Similarly, unexpected disasters highlight the ongoing challenges of housing,

finances, and socioeconomic factors faced by BIPOC when disaster planning. BIPOC populations continue to face significant systemic inequities that impact health, quality of life, and social progression. The Groundwater Approach by Racial Equity Institute highlights structural racism across multiple care systems, including healthcare, education, legal and financial. The COVID-19 pandemic has further emphasized disparity in underrepresented populations. The CDC reports significantly higher rates of infection, hospitalization, and death for BIPOC individuals with risk indicators related to socioeconomic status, access to health care, occupational exposure, and underlying health conditions when compared to Caucasians. During this presentation, we will explore the barriers, challenges, and needs of underrepresented populations during and after disasters and discuss how to promote diversity, equity, and inclusion in our work.

Women's Mental Health Care in 2022: Practice Tips and Resources for Advancing Quality and Reducing Risk

Chair: Jacqueline A. Hobbs, M.D.

Presenters: Richard Holbert, Lauren Schmidt, M.D., Donna Vanderpool, J.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) - Discuss relevant cases common in women's mental health care practice; 2) - Review foundational knowledge required for safe and quality care of women who are pregnant, postpartum, or lactating; 3) - Locate reliable and expert online resources and literature regarding women's mental health care concerns (e.g. psychopharmacology, neuromodulation) for clinician and patient education; and 4) - Demonstrate sound risk management strategies in caring for women who are pregnant, or lactating.

SUMMARY:

The care of women in life stages related to childbirth (pregnancy, postpartum, lactation) poses unique challenges and risks for psychiatrists. The adverse effects of untreated maternal mental disorders such as perinatal depression on fetal and infant

development are significant such as low birth weight and pre-eclampsia. Fetal and/or infant exposure to psychotropic medications is a major concern for psychiatrists and patients due to the possibility of major congenital malformations or other long-term developmental problems in children. The use of neuromodulation therapies in this patient population is also growing and offers some advantages such as possible lessened need for psychotropic exposure, but with unknown long-term risks. Obtaining timely, relevant, and evidence-based information in a rapid and easily understandable format is critical for both psychiatrists and patients. Developing strategies for ensuring safe and quality care as well as mitigating any practice risks is key. The presenters are psychiatrists with decades of experience in the practice of women's mental health and neuromodulation (electroconvulsive therapy and transcranial magnetic stimulation) and experts in risk management who will review foundational knowledge and relevant cases from their practice to illustrate quality and safe women's mental health care. Participants will discuss relevant cases with colleagues and debate best practices. Sound risk management strategies including the ABCDEs and the 3 Cs will be reviewed. Helpful resources including online and literature references for the practicing psychiatrist and residents/fellows will be provided and demonstrated.

Wednesday, May 25, 2022

2022 Psychiatric Services Achievement Awards

Chair: Victor Luna

Presenter: Peggy Swarbrick

Chair: Thomas F. Betzler, M.D.

Presenter: Adam Mcgahee

Discussants: Victoria Goldstein, Eileen Rivera, Teresa Vassallo

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define SDoH in the context of wellness model to design and deliver services and supports; 2) Describe how the Wellness in 8 D model and SDoH intersect; 3) Describe how the wellness in 8 D model led to five peer led community support programs; 4) To understand the importance of

system changes to allow open access and engagement; and 5) Understand the importance of team engagement to yield better performance outcomes and of analytics to influence operational decisions.

SUMMARY:

Wellness in 8 D: A Peer led model to address the Social determinants of Health (SDoH): There is a growing awareness of the impact of the social determinants of health (SDoH) on the well-being of people with mental health and/or substance use challenges who face co-occurring medical conditions. This session will examine the how a peer led agency used a wellness in 8 D model considering SDoH as a lens for designing and delivering a variety of peer led community supports (wellness respite, supportive housing wellness institute, financial services). **Meeting the Changing Needs in Community Mental Health:** Montefiore Behavioral Health Center (MBHC) at Westchester Square is a Community Mental Health Center that provide timely access to evidence-based services for patients diagnosed with Serious Mental Illness (SMI). The clinic is located in New York City in the Southeast Bronx and serves a population of 290,052 (Bronx population 1.4 million). As the largest provider of outpatient mental health services in the Bronx, the clinic provides services to one of the lowest income communities in the nation. Approximately 90% of the 4,632 patients receiving care have a public payer as their insurance provider with 61% Medicaid and 29% Medicare. The mixed patient population reflects the Bronx community. The breakdown of patient population by diagnosis is: Major Depression 39%, Psychosis 18%, Bipolar Disorder 15%, Anxiety Disorders 12%, Attention Deficit Disorder 7%, Other Diagnoses 9%. The clinic has been designed to implement systemic changes to meet patient needs at point of contact and to facilitate immediate access to treatment for mental health and primary care, intensive outpatient programming, and ongoing development of specialty tracks (Transcranial Magnetic Stimulation/Esketamine) to improve access and outcomes in the Community Mental Health setting. MBHC combines analytics and an evidenced based system's approach to achieve clinical and fiscal sustainability.

Applying the DSM-5-TR Outline for Cultural Formulation for Culturally Competent Care: Three Cases

Chair: Francis Lu, M.D.

Presenters: Rajesh Kumar Mehta, M.D., Narpinder Malhi, M.D., Raman Marwaha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the five sections of the DSM-5 TR Outline for Cultural Formulation, especially the changes from DSM-5.; 2) Utilize the DSM-5 TR Outline for Cultural Formulation to include cultural issues in diagnosis and treatment planning.; and 3) Apply the DSM-5 TR Outline for Cultural Formulation in their clinical work with patients at their institutions..

SUMMARY:

The DSM-5 Outline for Cultural Formulation, which initially appeared in the DSM-IV, was revised for DSM-5 TR. It contains five sections including cultural identity, cultural concepts of distress, cultural stressors and supports, cultural elements of the relationship between the clinician and the patient, and overall assessment for diagnosis and care. After a brief review of these changes, three cases will be presented to illustrate the use of the DSM-5 TR Outline for Cultural Formulation to include cultural issues in diagnosis and treatment planning. Interview developed by Lewis-Fernandez et al is the result of much work to guide providers to contribution of culture, cultural identity and cultural explanations of the illness, Cultural definition of the problem, Cultural perceptions of cause, context, cultural identity and Cultural factors. Research has shown that culturally minorities receive lower quality of mental health care, are prescribed drugs differently, and have less money spent on their care. Our case series focuses on how mental illness of adolescent and young adults are impacted by their culture, religion and gender identity. Culture is dynamic and evolves overtime with individual and family dynamics, which passes on to succeeding generations. Religion and spirituality can be considered subsets of culture. The unique and profound role of religion and spirituality in virtually all cultures and their pervasive influence on mental

health demand special consideration. One hand personal faith, devotion, relationship with divine, and family core beliefs are at most important to individual culture and on other hand can be a limiting step to healthy mental well-being. It is anticipated that in a decade, in America international migration will be the most important factor for population growth rather than birth and death rate. This trend will yield a culturally rich society with mixture of multi-cultural, ethnicity and religious diversity which would warrant a special attitude and cultural competency from mental health providers. Impact of cultural factor in various mental illnesses and psychotherapy is well studied in the past. By now we all know that a culturally competent provider will be able to provide that safe and mutually understanding environment to patient with different cultural background. It is observed that some are culturally suspicious of seeking mental health and some have logistic challenges to seek help secondary to their personal partial acculturation.

Best Practices in Managing Patients With Kratom Addiction

Chair: Corneliu Natanael Stanciu, M.D.

Presenter: Thomas M. Penders, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the current state of knowledge surrounding Kratom and its impact on patients with addictive disorders; 2) Cite the clinical evidence from literature and our survey of national addiction experts in managing Kratom addiction; and 3) Discuss challenges and approaches to best manage this comorbidity.

SUMMARY:

An increasing number of Americans are turning to kratom for self-management of various pain, anxiety and mood states; and for those with OUD, as an opioid substitute. With use of this botanical on the rise, it is pertinent for psychiatrists to stay up to date with the latest regarding best practices surrounding this agent and management. In this session, we plan to briefly cover such updates but with a main focus on providing guidance on treatment of patients with

such co-morbidity. Here we will present all available information on management of kratom addiction from the literature (systematic review of all cases involving psychopharmacological management) as well as the results of a survey of addiction experts' practice patterns, which we conducted at the national level. Part of this session will also serve as an open forum for attendees to ask about and discuss challenging cases and experiences.

Caring for Refugees in Crisis

Chair: Vanessa Torres Llenza, M.D.

Presenters: Vanessa Torres Llenza, M.D., Pamela Carolina Montano, M.D., Anjali Niyogi, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply a culturally sensitive and trauma informed approach to a psychiatric interview of refugees; 2) Explain signs to look for to identify potential human trafficking victim; 3) Discuss how to advocate for refugees in outpatient settings; 4) Describe acute needs of refugees in times of crisis; and 5) Understand basics in asylum evaluations in medical and psychiatric setting.

SUMMARY:

Refugees leave their home countries due to persecution, war, natural disasters, and for many other reasons. With increasing climate disasters caused by global warming, displaced people around the world are seeking homes in new countries. Countries influenced by migration due to climate change include Indonesia, Mexico, Bangladesh, South Africa, Pakistan, among others. Another example of migration due to hurricanes in 2017 Maria and Irma leading to displaced migrants in the Caribbean. Political instability is also contributing to migration. Migrant caravans from Central American countries fleeing persecution and violence have led to a crisis at the border. Slowing down occurred during the pandemic but recent rebound was noted. The fiscal year for 2021 marked the highest encounters with border patrol with approximately 1.66 million. In 2021, US military left Afghanistan and the Taliban quickly took over, leaving a significant number of vulnerable Afghans in danger. As a result, the United States and many other

countries around the globe began accepting Afghan refugees. The Covid-19 pandemic has presented a new set of barriers atop the many that already existed for this vulnerable population. Lack of access to care, homelessness, the risk of victimization such as human trafficking are all huge issues that affect refugee populations. (Latham-Sprinkle, 2019) Providing psychiatric care for refugees can also present challenges. Differences in culture, stigma around mental health issues, in addition to legal hurdles and social disadvantages can impact the quality of psychiatric care a refugee is given, but providing culturally sensitive, trauma informed care has been shown to improve outcomes in this population. (Butler, 2011) This multidisciplinary workshop will help address common scenarios, dilemmas, and questions that may arise when caring for refugees.

Common Sexual Concerns in Patients

Presenters: Jennifer I. Downey, M.D., Jack Drescher, M.D., Richard Krueger, M.D.

Moderator: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session participants will be able to discuss parenting issues with families dealing with adolescent children's gender presentations, such as declarations of being non-binary; 2) At the conclusion of this session the participant will be able to discuss with teens and adults concerns about sexual orientation identity, such as "Am I gay?"; and 3) Participants will become acquainted with patterns of atypical sexual behavior known as paraphilic and compulsive sexual behavior disorders, contained in the DSM-5 and.

SUMMARY:

In recent decades psychiatric residency training in the United States has mostly avoided teaching about sexual dysfunctions, sexual disorders, and even the basic skills required to take a sexual history. The proper diagnosis of sexual disorders is often not taught in many psychiatric training programs. Despite this current situation in our profession, patients entering treatment for a range of different problems may also have many concerns about sex,

sexuality, and gender. A small number will ask these questions unprompted. Most will need an invitation to express their concerns. This panel, composed of 3 speakers and a moderator, will address three questions that come up in the general psychiatrist's office: What do we do about our teen? They are calling themselves "non-binary!" Doctor, I want you to tell me, "Am I gay?" "I'm watching too much porn on-line and some of it's weird. My wife sent me."

Criminal Justice Reform in Jacksonville, FL: Reallocation of City and Police Resources to Keep Misdemeanor Offenders With Mental Illness Out of Jail

Chair: Colleen E. Bell, M.D.

Presenters: Ana T. Turner, M.D., Muhammad Sharifi

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how the Miami Model inspired Jacksonville to rethink their approach in incarcerating those with misdemeanor offenses and severe and persistent mental illness; 2) Illustrate how criminalization of homelessness affects those on the streets and increases community costs; 3) Describe key community stakeholders came together to decrease arrests, hospitalizations, and associated community costs for repeat misdemeanor offenses related to mental illness; and 4) Illustrate a novel community program aimed at reducing recidivism through the court system and wrap around support.

SUMMARY:

Jail diversion initiatives have garnered much support as a strategy for reducing the presence of persons with mental illness in the criminal justice system. Jails have become the largest mental health facility in the community, despite a widespread belief that those with mental illness do not belong behind bars. According to a special report published by the Bureau of Justice Statistics, states that 43% of state and 23% of federal prisoners had a history of a mental health problems. In February of 2021, a very unique and exciting program, the Mental Health Offenders Program (MHOP) was launched in Duval County, FL. The program is a partnership of the Duval County Judges, State Attorney's Office, Public

Defender's Office, City of Jacksonville, Jacksonville Sheriff's Office and Sulzbacher, a federally qualified healthcare center. The purpose of the program is to reduce the demands on the criminal justice system by helping those with mental illness who rotate through the jail due to non-violent misdemeanor arrests. The program provides pretrial release from custody, a customized plan of care to stabilize defendants, and court supervision to ensure compliance with a program developed by Sulzbacher. Clients are assisted in applying for benefits, and they get free medications and referral to other specialists if needed. The program is based on the very successful Miami model entitled the Eleventh Circuit Court Criminal Mental Health Project which was initiated by Judge Steve Leifman in 2000. The services are being funded 50% by the City of Jacksonville through the Social Justice Committee and 50% by the Jacksonville Sheriff's Office. We will present data on the number of arrests, jail time, officer time, crisis unit and hospitals admissions and use of Jacksonville Fire and Rescue, as well as income attainment and reduction in homelessness among other items. We will also highlight several case examples of those who not only remained out of jail but obtained remission of symptoms, reconnected with family, and became contributing members of society. Finally, we will discuss the Mental Health and Substance Use Courts to aid patients in recovery in order to decrease recidivism.

Depression, COVID-19, and the Social Determinants of Health in Women From Latinx/Hispanic America

Chair: Thelma S. Sanchez-Villanueva, M.D.

Presenters: Pamela Carolina Montano, M.D., Elvia Velasquez, Ana Maria Saavedra Sanchez, Tatiana A. Falcone, M.D.

Discussant: Ruby C. Castilla Puentes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To investigate the social determinants of depression among Hispanic women in US and Latin American countries.; 2) Recognize the differences of the Impact of COVID-19 on Women's depression based in the socioeconomical context among Latinx/Hispanic populations.; and 3)

Understand how countries in Latin America are addressing economic gender disparities during COVID-19.

SUMMARY:

Background: Depression is the number one cause of disability in the world. Across different societies and social contexts throughout the world, depression affects significantly more women than men. Social determinants of health (i.e., income, education, and health status) may play a crucial role in the development or exacerbation of depression among Latinx/Hispanic women. **Methods:** According to a WHO definition, the social determinants of health are the conditions in which people "are born, grow, live, work, and age." Recent studies found U.S. women experienced increased incidence of health-related socioeconomic risks, such as food insecurity and interpersonal violence, early in the COVID-19 pandemic. This was associated with high rates of mental health problems, including depression and anxiety. The effect of the pandemic on women in vulnerable situations has been largely forgotten. We examined the relationship between the social Determinants of Health and depression in Women from Latinx/Hispanic America. **Analysis:** Hispanic/Latinx culture is, traditionally, very family oriented but it retains firm gender divisions. The COVID-19 pandemic has sharply revealed the inequalities that already exist in terms of socioeconomic status. Women are principally responsible for parenting, family caregiving and other essential work — they are key to managing and recovering from this pandemic, and now are afflicted by very significant socioeconomic risk levels that appear to be drivers of depression. **Conclusion:** Among the social determinants of health, poverty, is a vital stressor in which a substantial number of threats and unmet needs converge. We should be especially concerned that socioeconomically vulnerable women are at high risk for developing pandemic-related psychiatric morbidity. It is necessary to pay more attention to Latinx/Hispanic women in vulnerable situations due to the high risk of depression. Women require a broader approach to analyze variables associated with depression and, consequently, specific strategies. This symposium is in collaboration with the American Society for

Hispanic Psychiatry (ASHP) and WARMI (Mental Health Network for Women's Mental Health in LA)

Developing New Treatments for Neurodevelopmental Conditions: A Hopeless Cause?

Introduction: Ron M. Winchel, M.D.

Presenter: Declan Murphy

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the problems in discovering new treatments; 2) Critically evaluate the potential utility of putative biomarkers; and 3) Appreciate the need to develop personalized medicine approaches.

SUMMARY:

There have been very few highly effective new drug treatments developed in psychiatry over the last decade. In this presentation I will discuss why that is, and the progress that is being made in one exemplar condition by an EU Network. The lessons learnt, from that our work are likely of relevance to a wide range of other conditions. Autism Spectrum Disorder (ASD) affect over 5 million people in the European Union (EU). In addition, up to 70% of individuals have one or more psychiatric and/or medical comorbidities (e.g. intellectual disability, epilepsy). The symptoms of ASD place a very high burden on society; and people with ASD die early. Currently, however, there are no effective drug treatments for the core symptoms of ASD. Several compounds have been tested – but none translated into approved treatments. This is most likely due to limitations in the; 1) testing of drugs with specific actions in biologically heterogeneous populations; 2) clinical trials experience of centres; 3) trial designs (e.g. placebo effects); and 4) alignment of findings from basic cellular and rodent models to humans. Hence we launched EU AIMS (<http://www.eu-aims.eu/>) and subsequently AIMS-2-TRIALS (<https://www.aims-2-trials.eu/>) to address these shortcomings by developing precision medicine approaches that are tailored to the biological profiles of particular patients. To do this we propose to; 1) validate and qualify stratification biomarkers (e.g. genetic, molecular and inflammatory markers, neuroimaging)

and objective outcome measures that can be used in trials; 2) develop a European-wide clinical trials network trained to good clinical practice (GCP) standards; 3) carry out better targeted clinical trials linked to other international efforts; and 4) translate molecular mechanisms and drug effects between preclinical models and particular subtypes of ASD from infancy to adulthood. I will present our initial findings showing; 1) we have identified novel drug targets (but importantly ruled out others); 2) discovered and validated stratification biomarkers – some of which (e.g. prognostic markers of clinical outcome) have now been accepted by the FDA into their development program, received support from the European Medicines Agency, and been incorporated into international drug trials; and 3) demonstrated that we can 'shift' biological differences in brain function (and even in adults). We hope that these advances will help underpin new personalised medicine approaches.

Deviant Sexual Behavior Among Persons With Intellectual Disability: From Etiology to Management

Chair: Kathryn Baseline, M.D.

Presenters: Kathryn Baseline, M.D., Sara Gilmer West, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe possible etiologies of problematic sexual behavior among persons with intellectual disability.; 2) Review diagnostic considerations in relation to problematic sexual behavior in persons with intellectual disability.; and 3) Evaluate potential treatment options in cases where they encounter patients with intellectual disability who demonstrate inappropriate sexual behaviors..

SUMMARY:

Persons with Intellectual Disability (PWIDs) that act out sexually are a heterogeneous group whose motivations and pathology range from a simple lack of adaptive functioning to more complex, comorbid paraphilias. These behaviors can be seen anywhere... from the inpatient unit to a group home, even in the community at large. They may result in a variety of

negative consequences for PWIDs, including administrative discharges, removal from care facilities (with subsequent challenges finding alternative housing) and even criminal charges. The behaviors also negatively impact those who witness them and of course their victims. Further, clinicians are often not well equipped to manage behavioral issues in those with intellectual disability; thus, the management of sexual acting out in the PWID population can prove a daunting task to many practitioners. This session aims to supplement the psychiatrist's knowledge about PWIDs by discussing the evaluation and management of these inappropriate sexual behaviors. We will first present two complex cases, focusing on how such inappropriate sexual behavior by PWIDs may manifest itself. We will then address the etiology of these behaviors. We will review diagnostic considerations relevant to paraphilic disorders in PWIDs and discuss ways to distinguish these from non-paraphilic disorders. We will then cover treatment and management considerations. After the presentation, small groups will be formed; each group will discuss the aforementioned cases and apply their newly acquired knowledge to each situation. The group will then present their findings for further discussion and collaboration. The presentation will conclude with a Q&A session.

Double Minorities: Exploring Systemic Barriers Against Non-U.S. International Medical Graduates in Academic Psychiatry

Chair: Ramotse Saunders, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the concept of double minorities within the foreign medical graduate cohort.; 2) Understand the analytic and practical implications of the immigrant experience, extrapolating it to barriers for advancement; 3) Learn about the challenges faced by various FMG minorities in healthcare; and 4) Appreciate the role of mentorship in the IMG's journey into integration in the American psychiatric workforce.

SUMMARY:

International Medical graduates (IMGs) make up around a quarter of licensed physicians in the country. Up to a third of all psychiatrists in the USA and more than a quarter of psychiatry trainees are IMGs. The vast majority of IMGs is composed of non-US IMGs, with most coming from the global south. Many of the non-US IMGs also fall into the category of double minorities given their immigrant status in addition to racial/ethnic background, gender and sexual orientation. Immigration, in of itself, has been the topic of much debate in the psychiatric/psychoanalytic literature. However, little data exists on the immigration and acculturation of non-US physicians within the medical workforce generally or the psychiatric workforce particularly. At the start of training, non-US IMGs face a dual learning curve, both as immigrants and trainees. Often there is limited support and understanding of their struggles. Non-US IMGs have been shown to face bias and discrimination by patients, peers and supervisors. They are held to a different, tougher standard and come to accept limitations to career advancement as part of the package. During the session, we will summarize the existing literature on the stress faced by international graduates and the struggles of being an IMG of minority background. We will invite the attendees to reflect on case vignettes for challenges faced by such physicians. During the session, we will review the issues faced by specific groups: racial/ethnic minorities, women and those who belong to the LGBTQ community. The session will then highlight the various issues raised by intersectionality, with a focus on barriers to professional success and progression. We will also present models that assist in addressing these concerns. For example, for trainees at the beginning of training, the transition can be made easier by providing specialized orientation to both the medical and geographical culture while also providing logistical support as they settle into a new country. Efforts at cultural awareness should also extend to IMGs and institutional policies should be routinely reviewed to ensure a level playing field. Ally training, implicit bias training and anti-racism/sexism training may be helpful in fostering a better learning and academic environment. Peer as well as intergenerational mentoring can be a very vital tool to assist non-US IMGs career progression during

training and beyond. As the numbers of IMGs matching in psychiatry declines, meeting their specific needs in academic psychiatry is vital. We hope to have a discussion that aims at identifying ways of assisting IMG in navigating American academia and reaching full career potential. Inviting institutions to optimize the environment for IMG.

Early-Stage Investigators and Timely Support: The OPAL Center and Its Mission to Fund and Train the Next Generation of Schizophrenia Researchers

Chair: T. Scott Stroup, M.D., M.P.H.

Presenters: Stephanie Alexia Rolin, M.D., M.P.H., Ana Stefancic, Natalie Bareis, Ph.D., L.M.S.W., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Present the OPAL model of supporting emerging translational research in schizophrenia; 2) Compare the effectiveness of different approaches to violence risk assessment in schizophrenia; 3) Identify geographical variation in psychotropic prescribing in the U.S. for schizophrenia; 4) Understand physical health needs of young adults with early psychosis; and 5) Consider new ways to support novel research by early-stage investigators.

SUMMARY:

OPAL (Optimizing and Personalizing interventions for people with schizophrenia Across the Lifespan) is a NIMH-funded ALACRITY (Advanced Laboratories for Accelerating the Reach and Impact of Treatments) center specifically focused on the needs of people diagnosed with schizophrenia. The goal of OPAL is to identify the needs, and accelerate the development, implementation, and adaptation of effective, personalized treatments for schizophrenia in real-world settings. As part of ALACRITY funding, the OPAL Center provides competitive pilot awards for early-stage investigators who have clear potential to lead larger, externally-funded research projects in the future. This session will present the OPAL Center and its broader goals (Stroup). Participants will learn about unmet needs of this population (including impaired social and occupational functioning, persistent psychotic and mood symptoms, and risk for disability and premature death) and how

translational research can address these needs. Then, three OPAL pilot awardees (Rolin; Stefancic; Bareis) will present their research, which addresses important areas of need including violence risk assessment, variation in medication prescribing, and physical health. Dr. Rolin will present a longitudinal pilot study which compared the clinical utility of different methods of violence risk assessment for young adults receiving treatment at coordinated specialty care clinics serving people with first-episode psychosis (FEP). In her project, she used a variety of tools to assess violence risk and then followed participants longitudinally for up to 12 months to track actual violent behavior. Next, Dr. Stefancic, will present a study that identified priority health needs of young adults experiencing FEP, described health services within FEP treatment, and synthesized research on effectiveness of health interventions for this population. Using a systematic literature review, secondary analysis, and stakeholder input, her findings inform further development of health promotion efforts within coordinated specialty care clinics. Both Drs. Rolin and Stefancic's pilot projects were supported by the Early Psychosis Intervention Network (EPINET) program and they will describe how this advanced their research careers. Last, Dr. Bareis will present a study detailing substantial variation in psychotropic prescribing practices for individuals with schizophrenia across states in a nationwide Medicaid sample. This variation in prescription of psychotropics for individuals with schizophrenia still exists in real-world settings and demonstrates disparities in treatment, despite decades of evidence-based treatment guidelines promoting equitable treatment. Participants will also learn about future career trajectories for these early-stage investigators. Attendees will be engaged after each presentation with Q&A, and at session close with a discussion on facilitating independent research for early investigators.

Eating Disorders: A Clinical Update

Presenters: Evelyn Attia, M.D., B. Timothy Walsh, M.D., Joanna E. Steinglass, M.D.
Moderator: Eric R. Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize restrictive eating disorders and make initial treatment plans; 2) understand recent developments in eating disorders treatment research including habit interruption, neuromodulation, and psychedelic agents.; and 3) know which medications are helpful for the treatment of binge eating episodes in bulimia nervosa and BED..

SUMMARY:

Eating disorders are serious psychiatric conditions associated with significant medical and psychiatric morbidity and high mortality rates. Eating disorders affect all ethnic and racial groups and have been identified in all parts of the world, although prevalence rates vary for different populations. The purpose of this Clinical Update is to review some of the current issues relevant to identifying and treating eating disorders. Drs. Joanna Steinglass and Evelyn Attia will discuss the restrictive eating disorders including Anorexia Nervosa, and Avoidant-Restrictive Food Intake Disorder (ARFID) as well as emerging data about the importance of recognizing Atypical Anorexia Nervosa, one of the conditions included in the Other Specified Feeding and Eating Disorders in DSM5. Dr. B. Timothy Walsh will discuss Bulimia Nervosa and Binge Eating Disorder (BED), focusing on pharmacotherapy that has demonstrated efficacy for these conditions. The Clinical Update is intended for practitioners who see individuals with eating disorders in their clinical practice and are interested in new issues, and advanced discussion of treatment strategies. Program format will include time for audience Q & A.

**Equity Through Better Diagnostic Reasoning:
Reducing Cognitive Biases in Clinical Practice**

Chair: Adam Lee Hunzeker, M.D.

Presenters: Mary Thomas, M.D., Veronica Wright, M.D., Jarred Hagan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize typical diagnostic processes and methods of clinical reasoning.; 2)

Recognize four common types of cognitive biases leading to diagnostic thought errors among psychiatrists.; 3) Summarize at least 2 techniques to reduce thought errors in psychiatric diagnostic evaluations.; 4) Using small groups, demonstrate techniques to teach diagnostic reasoning to your residents and fellow psychiatrists.; and 5) Using provided deliverables and lesson content, be able to implement the workshop in your didactics over a single session at your institution..

SUMMARY:

Psychiatry is a constantly evolving clinical science. As the body of knowledge grows, practitioners must constantly incorporate new information into their practice. This evolution is fraught with ambiguity manifesting itself in day to day clinical encounters. Without deliberate attention paid to the diagnostic process practitioners can inadvertently commit thought errors and invite cognitive bias. These preventable errors can lead to incorrect diagnosis, costly inappropriate interventions, and inadvertently harm our patients. While mistakes are inevitable, it is essential that psychiatrists hone our diagnostic skills to mitigate the effects of cognitive bias and cognitive error. It is necessary for a practitioner of medicine to focus inward and to analyze how we employ cognitive strategies, utilize heuristics, mitigate cognitive bias, and utilize fast versus slow thinking. Only by understanding how we diagnostically approach ambiguity can we begin to mitigate the effects of cognitive error. Data has shown that through education, providers can decrease diagnostic error and improve clinical outcomes. The objective of this workshop is twofold. first objective is to help learners become familiar with various cognitive strategy theories and learn to mitigate personal contributions of diagnostic error. Second goal is to assist teachers to create a concise approach to educating residents and fellow psychiatrists on these principles. Residency programs and daily practice are filled to capacity with educational requirements. Many curricula compete for the limited time available to residents and attendings. The goal of this workshop is to deliver this lesson in a single 90 minutes session. While not comprehensive, it will provide a foundation for continued self-learning and clinical growth. Participants will be provided teaching

content and other deliverables to easily incorporate this workshop into their residency's curriculum.

Exploring Limitations of Ethical Decision-Making Frameworks in Responding to Structural Inequity in the Mental Health Care Setting

Chair: Oyediji Ayonrinde, M.D., M.B.A.

Presenters: Elyse Platt, M.D., M.A., Oyediji Ayonrinde, M.D., M.B.A., Jeremy Butler, Ph.D., M.A., Shadé Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how the values of autonomy, beneficence, non-maleficence and justice are used in current ethical decision making frameworks in healthcare ethics.; 2) Appreciate ethical complexities in the mental-health care setting.; 3) Identify and appreciate issues of systemic racism and sexism within psychiatry.; 4) Identify some limitations in current ethical decision making frameworks to address issues of sexism and racism within mental health care.; and 5) Engage respectfully in small group conversations about an ethical approach to problems of sexism and racism in mental health..

SUMMARY:

Ethical frameworks are used in many healthcare organizations to support ethical deliberation and decision-making among clinicians, administrators, patients, and families. Ethical issues present frequently in mental-healthcare contexts because of the complex interactions between mental illness, decisional capacity, autonomy, justice-based considerations, and the social determinants of health. This presentation seeks to explore limitations of widely used ethical decision-making frameworks in addressing structural and/or systemic issues such as racism and sexism in the mental healthcare workplace. Using small-group, case-based discussion and application of some widely used ethical decision-making frameworks, we explore the idea that these traditional approaches to ethical deliberation in healthcare will not reliably provide useful guidance for responding to racist and sexist encounters experienced by clinicians and patients in the mental healthcare setting. We then consider

what an ethical framework which takes systemic racism and sexism into account might look like and what this could mean for individuals working in and receiving mental healthcare. We will look to insights from narrative ethics and virtue ethics, to explore possible avenues of improvement. We also discuss how a small conversation group of interdisciplinary colleagues working in mental health are trying to put some of these ideas into practice and the insights we have gathered from this experience.

From Rage to Recovery: Management of Violence Risk in the Patient With Borderline Personality Disorder

Chair: John S. Rozel, M.D.

Presenters: Vint R. Blackburn, M.D., Layla Soliman, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Evaluate risk for violence in people with borderline personality disorder; 2) Describe existing research on risks for violence in people with borderline personality disorder; and 3) Formulate appropriate clinical strategies to mitigate risk of violence in people with borderline personality disorder.

SUMMARY:

Often when psychiatrists discuss a patient with borderline personality disorder (BPD) the focus is on suicide risk, self-injury, and effective treatment engagement. Easily lost in the management of these complicates cases is the potential for violence risk – in fact, in one study by Harford and colleagues, people with borderline personality disorder or trait were both more likely to engage in violence towards others than only to engage in self-directed violence. Some of these violent acts can be severe and they often target people in some form of relationship with the patient including treatment providers. A series of recent studies has highlighted the importance of violence risk evaluation and management as an important part of treatment of borderline personality. Much of the canon of research on treatment of BPD is focused on outcomes aside from interpersonal violence. This presentation will provide a brief overview of the

research and will then feature case discussions involving experts and attendees exploring different aspects of violence risk evaluation and management in people with borderline personality. Management strategies for adversarial and contingent threats of violence and the perils of navigating power struggles will be explored. This workshop will begin with basic presentations about priorities for clinical management from the perspectives of inpatient, ambulatory, and forensic settings. Approximately half of the time will be devoted to audience and panel discussion of complex cases drawn from the experiences of the presenters. Cases will include a patient with persisting IPV and contingent suicidal threats if the partner leaves, a patient who becomes enmeshed with a therapist and stalks her, and a patient who makes provocative violent threats towards treatment providers to trigger an acute psychiatric admission. Presenters will include forensic and clinical psychiatrists with expertise in violence and personality disorder from a variety of settings. The emphasis will be on prepared case examples developed to highlight pertinent clinical teaching points but the presenters expect that this will be an engaging conversation with the audience and opportunities for the audience to present their own experiences will be integrated into the structure.

Holding Space for Gender Diversity: Tools for Psychiatrists in Everyday Practice

Presenter: Sarah C. Noble, D.O.

Moderator: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of the cultural and systemic influences on the mental health of transgender and gender nonconforming people (TGNC); 2) Employ the Gender Unicorn to discuss and understand gender and sexuality; and 3) Integrate new tools into clinical practice to support TGNC individuals.

SUMMARY:

A 2016 survey of transgender people found that 77% wanted to talk about their gender issues but only 55% had ever received therapy that addressed them.

This indicates a significant knowledge and/or comfort gap in the treating providers. This talk will provide concrete tools for general psychiatrists to feel they are competent care providers for trans and gender nonconforming patients. Didactics and case presentations will be used.

How Psychiatrists Can Talk With Patients and Their Families About Race and Racism: Theory and Practice Through Simulation

Chair: Micaela Owusu

Presenters: German E. Velez, M.D., Tresha Gibbs, M.D., Chevaughn Wellington, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand race and racism beyond the formal definitions and the inter-sections of the concepts that refer to race and discrimination; 2) Identify root factors that affect clinical interactions in mental health (barriers, communication, diagnosis and treatment); 3) Be able to use the toolkit "How Psychiatrists Can Talk with Patients and Their Families About Race and Racism"; and 4) Reflect on pre-recorded/live interactions: What racial/cultural tensions exist in this situation? What are some important considerations in this situation? What are the clinician's next steps?.

SUMMARY:

In recent years, there has been an increased acknowledgment of the longstanding inequities and injustices perpetuated by policies and structures rooted in racism. The field of medicine has contributed to these injustices, and disparities based on race have been detrimental to our patients and their communities. Persons of color often suffer from poor mental health outcomes due to misdiagnosis, lack of access to quality mental health care services, limited culturally competent mental health care, ineffective communication, and discrimination. For example, Black persons are less likely to be offered evidence-based medication therapy or psychotherapy and have lower rates of utilizing prescription medications and outpatient services, but higher rates for use of inpatient services. Additionally, implicit racial biases have been shown to play some role in mental health

assessment and intervention. These biases can negatively influence provider's willingness to engage in patient-centered care, provide referrals to specialized treatment, or adhere to evidence-based guidelines when serving diverse populations. With the increased awareness of the pervasive effects of racism and biases, Psychiatrists may feel ill-equipped to begin addressing these inpatient encounters. Clinicians are in a position to mitigate the impact of racism by becoming aware of their own implicit biases, providing space for patients to process personal experiences of racism/discrimination, and recognizing the impact of structural inequities on mental illness presentation and prognosis. While we will discuss definitions of concepts surrounding race and discrimination in our session, we plan to reach beyond definitions with practical applications of how to approach conversations about race and racism with patients and their families. During the session, we will review general principles for interacting with patients from various backgrounds, how to initiate a dialogue with patients about race/racism, tools for assessing experiences of racism and discrimination and discuss patient cases. There will be simulations of patient encounters, giving participants the opportunity to reflect on what racial/cultural tensions are present and to determine the next steps for the Psychiatrist to take in each scenario. This can help Psychiatrists learn to identify when race, ethnicity, or culture have an impact on patient experience and/or their perception of a patient and to utilize patient-centered methods to address these situations. We are at a critical point to transform the dynamic between patients and Psychiatrists, and this session is a concrete step towards cultural humility, improving therapeutic alliance, and ultimately better mental health care.

Identifying and Managing Virtual Fatigue in Psychiatric Residents and Faculty

Chair: Lauren Marie Pengrin, D.O.

Presenter: Joshua Benjamin Weasen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the signs of virtual fatigue in residents and faculty.; 2) Learn how to address and mitigate the fatigue of virtual learning in

our trainees and faculty.; and 3) Discuss strategies for building a curriculum with prevention of virtual fatigue in mind..

SUMMARY:

Many things have changed in a post-Covid world, including the way we educate psychiatric residents. As the public health crisis raged, many residency programs moved to a virtual or hybrid mode of didactic and clinical instruction. This change was abrupt and did not allow for much advanced planning in regard to user experience. After living with these new implementations for over a year, we now are able to identify a unique challenge of virtual learning - virtual fatigue. Virtual fatigue is a specific type of fatigue that is similar to burnout and is experienced as a result of spending more time in front of a screen and less time face to face with learners, faculty, and patients. Though virtual platforms may seem like a good substitute, there are some significant drawbacks. It is harder to decipher emotional content via video and so it takes more effort to engage in virtual didactics or in telehealth sessions. Learners and faculty must also contend with the limitations of our remote environment, including internet access reliability, privacy, and professional appearance of the workspace. Often learners and faculty are left feeling a diminished sense of fulfillment and enjoyment with virtual instruction as compared to in person experiences. This fatigue may also appear as avoidance of video calls, decreased engagement in virtual learning sessions, difficulty multitasking or staying focused, or as irritability and tension. We have encountered many reports of increased fatigue, decreased satisfaction with work, and feelings of isolation in our residents and faculty as a result of virtual learning, signaling that it is time to make some changes. In this session, we will discuss how to identify virtual fatigue in our learners and faculty, explore the impacts of remote learning on our trainees and faculty, and offer ideas on how to improve their experience by mitigating this fatigue through one on one intervention and through thoughtful curriculum design.

IYKYK (If You Know, You Know): Working With Generation Z in Colleges and Universities

Chair: Meera Menon, M.D.

Presenters: Amy Alexander, Anand Jayanti, M.D., Donna Tran

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) State the generational distinctions and characteristics of the current college population in comparisons to other past generations; 2) Explain the unique colloquialisms and idioms that characterize verbal and online communication with Gen Z; 3) Discuss how Gen Z uses social media, and how that impacts and is impacted by their mental health; 4) Examine feelings that members of Gen Z have about their relationships and understand the tools they use to engage with others; and 5) Select resources to help stay up to date with the rapidly changing environment of Gen Z issues and interests.

SUMMARY:

Current college mental health psychiatrists treat college students who are from a different generation than their own. Although college psychiatrists are likely from the Baby Boomer, Generation X, and Millennial generations, the current population of students entering colleges is from Generation Z. It is important for college psychiatrists to understand the defining characteristics, communication preferences, and unique considerations for working with emerging adults in Generation Z, as this population will continue to enter college over the next decade. Generation Z, which comprises those born between 1997 and 2012, numbers approximately 68 million in the United States. These newest members of the population have already made their mark on the culture, economics, and politics of our time, and bring with them a unique brand of worldliness, charity, and empathy. However, as the newest consumers in an ever-changing social landscape, they wrestle with entirely unique challenges than those of generations that came before. In treating patients of this cohort, we are empowered by an understanding of their milieu, both online and in academic or other social settings. This presentation surveys Gen Z communication, attitudes, social

habits, and tools and rules of engagement, as well as how we can stay up to date with changes as they come. Understanding the culture of Gen Z patients presents a tremendous opportunity for early intervention on a range of psychiatric issues which often present in early adulthood.

Lost in Translation: How Do We Get to There From Here?

Chair: Bradley Neil Gaynes, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Outline a public health depression care continuum model for management in primary care; 2) Review what the current evidence base for identifying and managing depression says about these different steps; and 3) Discuss how to translate, or apply, these findings to the care of patients in real world clinics.

SUMMARY:

This presentation, a lecture given as part of the American Psychiatric Association's 2022 Health Services Senior Scholar Research Award, addresses how to translate evidence-based medical findings to a population of real world clinics and patients through a public health framework.

Managing Behavioral and Psychological Symptoms of Dementia (BPSD) During COVID 19 Pandemic.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To discuss how COVID 19 has impacted the care of older adults with mental health disorders; 2) To describe how COVID19 has specifically affected the care of individuals with behavioral and psychological symptoms of dementia; 3) To describe the evidence based management of individuals with behavioral and psychological symptoms of dementia; and 4) To elaborate on the recent controversies in the treatment of individuals with behavioral and psychological symptoms of dementia.

SUMMARY:

The COVID19 pandemic has affected the life of all individuals on the planet. This has been especially true of older adults as COVID19 preferentially affects older adults. Older adults have the highest rates of morbidity and mortality rates from COVID19. There is emerging evidence that COVID19 has resulted in worsened outcomes among older adults with psychiatric disorders. This especially true for individuals with behavioral and psychological symptoms of dementia (BPSD). Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. In this symposium, I will first describe how COVID 19 has impacted the care of older adults with mental health disorders. Then I will describe how COVID19 has specifically affected the care of individuals with BPSD. This will be followed by a discussion on the evidence-based management of individuals with behavioral and psychological symptoms of dementia. I will conclude with a review on the recent controversies in the management of individuals with BPSD.

Measurement Based Care Education in Psychiatry Residency Programs: Challenges and Opportunities for Change

Chair: Karen Wang, M.D.

Presenters: Henry Nasrallah, David Freedman, Ahmed S. Aboraya, M.D., Daniel Elliot Elswick, M.D.

EDUCATIONAL OBJECTIVES:

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

measurement based care training in psychiatry residency programs; 2) Explore the process of designing an educational initiative on measurement based care for general psychiatry trainees; and 3) Discuss the challenges and barriers that exist in implementing Measurement Based Care for general psychiatry residency programs.

SUMMARY:

Laboratory tests are frequently used in general medicine as an objective measure of illness severity or improvement. In psychiatry, validated clinical rating scales are equivalent to lab tests to measure the baseline severity and treatment-related changes in psychopathology. Measurement based care (MBC) was introduced as a means of revolutionizing psychiatric care by addressing concerns around the effectiveness of care delivery. MBC is defined as the systematic administration of symptom rating scales to drive clinical decision making (Fortney et al., 2017) and allows for early identification of clinical deterioration, improved clinical accuracy, enhanced individualized treatment, improved patient symptom profile, and reduced time-to-response and remission of MDD (Guo et al., 2015; Fortney et al., 2017; Hatfield et al., 2010). However, current standard psychiatric care continues to depend on subjective clinical decisions rather than evidence-based approaches tied to measurable, validated outcomes (Zimmerman and McGlinchey, 2008). Despite this evidence supporting MBC, fewer than 20% of mental health practitioners use MBC in their practice and only 5% use MBC regularly (Gilbody et al., 2002). Thus, many psychiatric residents and supervisors are not familiar with how to utilize MBC in a systematic fashion. Previous reviews have shown that inadequate training and supervision coupled with poor technological infrastructure and workflow issues can impede successful implementation and limit the benefits of MBC for providers and patients (Arbuckle et al., 2013; Boyd et al., 2018; Lewis et al., 2019). There has been very limited research into how best to train future clinicians in this clinical approach. A recent survey of the literature identified few studies that examined how to implement MBC in general psychiatry training programs (Arbuckle et al. 2013; Collins, Mohiuddin, and Kerlek 2020). The lack of training in MBC among psychiatry postgraduate programs may explain in part the poor

uptake of MBC amongst general psychiatrists (Aboraya and Nasrallah, 2019). In this general session, we provide a comprehensive overview of measurement-based care in psychiatry residency programs. We start off the general session by reviewing the results of a scoping review on MBC educational programs for clinical trainees in mental healthcare. We discuss what evidence exists for MBC educational programs and how these programs can be delivered to trainees, using specific case examples. Also, we explore current gaps in the literature and contributors to positive educational and clinical outcomes for trainees. These results are particularly relevant to educators from diverse mental healthcare disciplines interested in preparing local MBC curricula. We then move into exploring the process and outcomes of developing MBC programs for two large urban psychiatry residency programs at the University of Toronto and also at the University of West Virginia.

Multi-Sector Partnerships to Meet the 988 Calling

Presenters: John J. Palmieri, M.D., Brian Matthew Hepburn, M.D., David W. Covington, L.P.C., M.B.A., Charles Smith, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the link between 988 and the National Suicide Prevention Lifeline; 2) Identify the guiding principles for crisis system transformation; 3) Identify both near- and long-term objectives for the Federal government in crisis system design; and 4) Identify the benefits and applications of a multi-sector partnership.

SUMMARY:

In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency, in partnership with the Federal Communications Commission and the Department of Veterans Affairs, working to make the promise of 988 a reality for America. Moving to a 3-digit dialing code is a once-in-a-lifetime opportunity to strengthen and expand the National Suicide Prevention Lifeline (the Lifeline). In

reality, 988 is more than just an easy-to-remember number – it's a direct connection to compassionate, accessible care and support for all Americans who might be experiencing suicidal thoughts, who are at risk of suicide, or who are struggling with emotional distress. Preparing for full 988 implementation and operational readiness requires a bold vision for a **crisis care system that provides direct, life-saving services to all in need**. SAMHSA sees 988 as a first step towards a transformed behavioral health crisis care system. An effective crisis system with 988 as its cornerstone will save lives and improve person-centered care by decreasing unnecessary law enforcement response, emergency department boarding and hospitalization. But the Federal government cannot do this alone. Success of 988 will rest heavily upon state and local leaders, along with key public and private sector partners, as we work in concert to meet the behavioral health crisis needs of people across our country. The session will review a number of specific examples of activities designed to build upon enthusiasm for crisis system redesign, with a particular focus on operational readiness, communications and ongoing implementation support. The panel will highlight how multi-sector partnerships can support: 1) Aligning vision and building momentum, 2) Assessing readiness for 988 implementation, 3) Ensuring system is designed from the perspective of the individual in crisis, 4) Identifying the messaging and design needs for individuals and populations at elevated risk of suicide, and 5) Providing ongoing technical assistance and learning opportunities.

Nonpharmacological Interventions for Individuals With Co-Occurring IDD and Mental Illness

Presenter: Allison E. Cowan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) describe non-pharmacologic interventions for autism spectrum disorder; 2) demonstrate non-pharmacologic treatments for individuals with neurocognitive disorders and IDD; 3) list interventions for people with IDD and common mental illnesses; and 4) participate in case discussions in small and large groups on the topic of IDD and mental illness.

SUMMARY:

The history of persons with mental illness and intellectual disability is profoundly intertwined. Both groups have been marginalized by society to varying degrees and many psychiatrists are not confident in providing care for this patient population. As society moves away from the institutionalization of patients with ID, psychiatrists are treating more patients with ID in the community setting. Due to limited training treating ID patients, many clinicians feel inadequately prepared to address the complexities in this patient population. Non-pharmacologic treatments are an underutilized resource. This presentation seeks to fill this knowledge gap. Treatment for co-occurring Autism Spectrum Disorder, IDD, and mental illness will be discussed as well as non-pharmacologic treatment for co-occurring neurocognitive disorders in individuals with IDD. Additionally, interventions other than medications for common mental illnesses will be described. This presentation seeks to increase confidence and knowledge in the treatment of people with co-occurring mental illness and IDD.

Pediatric Inpatient Psychotherapy Squad (PIPS) Initiative at a Community Hospital

Chair: Loraine Rosentsveyg, D.O.

Presenters: Caitlyn Pedone, D.O., Katie-Joy Zimmerman-Winslow, D.O., April Seay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the importance of having an in-hospital service that provides trauma-focused psychotherapy on the pediatric inpatient unit and Pediatric Psychiatric ER.; 2) Understand the steps necessary in implementing a new clinical service as an elective available for Psychiatry Residents.; 3) Identify resources necessary in Supporting children and adolescents in need of adjusting to difficult life-changing situations.; and 4) Incorporate expressive arts as part of a trauma-focused therapeutic modality for child and adolescent patients.

SUMMARY:

There has been a growing need for acute psychiatric intervention for children and adolescents hospitalized on a medical inpatient unit and/or coming to Psychiatric ER in New York City. The need for psychiatric care has grown immensely since the start of COVID-19, leaving patients isolated from social supports and coping with medical illness without proper therapeutic intervention.

Furthermore, pediatric patients in need of psychiatric inpatient hospitalization who are boarding in ERs are often left without adequate interim intervention prior to being transferred to a proper facility, delaying the necessary mental health care they require. In order to address the gap in mental health services for our child and adolescent population, we implemented a new resident-run hospital service: Pediatric Inpatient Psychotherapy Service (PIPS) with the goal of providing support to children and adolescents in need of adjusting to difficult life-changing situations, building resiliency and teaching valuable coping skills, as well as educating residents participating in this elective.

During this session, we will explain the process of how a resident-run clinical service was established in a community hospital and how it can be of use in other hospitals, urgent care centers, CPEPs, etc. We will share the steps that were taken to build a curriculum, recruit residents and supervisors, collaborating with other leadership departments and going through the necessary systematic steps. We will share case examples of pediatric patients who benefited from the service as well as show live media examples in the form of photos and videos of what the lecture series entailed. We will share resources (books, videos, images, music) that were used for patients in order to cope with illness, grief, bereavement. Short video clips from child life specialists and the resident learning process will be previewed. We will share expressive art therapy creations that patients made during the coping process that participants can implement in their practices. Participants will have the opportunity to break out in groups to think through the potential need for such a service, discuss personal accounts of how a service like this might be useful for their patients and what it would entail to start a service like PIPS. Another small group activity will teach the audience about expressive art therapy pieces that

patients can create in PIPS sessions to help them process the issues. Lastly, we will review some of the successes we have experienced being a part of the service.

Police Encounters and People With Mental Illness: Avoiding Tragedy and Improving Outcomes

Chair: Nils Rosenbaum, M.D.

Presenters: Benjamin Melendrez, Matthew Tinney, John Gonzales

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Give at least three specific reasons why police end up in potentially deadly encounters with people living with mental illnesses, including social determinants of health; 2) Describe three ways how to help a patient avoid a potentially dangerous interaction with police; 3) Described the three pillars of a strong Crisis Intervention Team Program; and 4) Describe how to promote a CIT program in your community.

SUMMARY:

Police encounter the most instantaneous and dangerous consequences of adverse social determinants of health. They're training and work are simultaneously a response to social determinants, and a social determinant in themselves. Police impact and reflect the health of their community. Depending on their training, demeanor and mindset, officers can make a disproportionate positive or negative impact on the lives of individuals in their community. Police encounters with people living with mental illness are potentially dangerous or even fatal for all those involved, even bystanders. Detective Ben Melendrez and Sergeant Matt Tinney from the Albuquerque Police Department (APD) will show lapel videos of dangerous encounters they have had with people living with mental illness. They will discuss what they did well and could have done better during those encounters, and will explain how these lessons learned are incorporated into department wide training. Dr Nils Rosenbaum and Lieutenant John Gonzalez will discuss the changes in the police culture over the course of the last 10 years, and how other communities can learn from the experience in

Albuquerque, NM. They will discuss how social determinants of health were taken into account during reforms made over these years, and their department's response, both good and bad. They will present internal data from police encounters with people living with mental illness, including police uses of force. Dr. Rosenbaum will explain his role as a psychiatrist employed full time by a police department. He will give a brief history of how he came to work with a police department and outline how any mental health professional can collaborate effectively with local law enforcement. The Detective, Sergeant, Lieutenant, and Dr. Rosenbaum will also talk about how to discuss police encounters with your patients and how to help them avoid encounters, or how to make them as safe as possible. The group will explain how their crisis intervention team (CIT) program functions and give an overview of their many collaborations with the local mental health system. They will discuss how to build collaborations and will highlight programs that anyone in the audience can join such as the free online training of the Crisis Intervention Team ECHO program. The CIT ECHO discusses police mental health cases each week and solicits feedback and guidance from a diverse group of psychiatrists, people with lived experience, and law enforcement all over the country. In addition to lecturing, there will be panel discussion, and plenty of time for Q and A. Throughout the talk, we will take straw polls of the audience using iClicker technology to gauge their understanding of police mental health interactions, as well as their opinions on these relationships.

Population Health in Psychiatry: Essential or Extraneous?

Chair: Mehul Mankad, M.D.

Presenters: Mehul Mankad, M.D., Jennie Byrne, M.D., Ph.D., Nora Marion Wilson Dennis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Differentiate Population Health approaches from the traditional Public Health model in understanding the divergent health needs of communities; 2) Describe the roles of psychiatrists in the overall structure of Population Health policies and programs; and 3) Apply specific Population

Health methods to achieve greater health outcomes in service to the quadruple aim of healthcare.

SUMMARY:

Healthcare spending in the United States approaches four trillion dollars annually and comprises 18% of the gross domestic product. However, health outcomes in the US lag behind other developed countries in nearly all measures with widespread racial and ethnic disparities in health outcomes. Evidence suggests that serious mental illness and intellectual/developmental disability are both drivers of healthcare cost and correlated with less favorable health outcomes. Fragmentation between physical and behavioral health services has adversely impacted health outcomes for those with mental illness and substance use disorders. Psychiatry, as a discipline, has numerous structural reasons for separation from the greater healthcare context, and this isolation carries tangible impact on overall morbidity and mortality. As examples, individuals with schizophrenia live 20-25 years shorter lifespans than people without the diagnosis and in the general population, unintentional overdoses have continued to rise almost yearly for the past decade. Applying modern population health approaches to psychiatry is an essential aspect of 21st century practice. The authors will begin by distinguishing traditional public health from population health, highlighting similarities and differences in approach. The presentation will proceed with an interactive assessment of population health knowledge of the session attendees. Based on the attendee knowledge base, the remainder of the session will be tailored to deliver the highest yield to participants. The subsequent component of the session will introduce risk stratification/predictive analytics, complex care management, value-based care and primary care-behavioral health integration. With regards to integration, authors will expand on this topic beyond collaborative care approaches for mild to moderately ill individuals and discuss integration for patients with SMI and IDD. In the next segment, authors will describe the Centers for Disease Control 6:18 initiative as a model population health strategy. Psychiatrists can and should play a central role in the ongoing evolution of population health, particularly as behavioral health disorders are increasingly understood as drivers of high cost and poor

outcomes among those with chronic conditions. Authors will explore strategies to facilitate psychiatrist involvement in population health and overcome obstacles such as privacy concerns, interoperability, and payer alignment. Finally, authors will discuss the patient-centered medical home model as it relates to population health. They will provide the attendees an opportunity to role play the experience of working in a data-informed, population-based team within a value-based environment. This component of the session will also incorporate social determinants of health to address equity in health outcomes. Attendees will apply elements learned earlier in the session to the dynamic context of the care of complex patients.

Practical Sleep Medicine for Psychiatrists

Presenters: Zhixing Yao, M.D., William Vaughn McCall, M.D., Richard Bogan
Moderator: Eric R. Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize sleep disorders and their bidirectional impact with mental health; 2) Understand common treatments (including pharmacologic and cognitive behavioral strategies) and parameters to judge efficacy; 3) Know when to refer to specialized sleep clinic and how to incorporate test results into psychiatric follow up care; and 4) Incorporate recommended treatment durations and effective taper off strategies.

SUMMARY:

Human sleep has redundant neurologic processes to ensure sleep/wake stability and satisfy sleep homeostasis. Inadequate sleep quantity, quality and continuity interfere with sleep homeostasis resulting in impairment of wake state to include symptoms of excessive sleepiness, fatigue, mood changes, cognitive impairment, impaired coping skills and altered pain threshold. Recognition of psychiatric disorders' effect on sleep as well as prescription therapeutic intervention and the interaction of sleep disorders on psychiatric disease manifestations and therapeutic response are important considerations in the management of psychiatric disorders. We will discuss a practical approach for how to incorporate

sleep medicine in psychiatric practice including a review of the evidence behind sleep interventions, when to refer to an outside specialist, and when/how to wrap up targeted sleep intervention.

Prescribing Together: Evidence-Based Ways to Build Therapeutic Alliances During Prescribing Encounters

Chairs: Abraham M. Nussbaum, M.D., Warren A. Kinghorn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Estimate the additive effect size of the therapeutic alliance in the care of persons with mental illness; 2) Define three components of an alliance which underlie evidence-based assessment measures; 3) Develop practical, evidence-based strategies for building alliances while prescribing for common mental illnesses; and 4) Strategize ways to move from the dispenser to the collaborator model in clinical practice.

SUMMARY:

Building a positive therapeutic alliance is vital for effective medication prescribing in psychiatry. A strong therapeutic alliance improves patients' willingness to take medications, accounts for up to 20% of the variance in antidepressant treatment outcomes, and improves the experience of patients and clinicians. This vital contributor to clinical outcomes is the core skill of mental health practitioners. However, it is often overlooked in psychopharmacology education. In this session we review the components of the prescribing alliance, the evidence base for the essential role of the alliance in medication prescribing, and actionable steps for building alliances in clinical practices and across health systems. We introduce a diverse range of clinicians and researchers who are advancing the therapeutic alliance. Through large group practice, we show psychiatrists how to move from a "dispenser model" of prescribing, in which the focus of the encounter is prescribing right medications for specific conditions and symptoms and the alliance is relatively neglected, to a "collaborator model," in which clinicians build strong alliances with patients that allow them to understand patients' experiences,

clarify goals, and prescribe medications that promote patients' capacity to act toward goals and to build strong relationships with others. Focusing on practical strategies that psychiatrists can immediately implement in daily practice, we then show how psychiatrists can implement the collaborator model when prescribing medications for three common mental disorders—schizophrenia, bipolar disorder, major depressive disorder, and post-traumatic stress disorder—while inviting clinicians and patients to prescribe together.

Psychiatric Approaches Involved in the Treatment of Traumatized Refugees

Chair: John David Kinzie, M.D.

Presenters: George Alan Keepers, M.D., James K. Boehnlein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List the various cultural and traumatic experiences which impact refugee psychiatric patients; 2) Describe the issues involved in the psychiatric treatment of refugees, including principles of psychotherapy of refugees, and the psychopharmacology for PTSD, depression; and 3) Discuss the major issues in treatment of refugees, including research needs, societal attitudes toward refugees, and future problems.

SUMMARY:

Because of wars, natural disasters, and political persecution, hundreds of thousands of people have been forced to leave their homeland to seek a better life. Refugees are persons outside of their country of origin, who are not able to return to their own countries due to persecution, political beliefs, memberships in certain groups, religious beliefs or ethnicity. A special group of refugees are asylum seekers who arrive in a country seeking safety and who then apply for protection. The legal process to finally gain asylum in the United States is complicated. In 2018, there were 38,000 people who were granted asylum in the United States. In the response to the Covid-19 pandemic, the CDC suspended the arrival of persons from Corona Virus impacted areas. Most asylum seekers, as well as high proportion of refugees, have had many severe

traumatic experiences. PTSD and depression are the most common psychiatric diagnoses and account, by far, for the majority of psychiatric diagnoses in refugees, with an 80% comorbidity between these two diagnoses. The traumas are unusually severe and have often occurred over a long period of time. When settled in the U.S., refugees have post migration problems of learning a new language, finding employment, and reestablishing social relationships. These refugees are often subject to discrimination and physical attacks in their new country. Effective psychiatric treatment of refugees must be a sensitive process. The refugee may enter the treatment with distrust or even suspicion of doctors. Clearly, the first goal of the refugees' treatment is for the psychiatrist to provide safety, which means forming an authentic relationship with a non-judgmental, accepting attitude. An important part of the treatment is the role of the interpreter(s). The goal is to have the psychiatrist and the counselor work together with the same ethnic group. The psychiatrist's role is to diagnose the disorders, provide explanation, give a prognosis, discuss treatment options, provide supportive, usually interpersonal, psychotherapy, and prescribe medicine. Psychotherapy, which requires subjective awareness or cognitive restructuring, seems difficult for refugees to understand and usually is ineffective. However, all refugees have visited doctors, and the refugees know that doctors ask personal questions and provide information. When the psychiatrist starts in the medical role, which is familiar to the patient, a good relationship is possible. With time, it is possible to explore interpersonal dynamics. Reexploring the patient's trauma, except in the original interview, is counterproductive because it can lead to re-experiencing. The usual focus in therapy is on post migration life stressors. The interview is low key, practical, safe for the patient. Medicine has been shown to provide important relief from symptoms, the most disturbing of which are usually insomnia and nightmares. There's a need for more peer-reviewed research.

Psychiatric Euthanasia and Expanding Assisted Dying Laws: Controversies and Challenges

Chair: Rebecca W. Brendel, M.D., J.D.

Presenters: Karandeep Sonu Gaiind, M.D., Mark Sinyor, M.D., Marie Nicolini, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the tension between 'overinclusion' and 'underinclusion' in the context of expanded assisted dying laws and psychiatric euthanasia, and the impact on vulnerable and marginalized populations; 2) Understand the scientific process normally followed when introducing interventions in medicine, and relevance of that process when considering expansion of assisted dying and psychiatric euthanasia; and 3) Appreciate the tension, in policy and practice, between psychiatric euthanasia and suicide prevention when considering wishes to die..

SUMMARY:

Physician Assisted Death (PAD) has been legalized or decriminalized in well over a dozen jurisdictions around the world, and assisted dying policies continue to evolve rapidly. Many jurisdictions are exploring whether to introduce assisted dying laws, or expand existing laws. There is wide variation between policies, including how policies address potential applications for assisted dying for mental illness. PAD for sole criterion mental illness is available in the Netherlands, Belgium, Luxembourg and Switzerland, and recent Canadian legislation will permit psychiatric euthanasia by 2023. This session will explore medicolegal, scientific, ethical and public policy issues related to PAD, focusing on the particular challenges posed with mental illnesses in the context of PAD. Dr. K. Sonu Gaiind, a University of Toronto professor and psychiatrist, a past president of the Canadian Psychiatric Association and panelist from the Council of Canadian Academies Expert Panel reviewing psychiatric euthanasia, will review the Canadian experience and significant recent policy developments. This session will also explore differences between groups who seek PAD for different reasons, and discuss potential impacts of expanding PAD laws on marginalized populations suffering from life distress. Dr. Mark Sinyor, a psychiatrist and mood disorders and suicidology expert at the University of Toronto, will review the approach, based on scientific inquiry and evidence,

typically taken in medicine for evaluating any novel proposed intervention, and discuss the implications of this process in the context of PAD expansion. The session will include exploring the nature of evidence necessary, including evidence currently lacking, to estimate the “number needed to harm” when evaluating the potential impact of psychiatric euthanasia. Dr. Marie Nicolini, psychiatrist and researcher at the KU Leuven Center for Biomedical Ethics and Law, and former postdoctoral fellow at NIH, will review the potential tensions, in policy and practice, between allowing psychiatric euthanasia while prohibiting suicide. The session will include a critical review of the ethical standards used in clinical practice for persons who wish to die, which in one situation may lead to access to PAD, and in another could lead to psychiatric hospitalization and suicide prevention efforts.

Psychopharmacological Challenges, Ethical Dilemmas and Concerns of Health Care Workers: Lessons in Geriatric Psychiatry During the COVID 19 Pandemic

Chair: Daniel Carl Dahl, M.D.

Presenters: Badr Ratnakaran, M.B.B.S., Laura Bevilacqua, M.D., Ph.D., Rachel Han

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the challenges faced in prescribing psychotropic medications in older adults during the COVID-19 pandemic.; 2) Review the potential side effects of psychotropic medications when prescribed in patients infected with COVID-19 virus.; 3) Provide an overview of likely ethical dilemmas and how to apply ethical principles to situations such as treatment priorities, isolation measures, and prioritizing experimental therapeutics and vaccin; 4) Discuss strategies to address the disproportionately higher COVID-19 cases and deaths in older adults and in Black and Hispanic patients in the United States.; and 5) Describe three approaches to supporting the acute psychosocial needs of health care workers during the pandemic..

SUMMARY:

The first part of the presentation discusses challenges prescribing psychotropics to older adults

during the COVID-19 Pandemic. Older adults belonged to a vulnerable population during the COVID-19 pandemic. They were vulnerable to severe illness from an infection by the COVID-19 virus. Steps taken to mitigate the spread of COVID-19 virus created disruptions in access to care and medications for older adults. Older adults were ill-prepared for the rapid acceleration of care via telehealth. Limitations in physical examination via telehealth can also be barriers in the assessment of older adults for prescribing medications. Due to multi-organ involvement in COVID-19 infection in older adults, caution is needed in prescribing psychotropic medications to prevent side effects and potential drug-drug interactions with medications used for COVID-19 infection from psychotropic medications. Medications used to treat the COVID-19 virus also have potential neuropsychiatric side effects that can pose further challenges in management of infected older adults. These challenges will be presented and time given to discuss. There are numerous ethical challenges for psychiatrists treating older adults during a pandemic. Early on, it became apparent that older adults were dying from COVID-19 at vastly disproportionate rates, with 80% of SARS-CoV-2-related deaths occurring among adults aged 65 and older. The greatest risk for disability and death occurred within the population over 85 years of age, particularly those residing in skilled nursing facilities. From the onset, it has been apparent that Black and Hispanic groups have been disproportionately affected. Treating patients under difficult circumstances gave rise to a significant burden of moral distress and moral injury among healthcare providers and others. In some parts of the world, healthcare professionals were forced to decide how to allocate scarce resources, such as ventilators and ICU beds, as demand grew exponentially. These challenges will be presented and time given for discussion. The third part of the presentation provides an overview of the acute and recovery phase efforts put in place to support the mental health and resilience of health care workers during the COVID-19 pandemic. Health care systems employed programming to provide for basic needs, ensure dissemination of accurate and timely information, increase a sense of safety, and address emotional well-being. Informed by responses to

prior community traumas, including the terrorist attacks of September 11, 2001, the Mount Sinai Health System founded the Center for Stress, Resilience and Personal Growth (CSRPG) to promote resilience and address mental health needs during and beyond the pandemic. CSRPG's multi-pronged approach included resilience workshops, a digital health platform, community engagement, and short-term mental health treatment. Lessons learned from these efforts are reviewed with an eye toward contributing to best practices for the ongoing pandemic and future emergencies differentially affecting health care workers. The lessons will be presented and time given for questions and discussion.

Public Health Resources for Mental Health During COVID-19

Chair: Elissa Meites, M.D., M.P.H.

Presenters: Debra Houry, M.D., M.P.H., Ahoua Kone, M.P.H., Amelia Burke-Garcia, Ph.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Briefly discuss COVID-19 epidemiology and prevention recommendations in the United States; 2) Understand impacts of the COVID-19 pandemic on mental health; 3) Identify resources for mental health support and positive coping mechanisms during COVID-19; and 4) Use best practices and measures to support public health workers during COVID-19.

SUMMARY:

The COVID-19 pandemic is a formidable global public health challenge. The Centers for Disease Control and Prevention (CDC) COVID-19 emergency response objectives include understanding COVID-19 epidemiology and social and mental health impacts of the pandemic, as well as sharing timely and accurate information. A key activity identified by CDC is measuring and improving mental health outcomes in the public health workforce and other frontline workforce populations. This panel will provide an overview of mental health impacts of the pandemic and share examples and resources to support mental health during the COVID-19 pandemic. Public health and other frontline workers

are under stress. In a convenience sample of 26,174 state, tribal, local, and territorial public health workers surveyed during March–April 2021, 53% reported symptoms of at least one mental health condition in the past 2 weeks. Data from the Household Pulse Survey indicated that the percentage of U.S. adults with symptoms of anxiety and depressive disorders increased nationwide during 2020, then decreased from December 2020–June 2021. Organizations can support worker health by addressing work practices that contribute to stress and trauma. Several CDC campaigns provide resources for understanding and addressing mental health. One example of an effective campaign is How Right Now (Qué Hacer Ahora), an evidence-based, culturally relevant communication campaign designed to promote and strengthen the emotional well-being and resiliency of populations adversely affected by the COVID-19 pandemic and beyond. Mental health resources are essential to strengthen resilience and emotional well-being.

Rabbit Holes, Red Pills, and Radicalization: Psychiatric Aspects of Extremism and Conspiracy Theorists

Chair: John S. Rozel, M.D.

Presenters: Christine Sarteschi, Joseph M. Pierre, M.D., Amy Barnhorst, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify social and personal factors increasing susceptibility to conspiracy beliefs; 2) Differentiate overvalued ideas from delusions; 3) Describe connections between extremism, conspiracy beliefs, and violence risk; 4) Evaluate treatment priorities in a patient involved in extremism or conspiracy beliefs; and 5) Explain the challenge of assessment of overvalued beliefs in patients with different cultural backgrounds.

SUMMARY:

If a patient came in to meet with a psychiatrist's office in 2011 and stated that they believed there was a government source communicating with them about conspiracy between Hollywood stars and past US presidents to traffic, sexually exploit, and cannibalize children around the world to gain

immortality, and that the military will take control of the government to overthrow the evildoers, that psychiatrist likely would have reasonable concerns about delusions or a major psychotic disorder. In 2021, polling indicated that approximately 15% of American adults believed in just this set of beliefs: the Q Anon Conspiracy Theory. Indeed, these beliefs were a motivating factor in the January 6, 2021 insurrection in the US Capitol. The evaluation and care of that hypothetical patient with their false belief system has now taken on new layers of complexity: detangling delusions from culture bound and overvalued beliefs, identifying opportunities for clinical intervention and engagement in a person who may have little interest in being in treatment, and considerations of the potential for risk of violence. Conspiracy theories and extremist ideologies are nothing new, nor is concern that both may be associated with increased risk of violence in adherents. Numerous social and cultural factors appear to have made such belief systems more common and such belief systems are often seen in people who plan or commit acts of violence. Clinical and forensic psychiatrists need to understand these phenomena and develop an evidence based, unbiased, and effective clinical approach to evaluation and treatment of people with overvalued beliefs including conspiracy theories and extremism. Effective clinical work across cultures is important and challenging; work with people with these belief systems – who are often engaged in broad social networks of people with similar beliefs – is a new iteration of the cross-cultural challenge. This presentation will feature mental health professionals with subject matter expertise in extremism, violence risk, and conspiracy theories. The session will open with a high-level overview of major schools of conspiracy theories and extremist ideologies as well as establish basic terminology. Subsequent speakers will explore the clinical assessment of belief systems and strategies for engaging with these patients, a discussion of correlations between these belief systems and violence, and strategies for acute assessment of risk. The presentation will close with extensive time for case discussion amongst the presenters and the audience. Attendees will leave with clinical strategies and tactics for the evaluation and treatment of patients who present with these belief systems.

Scaling-Up Comprehensive Mental Health Care Using Digital Tools Can Decrease Global Mental Health Disparities and Associated Social Determinants

Presenter: Milton Leonard Wainberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the burden of mental and substance use disorders.; 2) Demonstrate the global and local mental health treatment gap; 3) Define the research-to-practice gap and how science can help; 4) Demonstrate the scaling-up of comprehensive mental health using 100% task shifting/sharing.; and 5) Describe how digital screening, triage and treatment tools can help address both the mental health disparities and the social determinants driving the disparities..

SUMMARY:

Mounting evidence has shown the enormous impact of mental disorders on the global burden of disease. Considering the broad consequences of untreated mental illness on the individual and society, it is imperative that immediate efforts be made to expand mental health services and reduce the global treatment gap. At the same time, guidance of the implementation of specific mental health interventions by a strong evidence base is imperative to properly prioritize scarce resources in low-income and middle-income countries (LMICs), where 90% of the world's population resides and in low-resourced settings in the US, where mental health disparities among disenfranchised populations are vast. Several studies have assessed the efficacy of psychiatric evidence-based interventions (EBI) both in the US and in LMICs. Most of these studies address treatment of one or two disorders at a time through efficacy testing. Few test effectiveness or cost-effectiveness; fewer still address the lack of human resources by training community providers and testing strategies to deliver EBPs with fidelity. Further, these studies rarely address social determinants that drive the mental health disparities, and they seldom address sustainability by evaluating the mental health research-to-practice gap or leveraging human

resources not dependent on research funding. Meeting mental healthcare needs across the globe will require: (1) moving from single-disorder interventions to testing the sustainability of comprehensive approaches that address high burden mental disorders and the social determinants driving the burden, (2) leveraging novel technology to support the implementation and supervision of these practices and (3) employing implementation science methods to integrate EBPs into routine practice. This presentation will describe the global burden of mental and substance use disorders; demonstrate the global and US treatment gaps; define the research-to-practice gap and how implementation science can help address the gaps; demonstrate the scaling-up of comprehensive mental health using 100% task shifting/sharing; and describe how digital screening, triage and treatment tools can help address both the mental health disparities and the social determinants driving the disparities.

Sexts, Lies and Videogames: Adolescent Boys, the Internet and Mental Health

Chair: Kristopher Kaliebe, M.D.

Presenters: Paul Weigle, Meredith Gansner, Elizabeth Englander

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand motivations and experiences that youth who identify as male experience with sexting, and data that suggest effective educational approaches.; 2) Describe contemporary trends in video game play among adolescent males, and the mental health risks and benefits associated with specific habits and experiences.; 3) Describe how adolescent male's online experiences can foment hostile speech and violent behavior.; and 4) Understand digital phenotyping and other potential technological mental health applications that might enhance mental health treatment of male adolescents..

SUMMARY:

Male adolescents face distinct challenges due to biological, environmental and cultural factors. Males display more completed suicide, school discipline,

academic disengagement, sexual aggression and higher propensity for anger and violence. These four presentations will highlight differences in regard to technology use and screen media habits that may affect health and mental health. A powerful determinant of today's childhood social determinants of health are technologies such as video games, social media and smart phones. These tools create complex reciprocal interactions individuals, technological devices and online communities. Scientific literature reveals the extent, characteristics, and effects of videogame play on the mental health of adolescents. Gaming often displaces both healthy and unhealthy behaviors. Persistent engagement in excessive play despite negative consequences are symptomatic of a behavioral addiction, associated with deficits in functioning, and subsequent social anxiety, depression, insomnia, and academic failure. Certain psychiatric conditions predispose youth to engage in unhealthy VG play, a factor mediated by effective parenting and amenable to treatment. "Sexting," or sending nude pictures of oneself to peers, is a phenomenon that has been largely defined by sensational media stories. Research has caught up. This presentation will review new data on sexting behaviors as they particularly pertain to male youth. In 2020 and 2021, 1,437 youth aged 18 and 19 were studied at the Massachusetts Aggression Reduction Center. Male, female, and gender non-conforming youth were compared on details about their sexting behaviors. Males were found to be less receptive to some educational tactics to reduce sexting and less fearful about negative outcomes. They sent different kinds of pictures. They experienced peer pressure and the association between sexting and sexual relationships differently. Adolescent males have higher rates of school discipline problems, incarceration and aggressive speech and behavior. They also may join gangs and extremist groups. Criminal behavior and community violence is predominantly committed by males, and frequently emerges during teenage years. Online activities are a medium for social conflict, can co-mingle with expressions of anger and hate. These are profound problems for these adolescents and for society. Digital phenotyping and other mental health apps are emerging technologies which can help us identify individual characteristics, manage risk and guide

appropriate interventions. Digital phenotyping and mental health apps have the potential to augment existing data collection methods by incorporating valuable behavioral markers and providing more ecologically valid data. Mental health apps and digital phenotyping show promise in identifying social determinants of health and dissimilarities therein with regards to the different genders.

Spiritual, Self-Transcendent and “Anomalous” Experiences: Evidence and Implications for Clinical Practice and for the Understanding of Mind

Chair: Alexander Moreira-Almeida, M.D., Ph.D.

Presenters: Claude Robert Cloninger, M.D., Ph.D., Alexander Moreira-Almeida, M.D., Ph.D., Charles Bruce Greyson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess a person's past history of experiencing self-transcendence in their daily life.; 2) Recognize that self-transcendent experiences promote the maturation and integration of a person's character and self-awareness.; 3) Describe best practices for clinical care of people with near-death, trance, psychotic-like and other non-pathological anomalous experiences; and 4) Discuss implications of near-death, trance and self-transcended experiences for the mind-brain relationship.

SUMMARY:

A growing and robust body of research has showed that self-transcendent, spiritual, and “anomalous” experiences remain very prevalent in the general population, are usually related to better mental health and have marked implications for the understanding of the mind. Research with standardized assessments show that most adults (59 to 74%) report self-transcendent experiences at least occasionally in their life. These experiences, including oceanic feelings (boundlessness, ecstatic union) and/or inseparability (non-duality, non-locality), have been called peak experiences in psychology. However, modern genetic, biological, and ecological research emphasizes that people are always an inseparable aspect of the web of life. Treatment studies show people can cultivate

experiences to help them grow in self-transcendence for greater physical, mental, social, and spiritual well-being. Training in mindfulness and contemplation promote the development of Self-transcendence as measured reliably by the Temperament and Character Inventory, which is a heritable trait related to the human capacities for self-awareness, creativity, prosocial behavior and healthy longevity. Near-death experiences (NDEs) are profound experiences with spiritual or mystical properties that often occur during a close brush with death. These very brief subjective experiences often lead to dramatic and long-lasting changes in attitudes, beliefs, values, and behavior, which sometimes are challenging for the experiencers and for their significant others. NDEs also raise questions about our current understanding of the relationship between the physical brain and the mind. In addition, other spiritual experiences often involve trance and psychotic-like phenomena (e.g., hearing voices and thought insertion), frequently creating difficulties in differentiating between a non-pathological Spiritual or “anomalous” experience and a mental disorder. It brings risks in both extremes: to pathologize normal experiences (promoting iatrogenic suffering) or neglecting pathological symptoms (delaying proper treatment). In order to mitigate these risks, we will gather the best current scientific evidence and propose clinical guidelines that have proven helpful in working with NDE and other spiritual and “anomalous” experiences, as well as their implications for our understanding of the mind-brain relationship.

Technique in Action: Utilizing Established Models to Navigate Racial Violence in Mental Health Settings

Chair: David Roberto De Vela Nagarkatti-Gude, M.D., Ph.D.

Presenter: Paul L. Maitland-Mckinley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define three levels of racism and manifestations of racial violence in the workplace.; 2) Describe the impact of racism on the mental wellbeing of healthcare providers and patients.; and 3) Employ strategies to respond to

incidents of racism in mental health treatment settings both in the witness and victim roles..

SUMMARY:

In recent years many factors have significantly elevated national and global awareness of the role that race continues to play in inequities of opportunity, access, and basic physical safety. While this new awareness may also extend to the individual, internal awareness alone does not create external change in the world. Bias is an essential element of the human condition. We are all vulnerable to biases, and we each carry a responsibility to navigate interactions in a way that encourages mutual respect. It is therefore essential that we as clinicians recognize that with each patient encounter comes opportunities and responsibilities to create equity. This session is about the meaningful practice of frameworks developed to help mitigate racial violence in clinical practice. Together we will create a shared language, establishing a foundation for collaborative discussion about racial discrimination within the field of psychiatry. Following the development of a shared perspective, we will consider various case examples involving patients and providers as both victims and witnesses of racial discrimination. After considering how related mechanisms (eg. implicit bias, ethics, institutional limitations, interpersonal tensions) interact to promote inequity, we will review informed approaches based off said models with the audience and then empower participants to use them to work towards positive change on both the group and individual levels.

That Doesn't Belong There! Intentional Self-Injury by Foreign Body Ingestion and Insertion

Chair: Lujain Alhajji, M.D.

Presenters: Vanessa Padilla, Mousa Botros, M.D., Mitchell Rovner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize characteristics, common presentations, physical and mental health consequences of deliberate foreign body ingestion and insertion.; 2) Identify challenges in addressing the complex mental health, psychosocial, medical,

and emergency needs of individuals presenting with foreign body ingestion and insertion.; and 3) Improve collaboration efforts across different specialities in providing non-judgemental, patient-centered care to patients with deliberate foreign body ingestion and insertion..

SUMMARY:

Intentional self-harm with foreign body insertion and ingestion are not uncommon presentations of self-harm behaviors. Individuals who engage in such behavior may present with underlying mental health issues such as obsessive-compulsive disorder, acute psychosis, or borderline personality disorder. Others may engage in these self-harming behaviors for secondary gain. Treating this population can be challenging as cases are typically complex owing to both psychiatric and physical complications, with some cases requiring surgical interventions. Psychiatrists may be called upon to assist in issues that may arise from these cases such as ethical and legal issues, staff and medical teams countertransference and frustrations, long-term physical disability and frequent hospitalizations, environmental safety issues, and countertransference. Diligent assessment of risk of self-harm via foreign-body ingestion or insertion, and close monitoring should continue to be conducted for all patients at risk, including environmental assessment of commonly used objects such as coins, utensils, pens, sharp objects, and batteries. Maintenance of safety, setting an individualized clinical plan, and proactive multidisciplinary collaboration are vital in the management of acute presentations and long-term follow up in these individuals. Our session will introduce participants to the deliberate foreign body ingestion and insertion, and showcase examples through clinical cases. We will provide information regarding common mental health themes related to this issue, as well as challenges that could impact both patients and healthcare providers. We will discuss a multidisciplinary care approach to managing individuals with deliberate foreign body ingestion and insertion, highlighting the role of mental health providers.

The Art of Psychopharmacology Circa 2021

Chair: Nassir Ghaemi, M.D.

Presenters: Ira Glick, Charles DeBattista, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the limitations of the med check concept; 2) appreciate the importance of the therapeutic relationship in psychopharmacology; 3) identify key factors related to medication non-adherence; 4) explain the method of existential psychotherapy as applied to medication management; and 5) have a structure for a complete psychopharmacology visit.

SUMMARY:

The practice of psychiatry has become, for better or worse, psychopharmacology. Physicians who specialize in psychiatry mostly prescribe drugs; most psychotherapies now are provided by non-physicians. Psychiatric practice now consists of the “med check”, a term with pejorative connotations: This drug-for-symptom practice has been criticized as both easy and ineffective. In fact, psychiatric diseases are complex conditions, difficult to identify at times, harder to treat, especially in the long-term, where they are chronic or recurrent. The “med check”, practiced superficially, is indeed harmful, as its pejorative connotations imply. But the practice of psychopharmacology, in a manner that is both scientific and humanistic, is much more complicated – and necessary. In this symposium, we will explore the art of practicing psychopharmacology in a manner that is both scientific and humanistic.

The Importance of Cultural Psychiatry With Children, Adolescents, and Families

Chair: Ranna Parekh, M.D., M.P.H.

Presenters: Maria Jose Lisotto, M.D., Rustin Dakota Carter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the sociocultural factors affecting the mental health of youth and their families; 2) Utilize the DSM 5 Outline for Cultural Formulation and the Cultural Formulation Interview in providing the most appropriate

assessments; 3) Recognize the role of social determinants of mental health in the evaluation and treatment of diverse populations; 4) Advocate confidently for patients and families from diverse and especially minoritized backgrounds; and 5) Integrate cultural competency into clinical best practice.

SUMMARY:

The presenters, who are also co-editors of the recent APA textbook, *Cultural Psychiatry With Children, Adolescents and Families*, will share the clinical urgency and impetus for this volume. The presenters will review how rapidly changing demographics in the US have lead child and adolescent mental health to be synonymous with cultural psychiatry. They will demonstrate how to best utilize the textbook and leverage it for everyday use, teaching and advocacy. Throughout the presentation, discussants will cite evidence based material and current literature on cultural psychiatry focused on children and adolescents to highlight each of the sections including special racial/ethnic minority populations and immigrants, refugees and rural populations. Presenters will discuss the chapters and literature related to intersectionality; specifically, gender identity, sexuality, spirituality, the impact of family values and culture will be detailed and case examples and clinical pearls examined. The role of adverse childhood experiences in child mental health assessments coupled with highlights from the chapters on social determinants of mental health and microaggressions will be presented; additionally, the disproportionate mental health impact on minority and underserved children and families will be examined through cases. The presentation concludes with the practical use of the DSM 5 Outline for Cultural Formulation and Cultural Formulation Interview. The remaining fifteen minutes will include a question and answer period.

The Path Forward for Women Leaders in Psychiatry

Chair: Altha J. Stewart, M.D.

Presenters: Jacqueline M. Feldman, M.D., Helena B. Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the literature regarding the history of women in medical leadership roles to identify gender based challenges and strengths; 2) Recognize some of the critical issues that have impacted women achieving positions of leadership in psychiatry; and 3) Identify effective strategies for developing personal and professional support networks for women in medicine that reduce burnout and promote advancement in their fields.

SUMMARY:

The question of why there are so few women in leadership in psychiatry is a longstanding concern which still defies an answer. From Carol Nadelson's election as the first woman president of APA in 1984 to the election of Altha Stewart as the first Black and 12th woman president of APA in 2017, the challenges of women in leadership has been a reminder of the fact that there are continued barriers facing those interested in being leaders in their chosen field. In writing of her experiences for the introductory chapter of the book, *Women in Psychiatry* (2012), Dr. Nadelson said: "...attributes that are valued in men, assertiveness, ambition, and tenacity, are viewed as negative for women in leadership". It is because of sentiments such as this which confront women today, that over a decade later we see that the proportion of women in leadership, whether in academia or organized psychiatry, has not kept pace with the increased number of women entering the field and still lags behind that of male counterparts. The structural barriers in academia – more clinical and teaching hours, fewer publications in peer-reviewed journals, and different professional activity and practice patterns - still prevent them from achieving leadership and can no longer be tolerated. We need intentional actions, not further research, to increase the number of women in leadership roles in academic psychiatry. The panelists will describe some of the history and prior work done in this area. They share strategies proven effective in making changes, including mentoring and creation of policies for transparent and accountable systems in academic institutions. They will also discuss their own career trajectories to leadership roles in psychiatry and recommendations for trainee and

early career psychiatrists who aspire to leadership roles in psychiatry.

Time for Psychiatrists to Stop Waffling About Psychiatry: Advocacy in the 21st Century

Chair: Daniel B. Morehead, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Contrast common perceptions of psychiatric illness and care with scientific research.; 2) Understand the difference between psychiatric nosology and psychiatric illness.; 3) Empathize with historical sensitivities of patients and families with mental illness.; 4) Respond to common criticisms of psychiatry.; and 5) Clearly and concisely articulate ways that psychiatric illness is common, serious, and treatable..

SUMMARY:

Public discussion of psychiatry lags far behind relevant scientific information. Public intellectuals, as well as many psychiatrists, describe psychiatry as biologically reductive, routinely corrupt, medically insubstantial, and clinically ineffective. These characterizations are demonstrably false. The results of such misconceptions have been catastrophic, and contribute to stigma, avoidance of mental health care, long delays in seeking care, and treatment non-adherence. In addition, such ideas have bolstered the denial and restriction of care by public and private funders, along with the scandalous under-treatment of severe mental illnesses. In this session, we will examine common and implicit assumptions about psychiatric care in public discussions, contrasting these to relevant science. We will develop a clear and concise articulation of mental illnesses as common, medically real, medically serious, and treatable. We will go on to discuss ways of empathizing with the special sensitivities of patients and families regarding psychiatrists and psychiatric illness, in addition to ways of building understanding while avoiding unproductive and polarizing debate. The perspective throughout will emphasize a "both/and" integration between biological and social understandings, patient and professional perspectives, and psychobiological and psychosocial interventions, in the interest of ending

"us versus them" debates which have marred past efforts to build professional and public consensus. We will discuss advocacy in its broadest possible sense, including private, clinical, and public settings.

Vaccination Dissuasion: Medical Mistrust, the Anti-Vaccination Movement, and the Role of Psychiatrists

Chair: Greg Sullivan, M.D.

Presenters: Adam Fusick, Megan Spelman, Steven Gunther

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the longstanding mistrust between the medical community and society regarding vaccines as well as how historical arguments against vaccines mirror contemporary responses.; 2) Outline the historical underpinnings of the Anti-Vaxx movement and consider how both laypeople and professionals may interpret evidence differently.; 3) Correlate general themes of traditional American identity and how these may foster distrust of the political field and, by extension, vaccination.; and 4) Demonstrate the skills necessary to approach education and advocacy in a manner which is effective, durable, and accurate..

SUMMARY:

A vaccine can only be truly effective at eradicating an illness if it is publicly accepted. Anti-vaccination movements and resistances to vaccinations have endured as long as vaccines themselves have existed, and overcoming vaccination resistance and hesitancy remains a challenge faced by physicians. The root causes of vaccine refusal must be appreciated and addressed. **Introduction:** Dr Greg Sullivan will moderate this session, introduce the speakers, and outline the goals of our talk. Special consideration will be given by all speakers to remain apolitical and nonpartisan. The role of any physician during a viral pandemic is to help eradicate the disease, and vaccines are one of many strategies being utilized against COVID-19. This critical analysis is intended to provide both a historical understanding and contemporary context for vaccine rejection as well as provide insight into the contribution of psychiatrists to effective dialogue

surrounding this topic. **History of Vaccinations:** Dr Adam Fusick will provide the historical context of the Anti-Vaxx movement, beginning with its origins that predate the first vaccine, leading up to the current vaccination hesitancy seen during the COVID-19 Pandemic . Several historical moments will be discussed including how logical fallacies in both laypublic and professionals may result in an inaccurate perception of the evidence. Specifically, parallel historical arguments to today's Anti-Vaxx movements will be highlighted. **COVID-19 Vaccine:** Dr Steven Gunther will review data of the current COVID-19 pandemic, with a focus on the currently available vaccines as they compare to historical vaccines. Highlighted will be: precedents of mRNA vaccines, how the development approval process was expedited, and how this shift from the standard expected course of development may have led to vaccination hesitancy and provided additional fuel for the Anti-Vaxx movement. **Issues America Faces:** Dr Greg Sullivan will explore themes of the traditional American identity, including political antiestablishmentarianism, autonomous thought, and exceptionalism. Within this framework, characteristics of the available vaccines and presumptions of medical conspiracy will be examined, in order to pose hypotheses as to why these overlapping elements may have compounded distrust of the broader medical field and primed healthcare for politicization. The role of social media and tailored information delivery will also be examined briefly, with a focus on availability heuristics in decision-making. **Psychiatrists' Role:** Dr Megan Spelman will explain how psychiatrists may be uniquely equipped in bridging the gap between pro- and anti-vaccine arguments by using clinical tools that can be broadened and applied to those who are diametrically and politically opposed to vaccinations. After all, history has shown that citing empirical research alone is rarely effective in combating misinformation.

Wabanaki Indigenous Approaches to Fostering Recovery and Resilience From Substance Abuse and Mental Comorbidities

Chair: Lewis Eugene Mehl-Madrona, M.D.

Presenters: Barbara Mainguy, L.C.S.W., M.A., Lisa Sockabasin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will list three elements of Wabanaki culture that can be incorporated into addictions treatment; 2) Participants will describe three ways in which addiction counseling can be modified to better serve indigenous people.; 3) Participants will describe the relationship between epigenetics and intergenerational trauma.; 4) Participants will describe the relationship between historical trauma and addictions in indigenous North American communities.; and 5) Participants will describe the role of spirituality in addictions treatment for indigenous people in North America..

SUMMARY:

Introduction: Addictions and mental health problems are prominent among indigenous people in North America in relation to historical and contemporary trauma. This trauma includes residential schools, removal of children, denial of access to employment and other resources, and more. **Objectives:** We describe the approach emerging in our services for the five indigenous tribes of Maine (the Wabanaki Confederacy) for culturally sensitive treatment of opiate use disorder and co-occurring mental disorders. We show that an approach that includes culture and emphasizes relationships is more effective than conventional approaches for indigenous people. **Methods:** We introduce or re-introduce participants to cultural beliefs, values, and methods for treating addictions, inclusive of narrative methods (storytelling) which receive greater acceptance by indigenous and marginalized peoples than cognitive approaches. Indigenous philosophy states that we see the world using the stories that we have absorbed or constructed to explain our perceptions. Using substances is a story that is connected to poverty and adverse childhood events. We create new stories to develop a sense of agency, the sense that one's actions can make a difference in one's life. Mental disorders are linked to trauma, historical and contemporary, especially within concepts similar to

the power-threat-meaning framework. We use qualitative methodology (constructivist grounded theory) to explore participants' responses to the treatment approach and compare results after the implementation of this approach to results beforehand. **Results:** We present the lessons learned and the results of our using this approach with a tribal population in Maine. Some key concepts include (1) reframing the person's self-story about being addicted and/or suffering emotional distress within a threat-power-meaning network in which we explore how people managed inescapable trauma, (2) working with stories about the spirit of the addiction and the consequences of ingesting spirit-laden substances without knowing their songs and protocols, (3) constructing future-self-narratives that explore right relationships and meaningful conduct, (4) constructing stories about the intergenerational transmission of addictions and exploring the question of "whom will be the recipient of your addiction?", and (5) relating contemporary emotional distress to past, historical, and contemporary trauma. We present summary and qualitative data from our recovery house and our crisis intervention work with the indigenous people of Maine. Outcomes are substantially better after the incorporation of culture into treatment. **Conclusions:** We come to understand that the client sets their goals and defines what recovery means for them, which is the heart of a harm reduction approach. Culturally relevant approaches are more effective than conventional approaches for indigenous people, especially those of Maine.

What Happened to My "Bread and Butter?" When the Consultation-Liaison Psychiatrist Becomes an Inpatient Psychiatrist for Covid-19 Positive Patients

Chair: Megan White Zappitelli, M.D.

Presenters: Matthew T. Edwards, M.D., Sara Chandler Infield, M.D., Sunny Patel, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the Challenges of providing treatment for COVID-19 positive patients who need inpatient psychiatric treatment and are quarantined within a medical hospital; 2) Outline the creation of an inpatient "annex" philosophy for

providing treatment for COVID-19 positive patients who need inpatient psychiatric treatment and are quarantined within a medical hospital; 3) Identify solutions for the challenges of providing treatment for COVID-19 positive patients who need inpatient psychiatric treatment and are quarantined within a medical hospital; 4) Discuss the ethics of involuntary inpatient psychiatric treatment regards to the provision of care for patients with COVID-19; and 5) Discuss the disparities in the treatment options for patients who are COVID-19 positive and of a low socioeconomic status and need inpatient psychiatric treatment during quarantine.

SUMMARY:

The practice of psychiatry has been re-invented many times to accommodate for the changes seen during the COVID-19 global pandemic, particularly for consultation-liaison psychiatrists. Specifically, now that most inpatient psychiatric hospitals require COVID-19 testing, patients who need an inpatient psychiatric level of care are faced with prolonged medical hospitalization while they are in quarantine prior to transfer for inpatient psychiatric treatment. Patients are often referred involuntarily for treatment, and the prolonged wait during this time poses significant burden on patients and psychiatrists alike. Our child psychiatry consultation-liaison service has seen a significant rise in the number of patients who present with a psychiatric emergency and are referred from the emergency department for inpatient psychiatric treatment. They are tested for COVID-19, found to be positive, and then admitted to the children's hospital for a 10-day quarantine before they would be considered for admission to an inpatient psychiatric treatment program. Many times, the patients are on an involuntary psychiatric hold, and the extended wait time between the disposition recommendation and transfer causes new clinical and ethical dilemmas that have changed the "bread and butter," of consultation-liaison psychiatry. For example, consider a patient admitted with suicidal ideation on day one who no longer has suicidal ideation on day five of quarantine but continues to have severe depression symptoms. If such patients no longer suicidal, they may no longer meet criteria for involuntary commitment. In this case, it may not be ethical to continue the involuntary psychiatric hold

process and to continue their involuntary admission. Alternatively, it may also be unethical to discharge them home, thus providing them with a lesser intensive treatment than would otherwise have been provided to them if they were not positive for COVID-19. During this presentation, this and several other clinical scenarios will be presented to illustrate the challenges faced by patients who are positive for COVID-19 and who need inpatient psychiatric treatment. Additionally, our team will outline several strategies that we have implemented throughout this time in effort to best emulate inpatient psychiatric care within the medical hospital setting. Next, we will discuss the disparities in treatment that we have observed throughout this time for patients with COVID-19 as well as patients with COVID-19 who are of a lower socioeconomic status. Finally, participants will have break out groups, using a "pair and share," model to brainstorm their own challenges and potential solutions within their home systems of care. The breakout groups will report back to share their plans for change and to invite further large group discussion. The session will conclude with a wrap up and question and answer session.

What Is a Public Health Approach to the Social Determinants of Mental Health?

Chair: Kenneth Stewart Thompson, M.D.

Presenters: Michael T. Compton, M.D., M.P.H., Sanya A. Virani, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of prevention and mental health promotion in psychiatry; 2) Understand public health programs and policies that address the social determinants of mental health; and 3) Appreciate the role psychiatrists can have in improving the health of the nation and eliminating inequities in health and mental health.

SUMMARY:

This session, organized by the Public Health Workgroup of the Presidential Task Force on Social Determinants of Mental Health, will outline the elements of a path to a reinvigorated "public health psychiatry". A tiny proportion of mental health

funding is dedicated to public health research and interventions even in countries that hold mental health important for their overall public health outcomes. Nonetheless the concept of prevention in psychiatry is acquiring traction. For example, the indicated prevention of psychosis that originated in Australia twenty-five years ago is being implemented across Western Europe, North America, and East Asia with impacts on international clinical guidelines and diagnostic manuals. Indicated prevention for bipolar disorder started becoming a concept only 15 years ago and there are leads for many other disorders.” There has also been progress in mental health promotion with gains in understanding resilience and enhancing well being at the individual, family and community levels. Place-based initiatives and the Health in All Policy approaches are demonstrating utility in addressing the social determinants of health and mental health and the inequities that they cause. It is possible to protect and promote the mental health and well being of all people. Dr. Compton will give an overview of the field of public health and will compare/contrast it to the field of medicine and the healthcare system. He will describe three ways of approaching and understanding prevention (primary, secondary, and tertiary prevention; universal, selective, and indicated preventive interventions; and the social determinants of health approach), including how they overlap and how equity must be considered. He will give examples of prevention across these various approaches, in both the field of general medicine and in psychiatry. Dr. Virani will present an specific example to bring out the most preventable aspects of the social determinants of mental health, explain how they are interwoven and what their downstream collective implications are. This will be followed by an amalgam of various clinical scenarios highlighting areas of need in the context of the current political climate. Emphasis will be laid on how war, violence, displacement, and immigration affect global mental health, and comparisons will be made between the US and other countries with regard to prevention frameworks and established policies. Dr. Thompson will propose next steps for the APA, describing programs and policies based on the core principles of public health that are needed to help American psychiatry meet the challenges of mental health inequity caused by the social

determinants of mental health. He will describe similar efforts underway in the UK and Canada and provide thoughts about how the APA might take a leadership position in prevention and mental health promotion in a world in which other countries already have a head start.

When Pain Is Not Just in the Brain: A Biopsychosocialcultural Approach to Chronic Pain and Comorbid Psychiatric Illness

Chair: Shannon Ford, M.D.

Presenters: Chelsea R. Younghans, M.D., Adam Bumgardner, M.D., Meghan Quinn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the underlying pathophysiology where pain and psychiatric disorders intersect.; 2) Demonstrate an understanding and utilization of the biopsychosocialcultural formulation to understand functionality and impact of disease on a patient.; 3) Apply the biopsychosocialcultural formulation to a medically complicated patient case.; and 4) Understand at least 3 psychopharmacologic and non-pharmacologic treatment options to help address their patient’s pain and mental health diagnosis..

SUMMARY:

When our patients sit down in front of us, they bring a story associated with each ache and pain. Sometimes these injuries are visible--we see the calluses and swollen joints from years of manual labor, and sometimes they are not. There is little question that every aspect of a person’s life plays a role in their health. This could be the genetics they were born with, their position in society, the religion they practice, or the defense mechanisms they use to deal with stress. As psychiatrists, we are keenly aware of how these factors affect someone’s psychological wellbeing. Medical comorbidities, like chronic pain, are one such factor that play a significant role in someone’s mental health. The presenters will focus specifically on the intersection of chronic pain and mental health. Research shows patients suffering from chronic pain are more likely to experience depression and anxiety compared to

the general population and have an increased risk of suicide. Many of the same neurotransmitters in the brain related to psychiatric pathology share the same pathways as pain. Why do some patients with an injury fall into the path of pain chronification and others recover without any residual deficits? One way to answer this question, and conceptualize the vast and competing aspects of a person's life, is to use the biopsychosocialcultural formulation. This allows one to consider all the important factors of a patient's journey. The presenters will demonstrate how to use this formulation and engage the audience by applying it to a patient case. Not only does this approach allow a provider to understand a patient's whole being, but it demonstrates the need for a multidisciplinary approach. The presenters will conclude by highlighting the need to combine pharmacological and non-pharmacological treatment modalities, to address the many needs and concerns these patients have. Psychiatrists are gifted with knowing some of the most intimate parts of a patient's life. By using this information, we can attempt to treat and support the many visible and invisible wounds our patients have.

“Why Doctors Write: Finding Humanity in Medicine” Film Screening and Discussion

Chair: Michael F. Myers, M.D.

Presenters: Jennifer Pien-Wong, M.D., Ken Browne

Discussant: David Weill, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate fundamental principles of medical humanities by integrating creative writing and clinical practice; 2) Identify key components of the theory and practice of Narrative Medicine (Rita Charon, MD); and 3) Participate in a hands-on demonstration of creative clinical writing with a guided writing exercise and small group participation.

SUMMARY:

Why Doctors Write is the brainchild of Emmy award-winning filmmaker Ken Browne. It was sparked by his interest in reflective writing by clinicians and trainees and was launched thanks to funding from the Arnold P Gold and Josiah Macy Jr Foundations,

and other donors. Filming began in 2016 in NYC with Dr. Danielle Ofri at Bellevue Hospital and the Narrative Medicine Program at NY Presbyterian/Columbia. Production continued in Boston with poet-physician Rafael Campo at Harvard Medical School. Stanford School of Medicine's medical humanities program “Medicine & the Muse” was filmed along with the Pegasus Physician Writers. A Medical Student Story Slam at the Cleveland Clinic provided the final filming location. Why Doctors Write premiered in September 2020 amidst the Covid19 pandemic. This placed clinician well-being at the forefront of media attention. The film has been lauded as a tool to stave off burnout and build community with colleagues. It has been shown at several medical institutions across the nation and at a major combined meeting of the National Academies of Sciences, Engineering, and Medicine and the AAMC in December 2020, where it received rave reviews. Following an introduction by Mr. Browne, a screening of the 35-minute film will lead off the session with an overview of the “writer-MD” movement which now includes narrative medicine curricula, health humanities requirements and hospital-based writing groups and journals. Remarks from psychiatrist-writers Drs. Pien and Myers will follow the screening - why do they write, how did they start, where do they publish, what are the benefits of practicing the craft of writing. This will be followed by a brief Q and A with the three panelists. Participants will then take part in a writing prompt exercise for 10 minutes (a sample prompt would be “Write about a first in medicine”), after which they will share their writing in small groups for 10 minutes. Attendees will then reconvene as a whole group to share selected responses to the prompt. Additional Q and A, and closing comments on writing and medicine will conclude the session. For information on the film visit: whydoctorswrite.org

Master Courses

Saturday, May 21, 2022

Buprenorphine and Office-Based Treatment of Opioid Use Disorder SOLD OUT

Director: John A. Renner, M.D.

Faculty: Petros Levounis, M.D., M.A., Dongchan Park, M.D., Stephen A Wyatt, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder.; 2) Apply the pharmacological characteristics of opioids in clinical practice.; 3) Describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching.; 4) Describe the legislative and regulatory requirements of office-based opioid pharmacotherapy.; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain..

SUMMARY:

This course is sold out.

This session requires advance registration and an additional fee. For more information, please visit <http://apapsy.ch/courses>.

This course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD) and review 1) DSM-5 criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality rules related to treatment of substance use disorders; 3) Drug Enforcement Administration requirements for recordkeeping; 4) billing and common office procedures; 5) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, and ADHD and how to distinguish independent disorders from substance-induced psychiatric disorders; and 6) common clinical events associated with addictive behavior. Special treatment populations, including adolescents; pregnant addicts; and geriatric, HIV-positive, and chronic pain patients, will be addressed, and small-group case discussions will be used to reinforce learning.

Sunday, May 22, 2022

**Master's Course in Clinical Psychopharmacology
SOLD OUT**

Director: Alan F. Schatzberg, M.D.

Faculty: Charles DeBattista, M.D., Michael J. Ostacher, M.D., M.P.H., Manpreet K. Singh, M.D., M.S., Charles B. Nemeroff, M.D., Ph.D., Rona J. Hu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Have a working knowledge of current development of novel antidepressant brain stimulation devices and medications, including hallucinatory agents, for refractory major depression; 2) Have a working knowledge of approaches to treating adults with bipolar disorder; 3) Have a working knowledge on the medication treatment of anxiety disorders, including PTSD; and 4) Have a working knowledge on managing children with ADHD, ASD and other childhood disorders.

SUMMARY:

This course is sold out.

This session requires advance registration and an additional fee. For more information, please visit <http://apapsy.ch/courses>.

After a relative dearth of new drug and device development for treatment of psychiatric disorders, considerable progress is being made in the field. This symposium will review recent advances in drug and device treatment, much of which can already be used in clinical practice. The program will include 6 talks, each with Q&A, as well as breakout sessions to allow for case discussion. The program will be about 8 hours in duration. Presentations (and speakers) will include the following: Brain stimulatory devices and psychedelics for major depression (DeBattista); maximizing outcome in refractory depression (Schatzberg); managing bipolar disorder (Ostacher); treating children and adolescents with major psychiatric syndromes (Singh); innovations in managing the anxious patient (Nemeroff); advances in the treatment of schizophrenia (Hu). A practical approach will be taken throughout the program.

Monday, May 23, 2022

**The Suicidal Patient: Principles and Practice of Assessment, Treatment, and Care Management
SOLD OUT**

Director: Kirk Strosahl, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the moral and ethical dilemmas associated with treating clients with suicidal behaviors; 2) Demonstrate the different forms of suicidal behavior and clinical implications for treatment; 3) Understand the risk prediction dilemma and the dangers associated with false positive risk assessment errors; 4) Appreciate a ACT based problem solving model of suicidal behavior and the components of effective intervention; and 5) Analyze the risks and benefits of using medications with suicidal patients.

SUMMARY:

This course is sold out.

This session requires advance registration and an additional fee. For more information, please visit <http://apapsy.ch/courses>.

Addressing suicidality is one of the most daunting challenges that psychiatric clinicians face in daily practice. This master class will introduce an innovative approach to the assessment, treatment and case management of suicidal patients. After examining the various forms of suicidal and self-destructive behaviors, as well as their prevalence and impact in clinical practice, we will engage in a self-examination process designed to highlight the moral, ethical and hot button legal issues associated with treating suicidal patients. We will examine the clinical implications of the prediction and control dilemma, namely, that suicide cannot be predicted or prevented on a case by case basis. Thus, there is a significant likelihood that conventional "risk management" strategies designed to protect clients from self-harm, may actually promote self-stigma and increase the likelihood of suicidal behavior. Participants will learn an approach to suicidal behavior based in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl and Wilson, 2011). ACT views suicidality as a problem-solving behavior designed to eliminate or control distressing, unwanted inner experiences, rather than as a sign of

underlying psychiatric illness per se. ACT intervention strategies for suicidality will be examined in detail, with role play demonstrations of key clinical principles, and opportunities for participants to practice core strategies in role play simulations. Along the way, we will address some issues unique to psychiatric assessment and treatment of suicidal patients, namely, the benefits and limitations of medications, and the use of in-patient hospitalization. Participants will also have an opportunity to practice ACT consistent responses to high risk, emotionally challenging communications that can occur in therapy with chronically suicidal patients.

Tuesday, May 24, 2022

A Primer on First-Episode Psychosis for the Practicing Psychiatrist: Keys to Providing Quality Psychiatric Care Within This Emerging National Mode SOLD OUT

Director: Jacob S. Ballon, M.D.

Faculty: Khalid A. Salaheldin, M.D., Katherine Eisen, Ph.D., Ashley Weiss, M.D., M.P.H., Doron Amsalem, M.D., Brandon Nelson, Russell Macaluso, Serena Chaudhry, D.S.W., L.C.S.W., M.P.H., Ariana J. Koster, M.D., Julio C. Nunes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least 3 of the advantages of early intervention for individuals experiencing psychosis, and will be able to describe some of the state and federal policy systems that support early int; 2) Describe the guiding principles of Coordinated Specialty Care, and to identify the key multidisciplinary specialists who are part of a CSC team, as well as the roles these team members play.; 3) Understand at least three factors to consider around decision making with regards to medication management with Clinical High Risk and Early Psychosis populations.; and 4) Identify the key principles of CBT for psychosis, and will be able to identify at least one behavioral and one cognitive approach that can be used to in CBT..

SUMMARY:

This course is sold out.

This session requires advance registration and an additional fee. For more information, please visit <http://apapsy.ch/courses>.

Early recognition and intervention for young people with early psychosis has become a national priority. Landmark studies in first episode psychosis (FEP; RA1SE) and Clinical High Risk for Psychosis (CHRp; NAPLS) have provided a solid base for program development. A key finding from this work being that shortening the duration of untreated psychosis (DUP) is crucial to improving overall outcomes. Following these research findings, over the last several years the federal and many state governments have and continue to make financial commitments to support expanded funding for early psychosis programs in each state. The number of US early psychosis clinical programs has thus exploded over that time frame. There is a consensus that such treatment requires an interdisciplinary approach, but with different proposed models, how does one conceive of and set up a new program or improve existing offerings to be in concert with best practices? Psychiatrists are key team members as part of the coordinated specialty care (CSC) team supporting those with CHRp and FEP. Many psychiatrists, however, have not been specifically trained in the current models of assessment and treatment that have been found to be most effective in supporting young people at-risk for or with early psychosis. This course will provide critical training for the general psychiatrist in the key aspects of assessment, work-up, and intervention models for the young person at risk for or facing a first episode of psychosis. Throughout this course, opportunities will be made available for small group practice, role playing, case discussions, and other opportunities to enhance your practice. The course components will include didactics and interactive training components. Key topics include an initial focus on the role of the psychiatrist as part of the CSC team, as well as skill development in the shared decision-making model of care. Furthermore, diagnostic and assessment issues in the approach to CHR intervention and early psychosis will be discussed. This training will include clarification of differential diagnosis issues, including key components of an appropriate assessment for early psychosis,

including interview focus, screens, bloodwork, and consideration of neurological assessment. Intervention components will focus on the continuum of care including CBT for psychosis, family intervention, medication and medical support, supported education/employment, and peer support. Furthermore, specific guidance for psychiatrists on appropriate engagement strategies and collaboration from the perspective of the individual with lived experience with psychosis will also be highlighted. Complexities of addressing co-morbid substance use issues, trauma, and the role of wellness and physical activity in intervention will also be discussed. An additional focus will include special considerations in working with the adolescent with early psychosis and their family, school, and community environment.

Wednesday, May 25, 2022

Motivational Interviewing: Practice Your Skills, Change Your Practice SOLD OUT

Director: Carla B. Marienfeld, M.D.

Faculty: Petros Levounis, M.D., M.A., Brian Hurley, M.D., M.B.A., Jeffrey DeVido, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the origin of motivational interviewing in the broader context of addiction treatment; 2) Apply the spirit of MI to engage patients; 3) Identify and utilize the four metaprocesses to structure clinical conversations about change; 4) Practice reflections, identify change talk, and apply the core skills of MI; and 5) Integrate the core skills of MI in their clinical practice.

SUMMARY:

This course is sold out.

This session requires advance registration and an additional fee. For more information, please visit <http://apapsy.ch/courses>.

Motivational Interviewing (MI) a directional conversation style focused on change grounded in humanistic psychology. 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. MI seeks to

hasten this natural change process by creating an interpersonal situation, wherein the clinician engages the patient in a collaborative dialogue that evokes and supports behavioral change from the patient's perspective. MI is something that is done with someone, such that it 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 honor the patient's experiences and perspective, affirm the patient's right and capacity for self-direction, and draw out the patient's goals, values, and perceptions that support change. By creating a therapeutic context 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. This course will review the basic concepts and skills of Motivational Interviewing (MI) and involve participants in exercises to practice skills and tools, to illustrate the practical applicability of these tools in clinical practice with their patients. An MI approach positions clinicians and patients as mutually collaborative experts, and participants adhering to MI can improve the efficiency of the limited clinical time we have with patients. Its introduction in the 1980's, the effectiveness of MI has been demonstrated across a wide variety of disciplines and issues. Despite this evidence, MI adherent practice has relatively limited penetrance into psychiatry, even in the field of addiction psychiatry. There is a tremendous potential benefit of employing MI to improve psychiatric care, particularly in addressing common problems such as medication non-adherence, increasing healthy behaviors such as diet and exercise, and reducing substance use. The session will introduce or refresh participants to the fundamentals of motivational interviewing emphasizing core ideas such as the 'righting reflex', the spirit of MI, the four processes of MI, and the skills in MI. Participants will practice these skills to enhance clinician effectiveness with structuring conversations using MI processes to evoke the patient's making arguments for change. The session will include discussion and exercises that demonstrate strategies for doing so, along with some of the other basic techniques of MI, with a focus on reflective listening. At the conclusion of this course, clinicians will have more competence using

motivational interviewing, will have greater knowledge of the concepts and terminology, and will be able to improve their performance working with patients to change behaviors.

Presidential Sessions

Saturday, May 21, 2022

National State of Emergency: Child and Adolescent Mental Health Crisis

Presenters: Warren Y. K. Ng, M.D., Tami Benton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the social determinants of mental health for children and adolescents; 2) Acknowledge the most important elements of the current crisis in child and adolescent mental health; and 3) Identify the strategies used to address the pediatric mental health crisis.

SUMMARY:

The American Academy of Child and Adolescent Psychiatry (AACAP) has responded to the emergent crisis in child and adolescent mental health throughout the COVID-19 pandemic. Within this national state of emergency, there have been multiple pandemics affecting children and adolescents, most notably mental health and racism. The impact of mental health has compounded an already challenging situation when 1/5 children and adolescents have a mental health or behavioral disorder while less than 20% receive the care that they need. In 2019 SAMHSA reported that 22% of adolescents had a severe mental impairment and the lifetime prevalence of any mental health disorder was 49.5%. Mental and behavioral health issues have been worsening over the years and suicide remains the second leading cause of death for youth ages 10-18 in the United States. This has only worsened during the COVID-19 pandemic, with a 24% increase in emergency department visits for mental health conditions for children aged 5-11 and 31% increase for youth aged 12-17 years old. The humanitarian crisis for children and adolescents is significant as untreated and undiagnosed mental

illness is associated with family dysfunction, poor school performance, juvenile incarceration, substance use disorder, and suicide. The COVID-19 pandemic has also exacerbated the risk factors known as the social determinants of mental health, the annual meeting theme. These determinants are risk factors including family mental health and substance use issues, adverse childhood experiences, racial disparities, social isolation, trauma, food and housing insecurity, economic stress, and poverty. However, not all children and adolescents are equally impacted, with children of color disproportionately affected by the systemic and structural racism and inequities embedded within the systems of care meant to serve them. The impact of racism on child and adolescent mental health and the disparities with access to quality and culturally competent care disadvantage racial and ethnic minority children, youth, and families. AACAP joined other organizations including the American Psychiatric Association and American Academy of Pediatrics in endorsing the Child and Adolescent Mental and Behavioral Health Principles including: Prevention, Early Intervention, and Early Intervention; School Based Mental Health; Integration of Mental and Behavioral Health into Pediatric Primary Care; Child and Adolescent Mental and Behavioral Health Workforce; Insurance Coverage and Payment; Mental Health Parity; Telehealth; Infants, Children and Adolescents in Crisis; and Justice-involved Youth. Our organizations are committed to responding to the crisis with opportunities and strategies among these different principles. Within each principle, the experience of ethnic minority, underserved, LGBTQ, justice-involved, child welfare-involved, and disabled youth should be highlighted.

Social (in)Justice and Mental Health

Introduction: Jacqueline M. Feldman, M.D.

Chair: Sarah Yvonne Vinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Examine the inadequacy of current medical and mental health education and training in countering the powerful forces of social injustice in mental health is discussed in detail.; 2)

Explore the role of social injustice and specific diagnoses and conditions, including substance use disorders, schizophrenia, personality disorders, and child trauma, is covered; and 3) Strategize ways for infusing social justice into clinical practice.

SUMMARY:

Social justice entails equal access to liberties, rights, and opportunities, as well as care for the least advantaged members of society. This session addresses the ways in which society's failure to deliver on that humane ideal harms people with mental illness. Dr. Sarah Vinson, at the forefront of the effort to make psychiatry responsive to critiques of institutional racism, will discuss how that in the United States, a perfect storm of unfair and unjust policies and practices, bolstered by deep-seated beliefs about the inferiority of some groups, has led to a small number of people having tremendous advantages, freedoms, and opportunities, while a growing number are denied those liberties and rights. Mental health clinicians must bear a special responsibility to be aware of these structural inequities, to question their own biases, to intervene on behalf of patients and their families, and to advocate for mental health equity. To that end, this session will provide a framework for thinking about why these inequities exist and persist and provide clinicians with a road map to address these inequalities as they relate to racism, the criminal justice system, and other systems and diagnoses.

Social Determinants of Mental Health and the Climate Crisis: Focusing on Rural and Indigenous Settings

Chair: Mary Hasbah Roessel, M.D.

Presenter: Edward Joseph Neidhardt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relationship between the Climate Crisis and Social Determinants of Mental Health; 2) Find solutions that will benefit both Climate Change and the SDOMH; 3) Understand ways of integrating this knowledge into a psychiatric practice.; 4) Individualize this general knowledge making it specific to rural areas and Indigenous cultures.; and 5) Have participated and

engaged in the Circle Way practice as a way of deepening this knowledge.

SUMMARY:

When you explore the social determinants of mental health and you understand the impacts from Climate Change occurring now, you realize there is a huge overlap in these two fields. When you project yourself into the future you realize the necessity of addressing these two areas simultaneously, as they mutually impact each other. Climate Change is a major social determinant of health and social determinants of mental health affect how we mitigate and adapt to Climate Change. Climate Change has been added as a Social Determinant of mental health. Rural and Indigenous communities have been impacted by many SDOMH and climate change. Significant areas of concern for both social determinants of mental health and Climate Change include: 1. Declining food production caused by rising temperatures, adverse weather events, and drought leading to food insecurity. This adversely affects BIPOC people even in areas where average income is adequate. Agricultural practices can address some of these deficiencies, create jobs, and enhance adaptation. The same agricultural practices can create carbon sequestration and thus climate mitigation. Increasing food production with certain fertilizers with irrigation can create short term solutions which cause CO2 release and make the Climate Crisis worse. 2. Stress and trauma are social determinants and are significant problems with adverse weather from Climate Change. Both lead to stress and trauma that leads to anxiety, depression, PTSD with health-related issues accentuated in Children. 3. Poverty is identified as being a social determinant and negatively impact mental health and it is disproportionately affected by Climate Change. 4. The Built Environment is identified as those things we do to create an environment for humans within nature and for nature. It directly impacts our mitigation and adaptation to climate change and directly and indirectly affects our health and the health of our environment. 5. Poor housing, contributes to climate change through materials acquisition and poor insulation and can lead to poor mental health. Construction practices with adequate housing can help mitigate Climate Change with solar advantages, better insulation, and a smaller carbon

footprint. We will explore the connections of each of these 5 areas with the goal of enhancing knowledge in what can improve mental health and what will mitigate climate change simultaneously. Our examples will focus on rural and Indigenous communities. We will also explore how short-term solutions can temporarily help but lead to more complications in the future. We will also look at enhancing resilience, with an aim at prevention. We will address common treatment strategies. We cannot solve the problems using the same thinking that caused the problems in the first place. We will offer some solutions and will engage our audience in finding other possibilities through an Indigenous Circle Way Practice.

Why There Are Two Classification Systems in Psychiatry and How They Differ

Chair: Michael B. First, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the relationships between past editions of the DSM and ICD; 2) understand how the differences in priorities, mandates and constituencies between the APA and WHO explain differences in DSM-5 and ICD-11; and 3) understand the factors that influenced DSM and ICD differences in the classification of childhood irritability and anger, compulsive sexual behavior, personality disorders and substance use disorders.

SUMMARY:

In 2013, APA published the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and in 2019 the World Health Assembly approved the 11th revision of the international Classification of Diseases (ICD-11), which includes among its chapters a classification of Mental, Behavioral, and Neurodevelopmental Disorders. It has often been suggested that the field would benefit from a single, unified classification of mental disorders, This presentation answers the question of why there are two classification systems in psychiatry by explaining the intertwining histories of the development of editions of the DSM and the mental disorders sections of the ICD, describing past attempts at harmonization, and indicating how the

different mandates, priorities, and constituencies of the APA and WHO mean that the two classifications will never be the same. To illustrate the factors and influences that led to the DSM-5 and ICD-11 workgroups making divergent decisions, four examples of diagnoses in which DSM-5 and ICD-11 significantly differ are presented. These include presentations of 1) severe childhood irritability and anger, which is diagnosed in DSM-5 as disruptive mood dysregulation disorder and in ICD-11 as oppositional defiant disorder with chronic irritability; 2) compulsive sexual behavior disorder which was considered for inclusion in DSM-5 (as hypersexual disorder) but ultimately rejected, whereas in ICD-11 is diagnosed as compulsive sexual behavior disorder, a condition located in the Obsessive-Compulsive and Related Disorders grouping, 3) personality disorders, in which DSM-5 retained the DSM-IV categories without any changes but included a hybrid categorical dimensional approach in its research appendix; whereas ICD-11 dispensed with the ICD-10 personality disorder categories and replaced them with a dimensional approach and 4) disorders due to substance use, in which DSM-5 adopted a single category, substance use disorder, with three levels of severity, whereas ICD-11 retained the ICD-10 substance dependence and harmful use categories.

Sunday, May 22, 2022

Artificial Intelligence and the Future of Psychiatry

Chair: P. Murali Doraiswamy, M.D.

Presenter: Robert M. Califf, M.D.

Moderator: Samantha Boardman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand history of AI in psychiatry; 2) Current research evidence with AI in psychiatry; and 3) Pros and cons of AI.

SUMMARY:

Prior to the pandemic, mental health conditions were a leading cause of disability worldwide, costing the global economy an estimated \$1 trillion annually. Since the pandemic, we have seen a further large increase in anxiety and depression and the impacts on children will likely reverberate for years to come. New digital technologies and AI offer

potential to enhance access and reduce stigma. Early studies suggest people may be more willing to share sensitive or embarrassing information with a virtual therapist (avatar or chatbot) than with a human clinician. The venture capital world had invested over \$2 billion into digital tools since the pandemic. However, as with self-driving cars, the process of developing and testing autonomous artificial agents for mental health care comes with many new ethical dilemmas and the potential to worsen disparities and quality of care if not done correctly. My presentation will highlight the promise and perils of AI applications in psychiatric care.

“Brain Fog”: What Is It Really?

Chair: Maria Tiamson-Kassab, M.D.

Presenters: Durga Roy, M.D., Jon Levenson, M.D.,

Susan Abbey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the symptoms observed in “brain fog” that is found in various conditions; 2) Understand the pathophysiology or causes of what is known as “brain fog”; and 3) Learn how to manage patients with “brain fog” in selected disorders.

SUMMARY:

“Brain Fog” is really not a medical diagnosis nor is it a scientific term. It is a colloquial term that describes what patients feel in any condition that causes them to be confused, have memory loss, word-finding difficulties, inability to concentrate and focus. This so-called “brain fog” is a common complaint in a host of conditions that range from pregnancy, menopause, medications, sleep deprivation, to disorders that may affect the brain such as lupus, fibromyalgia, chronic fatigue, multiple sclerosis, cancer and more recently, it has been increasingly noted in COVID “long haulers”. Patients with “brain fog”, regardless of cause, complain that the cognitive disturbances affect their day to day functioning and diminish the quality of their life. We are living in unprecedented times with the pandemic caused by the coronavirus, SARS-coV-2, that leads to COVID - 19. While COVID-19 is primarily a respiratory disease, it affects the brain. In a survey, 88% of

COVID “long haulers” reported that they experienced some form of cognitive dysfunction or memory loss that to varying degrees affected their everyday lives, including the ability to make decisions, have conversations, follow instructions, and drive. “Chemo-brain” or “brain fog” in patients with cancer who undergo chemotherapy has long been recognized as one of the most commonly reported post-treatment complication in cancer survivors. “Chemo-brain” considerably impairs cancer survivors to a great extent in their personal and professional lives. Fibromyalgia and Chronic Fatigue Syndrome appear to be associated with prominent cognitive symptoms of memory lapses, distractibility, word-finding difficulties and slowed thinking. The cognitive dysfunction in Fibromyalgia has also been termed “Fibro-fog”. This Presidential session will address the cognitive dysfunction seen in COVID long haulers, chemotherapy patients and patients with fibromyalgia and chronic fatigue syndrome. Psychiatrists, especially those in Consultation-Liaison, encounter these patients in the work they do, both in the hospital and in specialty clinics. We hope to clear the fog surrounding “brain fog” by focusing on the recognition of symptoms, the theories on the causality of the cognitive dysfunction in these disorders and the treatment strategies to manage the symptoms that will help improve the quality of life of these patients.

Challenges to Evidence-Based Practice in American Indian and Indigenous Community Mental Health

Presenter: Joseph P. Gone, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) summarize American Indian dissatisfaction with conventional mental health treatments and services; 2) explain American Indian commitments to traditional cultural practices and activities; and 3) discuss characteristics of a culturally grounded, alterNative American Indian approach to mental health treatment.

SUMMARY:

American Indian and other Indigenous communities exhibit alarming inequities in mental health disorders and associated problems. Despite such

needs, advocates and professionals in these settings insist that mainstream clinical interventions are frequently irrelevant and ineffective on cultural grounds. Instead, in the wake of a brutal Euro-American colonization, many American Indians today assert that “our culture is our treatment.” This presentation will review American Indian concerns and critiques of evidence-based practice in community mental health to ensure that researchers, professionals, and providers are prepared to address these challenges when undertaking service delivery within Indigenous communities.

Trauma in Crescent City: The Intersection of Social Determinants and Racial Injustice in New Orleans

Chair: Joseph McCullen Truett, D.O.

Presenter: L. Kasimu Harris

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Integrate knowledge of current psychiatry into discussions with patients; and 4) Identify barriers to care, including health service delivery issues.

SUMMARY:

Shortly after Hurricane Katrina inundated a majority of the city of New Orleans with flood waters, then Senator Barack Obama noted, “The people of New Orleans weren’t just abandoned during the hurricane. They were abandoned long ago.” These words echo the increasingly obvious reality that systems of power wield a social calculus that disproportionately places vulnerable communities in harm’s way. Four years prior to Katrina, the federal government retracted previous limitations on wetlands development around the city, further eroding New Orleans’ natural defense. Simultaneously, the local Army Corps of Engineers budget for levee management was slashed by 80%. The net result of these decisions and climate change driven storm intensity was a mass casualty event of more than two thousand deceased and over 1.5 million displaced residents, disproportionately impacting the Black community. The parallels within

the Katrina disaster resonate all too well with mental health practitioners in the United States. The weight of history hangs heavy in all aspects of psychiatric care. Housing laws, redlining, The War on Drugs, and failure to expand voting rights legislation are a few among the many injustices that have perpetuated race and class-based stratification affecting our patients daily. Within the field of psychiatry itself, implicit racial bias and racialized concepts such as cultural deprivation theory have previously entrenched subtle forms of racism in the name of race neutrality that to this day require dismantling. This session will explore historical injustices within the city of New Orleans as a backdrop for the systemic challenges that perpetuate inequities in care and exacerbate social determinants of mental health to the detriment of our patients, with the goal of fostering honest conversations that may begin to heal old wounds, lift up vulnerable communities, and ensure equitable mental health care across the country.

PRESENTER UPDATE: L. Kasimu Harris will also present.

Update on the Assessment of Psychiatric Bed Needs in the U.S.

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

Presenters: Jeffrey Lee Geller, M.D., M.P.H., Anita Everett, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide culturally competent care for diverse populations; 2) Identify barriers to care, including health service delivery issues; and 3) Apply quality improvement strategies to improve clinical care.

SUMMARY:

The 2020-2021 APA Presidential Task Force on Psychiatric Beds is charged with the development of a model that can be used to determine the number of psychiatric beds needed in any jurisdiction like a state or a county. The outcomes can be compared to the current capacity of psychiatric beds in the United States, with resultant recommendations depending upon the discrepancies between the model's results and actual bed counts. This session will highlight the status of the task force's work defining the

contemporary psychiatric "bed", reviewing funding mechanisms that support the current capacity of inpatient care, setting benchmarks for high quality or high fidelity, and assessing the impact of variability in diverse populations in need of inpatient psychiatric treatment. The session will also address the critical shortage of access to inpatient care and services for children/adolescents. Finally, the session will provide an update on where the Task Force stands with development of a white paper that includes psychiatric inpatient beds as well as community services and alternatives that might mitigate the demand for adult and child/adolescent inpatient beds.

Monday, May 23, 2022

Advancing Equity and Justice in Psychiatry: BPA and APA Leaders Address Opportunities and Challenges for the Future

Presenters: Benjamin Roy, M.D., Cynthia Turner-Graham, M.D., Rebecca W. Brendel, M.D., J.D., Vivian Pender, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify barriers to care, including health service delivery issues; 2) Provide culturally competent care for diverse populations; and 3) Apply quality improvement strategies to improve clinical care.

SUMMARY:

Racism, including structural racism or the social, political, and economic structures that prevent an individual, group, or society from reaching their full potential, has affected both psychiatrists and those who we serve. In this collaborative dialogue, the Immediate Past President of the Black Psychiatrists of America (BPA) Ben Roy, M.D., and BPA President, Cynthia Turner-Graham, M.D., join APA President Vivian Pender and APA President-Elect Rebecca Brendel for an open conversation about how a vision for the future of our profession and mental health care. Dr. Roy will incorporate concepts of shared humanity, intercultural understanding, and humility as essential features of embracing diversity and equity. Dr. Turner-Graham will draw on her ambitious vision for BPA, including its serving as a

leader in advancing the conversation on racism as a public health matter, advocating for mental health equity and justice, providing expertise, and engaging members. Dr. Pender will present the diversity, equity, and inclusion work of APA during her tenure, including the findings of her presidential task force on the Social Determinants of Mental Health. Finally, Dr. Brendel will draw on contributions from ethics to advancing antiracism and health care equity and justice in a roadmap for the future. This session will include ample opportunity for attendee questions.

Point on the Horizon or Desert Mirage: Will a Transition to Value-Based Care Save Psychiatry?

Chair: Tristan Gorrindo, M.D.

Presenters: Katherine Hobbs Knutson, M.D., M.P.H., Andrew Carlo, M.D., Nicole M. Benson, M.D., Luming Li, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Integrate knowledge of current psychiatry into discussions with patients; and 4) Identify barriers to care, including health service delivery issues.

SUMMARY:

As the demand for behavioral health services increases, many patients are unable to identify, access, or afford care. At the same time, behavioral health clinicians such as psychiatrists, psychologists, and social workers who accept insurance are struggling to implement evidence-based care and balance administrative burdens related to the electronic medical record, utilization review, and billing. A transition to value-based care has often been cited as the solution. Value-based care offers a pathway to increase payment to clinicians in return for improved population health outcomes and reduced cost. It incentivizes clinicians to think holistically about the physical, behavioral, and social needs of the patient, and offers flexibility in how clinicians provide those services. This session will describe the core components of value-based care, offer examples of collaborative efforts between

clinical providers and payers to create value-based care, and discuss the challenges of moving from a fee-for-service system to value-based care. Speakers represent various viewpoints on the topic including: payers, fee-for-service providers, community-based providers, and academia.

Psychodynamic Psychiatry Today: The Law, Shame, Taking a Sexual History and Resilience During the Pandemic

Chair: Gerald Paul Perman, M.D.

Presenters: William Butler, M.D., Jennifer I. Downey, M.D., Eugenio Rothe, M.D., Ahron Friedberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the legal and ethical aspects of psychodynamic psychiatry in the digital age.; 2) Learn the origins of the affect of shame and how to manage it in psychodynamic treatment.; 3) Learn how to introduce the topic of sexuality with different patient groups and learn about the different domains of the sexual history.; and 4) Learn how to apply resilience principles such as adaptability and flexibility with patients during the pandemic and how to instill optimism and hope..

SUMMARY:

The American Academy of Psychodynamic Psychiatry and Psychoanalysis Presidential Symposium workshop, "Psychodynamic Psychiatry Today," will present four strikingly different aspects of the current practice of psychodynamic psychiatry. William Butler, M.D. will present "The Digital Age: Psychodynamic Psychiatry and the Law" in which he will review the legal and ethical aspects of psychodynamic approaches during the COVID-19 pandemic. Eugenio Rothe, M.D. will present "The Elusive Chameleon: Working with Shame in Psychotherapy." Dr. Rothe will discuss the clinical presentations of shame, defenses employed to defend against shame, and the role of attachment in how shame is manifested among different patients. Jennifer Downey, M.D., world-renowned psychoanalyst and sex researcher, will describe and demonstrate through a case vignette how to take a sexual history with adult patients. Finally, Ahron Friedberg, M.D. will discuss the capacity for

resilience during the COVID-19 pandemic and how this can be facilitated in psychodynamic psychotherapy. He will be making reference to his recent book "Through a Screen Darkly: Psychoanalytic Reflections During the Pandemic" (2021). The program and each of the four panelists will be introduced by Gerald P. Perman, M.D., DLFAPA, Immediate Past President of the AAPDPP, who will present a recap following the presentations and who will moderate the Q&A session, if this takes place,.

Social Determinants of Mental Health: Perspectives From the World Psychiatric Association

Chair: Afzal Javed, M.B.B.S.

Presenters: Danuta Wasserman, M.D., Paul Summergrad, M.D.

Discussant: Edmond H. Pi, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the growing importance of global mental health; 2) To appreciate the interplay of general medical illness and psychiatric disorders; and 3) To become aware of increasing burden in low and middle income countries.

SUMMARY:

Social determinants of health affect all of health care but are of particular concern in regard to global mental health. In this program the leadership of the World Psychiatric Association (WPA) will present their view of the impacts of these social determinants on all of health including mental health and describe the work that the WPA executive committee, board, publications, meetings sections and programs are doing to address these burgeoning issues.

Social Determinants of Mental Health: Task Force Report

Introduction: Jacqueline M. Feldman, M.D.

Chair: Dilip V. Jeste, M.D.

Presenters: Dilip V. Jeste, M.D., Sanya A. Virani, M.D., M.P.H., Francis Lu, M.D., Dolores Malaspina, M.D.,

M.S., Kenneth Stewart Thompson, M.D., Gary S. Belkin, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess social determinants of mental health; 2) Evaluate the impact of social determinants on health inequity; and 3) Use strategies to reduce the adverse effects of social determinants on patients' mental health.

SUMMARY:

Beginning in 2002, the WHO and the CDC have emphasized the role of social determinants of health. However, mental illnesses and mental healthcare have not been a priority in these conceptualizations. More people with mental illnesses and substance use disorders are in prisons and jails than in hospitals. Our patients are less likely to receive needed treatments and more likely to die prematurely. The primary reasons for this state of affairs are social (e.g., stigma against mental illnesses) – and not biological – factors. During the last 25 years there has been a behavioral pandemic of loneliness, social isolation, opioid abuse, and suicides. The increase in deaths of despair due to socioeconomic dislocation and ongoing mental health inequities caused by systemic racism reflect policies riven with inequity. Recently the COVID-19 pandemic and structural racism have worsened health inequities. Fortunately, there are some rays of hope. There is a societal refocus on promoting inclusive and equitable personal and societal well-being. The recent child tax credit, reducing child poverty by 50%, is a case in point. In May 2021, an APA Presidential Task Force (TF) on Social Determinants of Mental Health (SDoMH) was established by Dr. Pender. This TF will propose innovative strategies to help reshape future healthcare for our patients through SDoMH-focused clinical care, research, and training. We recommend broadening the definition of SDoMH to include aspects that have a far greater impact on the health of psychiatric patients. These include pervasive stigma against mental illnesses and substance use disorders and against psychiatric treatments. There is continued lack of mental health parity. Meta-analyses have shown that social connections have

greater impact on both length and quality of life across the lifespan, and these have major effects in mentally ill persons. Dr. Lu will discuss what clinicians should do to assess and treat SDoMH in their everyday practice. The recommendations of the Clinical Workgroup will impact future APA Practice Guidelines. Dr. Malaspina will describe the type of research and training needed for making knowledge of SDoMH widespread at all levels, including the general public. Dr. Thompson will focus on the public health significance of SDoMH. He will review the literature on health consequences of SDoMH, and make recommendations for addressing them at systems level. Finally, Dr. Tasman will summarize what the APA and government policy makers should do to promote strategies to change the mental healthcare system to prioritize SDoMH in their economic and financing considerations. Attention to racial/ethnic minorities, LGBTQ, immigrants, and other marginalized groups is an important area for the entire TF. There will be at least 20 minutes for Q&A and general discussion at the end of the session.

Stopping the Revolving Door: How Psychiatrists Can Reclaim Individuals With Mental Illness Stuck in the Criminal Justice System

Presenters: Evelyn Stratton, J.D., Zachary Lenane, M.D., M.P.H., Thad Tatum, Michael Kelly, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe a basic overview of the criminal justice system and how it is relevant to their work as psychiatrists.; 2) Identify at least three ways psychiatrists and judges can (and should) partner together to improve outcomes for their community members.; and 3) List at least two ways to engage with community members who are justice-involved..

SUMMARY:

Far too often, individuals with serious mental illnesses become entangled in the criminal justice system. Once there, these individuals can suffer more harm and be retraumatized. Psychiatrists have an important role in understanding how this happens and what they can do to help divert these

community members out of the criminal justice system. This session provides an overview of just that through an engaging panel discussion with a retired Ohio supreme court justice, a psychiatrist working with community members entrenched in the justice system, and a person with lived experience. Following the panel, attendees will break out into interactive small groups to do a deeper dive of the intersections between psychiatry, criminal justice and advocacy and have the opportunity to learn from the panelists. Upon conclusion of the session, attendees will: have a better understanding of the justice system and how it is relevant to psychiatrists, be able to identify ways psychiatrists and judges can work together to divert community members and recognize ways they can engage with community members who are justice-involved.

The Impact of the COVID-19 Pandemic on Youth and Families

Chair: Warren Y. K. Ng, M.D.

Presenter: Lee Savio Beers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the direct and indirect impacts of the COVID-19 pandemic on youth and their families; 2) Discuss the underlying social determinants of health and disparities contributing and exacerbating the mental health impact on youth and their families; 3) Discuss the role of collaborative care and other multi-disciplinary partnerships in optimizing mental health care and well-being for youth; and 4) Identify strategies to improve the current system of care for youth, families, and communities.

SUMMARY:

Youth and families have been impacted in significant ways by the COVID-19 pandemic, though their needs have often gone unseen or unmet. Even prior to the pandemic, there was a silent pandemic of unmet health and mental health needs and health disparities. Suicide was already the 2nd leading cause of death for youth aged 10-24 years of age. This session will address the overall impact on youth and families as well as how mental health and

pediatric professionals can work together to improve care and outcomes. While most children recover uneventfully from COVID-19, a substantive number do experience severe illness, hospitalization or prolonged symptoms, often referred to as “long-COVID”. Additionally over 200,000 children in the US alone have lost a primary caregiver to COVID-19, and many more have lost other loved ones. Indigenous, Black or Hispanic youth were 4.5, 2.4, and 1.8 times respectively, more likely to have lost a parent or caregiver during the pandemic. The indirect effects of the pandemic, such as food and housing instability, family disruption and social isolation, have taken an additional toll on the wellbeing of children and families. The cumulative effect of these impacts layered upon an already fragile system of care and increasing rates of mental health concerns have led to a true crisis in youth mental health. Studies have shown that there has been a 24% and 31% increase in children and adolescents respectively, arriving at emergency departments with mental health conditions compared to 2019. There has also been a 51% increase in adolescent females seen in the emergency department with suspected suicide attempts compared before the pandemic. Youth, families and communities of color have been disproportionately impacted and continue to experience inequities in all dimensions. In order to holistically and most effectively address these challenges, it will require a collective effort to transform a broken system, increase collaborative care between multi-disciplinary professionals, and advocacy on behalf of children, families, and communities. During this session, attendees will learn strategies to advance these principles in their practices and communities.

Therapeutic Risk Management for Violence

Presenters: Hal S. Wortzel, M.D., Suzanne McGarity, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Perform clinical risk assessment for violence against others; 2) Augment risk assessment with structured instruments; 3) Stratify and characterize risk for violence; 4) Perform chain analysis to mitigate risk for violence; and 5)

Complete safety planning for other-directed violence.

SUMMARY:

Violence risk assessment is a requisite component of mental health treatment. Adhering to standards of care and ethical and legal requirements necessitates a cogent process for conducting (and documenting) screening, assessment, and management of other-directed violence risk. This presentation will present a model for achieving therapeutic risk management of the potentially violent patient, with essential elements involving a clinical interview augmented by structured screening or assessment tools; risk stratification in terms of temporality and severity; chain analysis to intervene on the functions of violent ideation and behavior; and development of a personalized safety plan.

Tuesday, May 24, 2022

Apps and Innovations to Support the Practice of Psychiatry: Current and Future Developments

Chair: John Luo, M.D.

Presenters: James H. Shore, M.D., M.P.H., John Torous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Properly evaluate psychiatric apps for recommendation to patients; 2) Implement telemedicine to reach diverse patient populations; and 3) Utilize professional networks and social media for advocacy, outreach, and decrease burnout.

SUMMARY:

The COVID-19 pandemic rapidly accelerated the adoption and implementation of many technologies in the practice of psychiatry. Overnight, in-person visits except for emergencies were prohibited, yet technologically ready and savvy organizations and psychiatrists were able to restore access with emergency adoption of video conferencing technologies. Additionally, adjunctive services such as psychiatric applications on the smartphone were able to provide psychotherapy and medication management whether via secure messaging with a provider or artificial intelligence-driven chatbots to provide therapy. Social media and professional

networks online helped psychiatrists connect their patients to available resources as well as facilitated wellness and decreased their own risk for burnout. This panel will review current best practices as well as future developments such as digital therapeutics and predictive analytics in the future psychiatric practice.

Breaking Down the Binary: Best Practices for Supporting the Mental Health of Gender-Expansive People

Chair: Lisa Razzano, Ph.D.

Presenters: Surya Sabhapathy, M.D., M.P.H., Caleb Reyes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Integrate knowledge of current psychiatry into discussions with patients; and 4) Identify barriers to care, including health service delivery issues.

SUMMARY:

Transgender and nonbinary identities are increasingly recognized but not always well understood. This session aims to help psychiatrists bridge that gap. We will review terminology and concepts essential to understanding gender diversity as it relates to mental health practice. The session will include several case presentations highlighting those intersections, with a particular emphasis on multiple minority identities. We will encourage attendees to reflect on their personal trajectories of understanding and expressing gender in order to better support patients in their own journeys.

Cannabis Legalization

Presenters: Tony Peter George, M.D., Howard Moss, M.D., Christopher Fichtner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the detrimental public health consequences of cannabis criminalization, notwithstanding the evidence for cannabis use disorders in a small minority of users;

2) Summarize research findings suggesting that progressive cannabis policies have been associated with decreases in harms related to opioid addiction and overdose.; 3) At the conclusion of this session, the participant will be able to understand how cannabis legalization in the US has altered the population risk for Cannabis Use Disorder.; 4) Discuss the potential risks of cannabis use and addiction on various psychiatric disorders.; and 5) Describe the types of study methods that are being used to investigate the association and/or causation between cannabis and mental illness, and evidence-based treatment and prevention approaches..

SUMMARY:

This presentation explores the current state of legalized recreational cannabis frameworks in both the United States and Canada and will review perspectives from the epidemiology, public policy and clinical and social impacts of this important policy change that has taken place in 18 U.S. states and the District of Columbia, as well as nationwide in Canada. The benefits and challenges associated with cannabis legalization will be discussed, with the goal of giving attendees a balanced perspective on this important topic, which will likely impact on psychiatric practice. Dr. Fichtner will discuss the current debate surrounding benefits of decriminalization and legalization of cannabis across North America. Advocates for decriminalization have made a case for cannabis substitution as a potential harm reduction effect of liberalized cannabis access relevant to both alcohol and opioid use. Studies investigating storefront dispensary counts as indicators of cannabis accessibility and use are making a stronger case for harm reduction benefits with respect to cannabis substitution for opioid use. Though receiving less attention in the context of the opioid crisis, there are studies suggesting potential harm reduction offsets relative to alcohol-related problems as well. The case is not closed, and debate continues. Dr. Moss will discuss recent trends towards legalization and changes in public attitudes towards cannabis and relations to cannabis use disorder (CUD). Effective prevention and treatment efforts require an understanding of etiological pathways to the development of CUD, the various subtypes of cannabis use behavior, the differing clinical manifestations of CUD, and their relationship

to severity and treatment response. However, much of what is known about these phenomena is based upon research employing data at a time when cannabis use was characterized as deviant and antisocial behavior. Thus, we will review these clinical phenomena and highlight areas requiring new investigation. Dr. George will discuss the potential impact of legalization on psychiatric patients, including evidence that cannabis use may be a risk factor for the onset and progression of mental illness in people with psychosis, mood and anxiety disorders, including in adolescents and young adults. He will review a programmatic series of studies which suggests that extended cannabis abstinence (28 days) may reduce symptoms and cognitive deficits in people with schizophrenia, major depression, and posttraumatic stress disorder (PTSD), which suggests that problem cannabis use in people with these psychiatric disorders is unlikely to be related to self-medication and rather to addiction vulnerability in these patients. Early evidence from Canada suggests a selective and significant increase (25%) in daily cannabis use for people with schizophrenia and other psychoses. Caution is needed when considering the effects of cannabis legalization especially for vulnerable populations.

Enhancing Clinical Care and Collaboration With Aging Patients: Geriatric Psychiatry and New Models of Care

Chair: Marc E. Agronin, M.D.

Presenters: Brent P. Forester, M.D., M.Sc., Prasad Padala, M.D., Elizabeth Santos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the unique presentations and needs of aging patients that can be missed during routine assessment and care; 2) Understand several common pitfalls that can limit or distort clinical care for aging patients; 3) Review existing deficits and challenges in collaborative care for aging patients; and 4) Discuss several collaborative care models: the Care Ecosystem (CareEco) model; The VA's Ask the Expert Geriatric Psychiatry program; and the Project ECHO (Extension for C.

SUMMARY:

Current mental health care for aging patients is often fractured across multiple clinicians and settings, and lacks timely and comprehensive access to geriatric-trained mental health professionals. These gaps are set against a background of a well-established shortage of both geriatricians and geriatric psychiatrists. At the same time, there is an explosion of mental health needs in aging patients, especially those living with Alzheimer's disease and other neurocognitive disorders. Without clinicians and caregivers who have an adequate understanding of how mental health issues present in late life, key diagnoses such as Alzheimer's disease and late-life depression and anxiety are often delayed or missed entirely, and treatment regimens are implemented without taking into consideration key age-related factors. Several unique care models have developed to bridge these gaps. One of them is the Care Ecosystem (CareEco) model, which is a telephone-based collaborative dementia care intervention that provides personalized support and standardized education through care plan protocols, and has demonstrated lower rates of emergency department utilization and reduced caregiver depression and burden. Another model is the VA's Ask the Expert Geriatric Psychiatry program, a new consultation service provided by the National Telemental Health Center in which a team of VA Geriatric Psychiatrists are made available to answer general questions that VA clinicians may have about psychiatric care of older veterans with potentially complex and interacting psychiatric, medical, neurocognitive, and behavioral care needs. A third model is Project ECHO (Extension for Community Healthcare Outcomes) which provides telementoring to connect geriatric mental health specialists from the University of Rochester to clinicians in long-term care facilities and state psychiatric hospitals across New York State. Each of these models has pioneered ways to leverage geriatric psychiatry expertise through telehealth platforms to better educate clinicians and caregivers and coordinate care for patients who would not otherwise have access to such specialized care.

Learning From the Global South: Psychiatrist Task-Sharing, Community Empowerment, and Population Impact

Chair: Gary S. Belkin, M.D., Ph.D., M.P.H.

Presenters: Benjamin Springgate, M.D., M.P.H., Vikram Patel, Ph.D., M.B.B.S., Daisy R. Singla, Ph.D., Pamela Yvonne Collins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe what “task-sharing” describes and several examples of research on its effectiveness; 2) Give an example of efforts to apply task-sharing in US contexts; and 3) Describe obstacles and/or opportunities for mainstreaming psychiatrist task-share roles in US.

SUMMARY:

Psychiatry is ready for new tools and energized purpose. While the profession begins to recognize the neglected necessity to address social determinants and the priority to close yawning treatment gaps especially in ways that move more “upstream,” specific roles for psychiatrists to substantively do that in practice, lag. Innovation in the Global Mental Health field has on the other hand, flourished. A deep evidence base referred to as “task-sharing” shows how clinicians can partner with and help grow the capacity of community members to use a wide range of skills to directly do the frontline work of mental health care, prevention, and promotion. Amid skyrocketing levels of measured despair, distress, and care gaps in this country driven largely by social adversity, divisions, violence, and trauma that may only accelerate, a serious look at such a role is ever more urgent, if not long overdue. This panel will explore and review the basic evidence and prominent developments behind this approach as well as examples of its application in the US. It poses the question of why not a new normal here? What are the obstacles and opportunities? How might this approach move our profession and its impact especially at a time of multiplying challenges that threaten the emotional wellbeing and resilience of the country?

Maps, Games, and Formulations: Educating Trainees and Faculty to Address Social Determinants of Mental Health

Chair: Ana Ozdoba, M.D.

Presenters: Paul Rosenfield, M.D., Sarah Mohiuddin, M.D., Brigitte Bailey, M.D.

Discussant: Melissa Arbuckle, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define social determinants of mental health and demonstrate how they contribute to mental illness severity and health disparities; 2) Understand the importance of teaching psychiatry trainees how to assess and address social determinants of mental health; 3) Explore different interactive teaching strategies utilized by residency training programs nationally to teach trainees how to assess social determinants of health and consider their impact on case for; 4) Discuss some of the opportunities and challenges addressing social determinants of health in the clinical setting; and 5) Discuss the importance of implementing training on the social determinants of mental health training for all mental health providers.

SUMMARY:

As mental health providers, it is essential to understand how social determinants of mental health play an important role in the lives of those struggling with mental illness. Social determinants of health and structural racism have affected the lives of our patients and introduce disproportionate medical and mental health risks. This makes it essential for us, as psychiatrists, to assess and address social determinants of mental health in clinical practice. Residency training programs have increased their efforts to address social determinants of health and how these impact daily life and mental health treatment. This general session aims to share how residency training programs across the country are tackling the task of including social determinants of health as part of the discussion in assessing and treating patients with mental illness. We will review the creative approaches used in residency training programs across the country, including our four programs: Adult Psychiatry Programs at Mount Sinai

Morningside/West and Montefiore Medical Center, and Child and Adolescent Programs at the University of Texas Health, San Antonio, and University of Michigan Health System. We will share how community mapping can be used as a way to explore social determinants of health and understand how these impact the patients and their psychiatric treatment. We will discuss the role of racism, bias, and social structures, which together with social determinants of health, impact the outcomes for our patients. We will also provide techniques of how to use community mapping in the therapeutic space with the patients. We will discuss how to incorporate the social determinants of health as part of your biopsychosocial formulation and part of your treatment planning. We will share creative approaches to discussing social determinants of health, using a game created at one of our residency training programs and incorporating community tours to understand the strength of our surrounding communities. Finally, we will discuss challenges our programs have encountered when teaching about social determinants of health. These concepts and strategies will be shared to help introduce mental health providers in the clinical setting on how to incorporate social determinants of mental health into clinical assessments and management of our psychiatric patients for both trainees and faculty.

Mental Health During the COVID Pandemic: A View From Three World Regions

Chairs: Bernardo Ng, M.D., Edmond H. Pi, M.D.

Presenters: Gautam Saha, M.D., Doug Urness, M.D., Sebolelo Letshego Seape, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Get an international perspective of mental health issues during the COVID-19 pandemic; 2) Understand the mental health service activity in Australia; 3) Have a view of the mental health challenges in India; 4) Understand the steps taken to address the pandemic in Canada; and 5) Learn the mental health challenges in South Africa during the pandemic.

SUMMARY:

It was recognized early on, that virus spread measures to contain the pandemic, would come with an inevitable impact in the mental health of citizens worldwide. Measures such as quarantine, lockdown, social distancing, travel bans, use of a mask, home office, and distant learning; indeed had an impact in the emotional, cognitive, and behavioral function of us all. On the other hand, the stress related to the rapid initial increase in hospitalizations and deaths, due to a partial understanding of the virus pathophysiology added to the strain in the mental health of healthcare personnel and entire societies. The challenge of successful treatment development and the race for a vaccine, created a scenery where science, politics and public health policies collided. Society's response to the financial crisis, acceptance of the vaccine, return to on-site work, sometimes with fear and others with disbelief, have been frequent issues in the clinical world. The CNS effects of the acute viral infection and the neuropsychiatric sequelae remain a matter of study and concern. Crisis support services and telephone hotlines, quickly witnessed and increased demand for services, and telepsychiatry emerged as an unexpected protagonist of the dominant environment, allowing mental health specialist to fill a growing demand of services, during a pandemic that is yet to be controlled. These phenomena varied across the world, and this Presidential Session presents a perspective from four different areas in the world. These are Australia, Canada, India, and South Africa. The demand for services, and the challenges to meet such demand will be presented by the Presidents of the Royal Australian and New Zealand College of Psychiatrists, the Canadian Psychiatric Association, the Indian Psychiatric Association, and the South African Society of Psychiatrists, with their various perspectives.

PRESENTER UPDATE: Vinay Lakra will no longer present.

Public Mental Health in the UK

Chair: Adrian James, M.B.B.S.

Presenters: Trudi Seneviratne, Subodh Dave

Discussant: Rebecca W. Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the impacts of mental disorder and wellbeing, and how its determinants cluster in higher risk groups; 2) understand the existence of effective interventions to prevent mental disorder and promote mental wellbeing, as well as treat mental di; and 3) understand the public mental health implementation gap and how to go about assessing it.

SUMMARY:

Giving a first-hand UK perspective, the Officers of the Royal College of Psychiatrists will discuss public mental health and prevention. They will look at how social determinants and risk factors influence the risk of mental disorder, as well as their tendency to cluster in particular higher risk groups. Effective interventions exist to address determinants to prevent mental disorder, but also treat mental disorder and promote mental wellbeing and resilience. However, only a minority of people with mental disorder in the UK receive treatment, with far less coverage in Lower- and Middle-Income Countries. Even less coverage occurs for interventions to prevent associated impacts of mental disorder such as premature mortality, with negligible coverage of interventions that address determinants to prevent mental disorder, or promote mental wellbeing and resilience. This implementation gap results in scale population suffering, broad preventable impacts across sectors, associated economic costs and breaches to the right to health. The Sustainable Development Goal of universal coverage by 2030 includes mental disorder treatment and prevention, and wellbeing promotion. The World Health Organisation's Mental Health Atlas (2021) highlights that mental health targets can be reached by 2030 only if there is a collective global commitment to make huge investment and expanded efforts at country level. The Officers will demonstrate the role the College are playing in this, through the Public Mental Health Implementation Centre which is supporting scale implementation, and also targeting higher risk groups to prevent widening of inequalities. It will also look to how the College is meeting the twin demands of personalised

care and public mental health through training and assessment.

Race and Excellence: The Continuation

Chair: Cynthia Turner-Graham, M.D.

Presenters: Cynthia Turner-Graham, M.D., Rahn K. Bailey, M.D., Ezra E. H. Griffith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Integrate knowledge of current psychiatry into discussions with patients; and 4) Identify barriers to care, including health service delivery issues.

SUMMARY:

We understand as psychiatrists the psychodynamics that support maintenance of a status quo, healthy or unhealthy. We understand the recalcitrance of repetition compulsions where we continually recreate the past in one's present. Yet we find it difficult as fellow psychiatrists and human beings to see ourselves with propensities to remain the same despite heroic efforts to change and grow. The current situation within our ranks around DEI issues, if sustained, we believe will not serve the mission of APA long term. The book penned by our own Ezra Griffith, *RACE AND EXCELLENCE: My Dialogue with Chester Pierce*, published in 1998 provides a unique perspective on the lives of two notable African American psychiatrists who rigorously grappled with these issues - Dr. Griffith himself and that of his colleague and mentor, Dr. Chester M. Pierce. Through the eyes of these consummate professionals, we can look at life and the practice of psychiatry, a lens with which we can all relate. However, the perspectives of diverse groups of psychiatrists on the realities of race and racism, remain widely divergent To bridge this gap, we posit that there is a need for *language* and *a set of interpersonal skills* to support the continuation of difficult conversations beyond our usual places of impasse. Achieving this will require individual investments of time and energy in order to effect meaningful change within ourselves and our organization. We believe that this can be achieved,

and that deeper mutual understanding can be cultivated to move us forward toward constructive intrapersonal and interpersonal change and growth.

Racism: The Social Determinant of Mental Health

Chair: Akeem N. Marsh, M.D.

Presenters: Lara J. Cox, M.D., Akeem N. Marsh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the concepts of implicit bias and systemic racism and describe real-world examples of racism's impact on medical and psychiatric history; 2) discuss the bias inherent in certain psychiatric terms and diagnoses, and evaluate biases in their application and use; 3) define the concept of racism-related trauma and explore its impact on an individual, including both internalizing and externalizing sequelae; 4) describe the detrimental effects of racism and implicit bias at multiple levels, from in-the-moment interactions between MD and patient to population health to the ramifications for society as a whole; and 5) identify the role of systemic racism and implicit bias in our own clinical thinking and practice, and examine how they may manifest in our interactions with patients and colleagues.

SUMMARY:

Recent events have forced us to confront the ugly truth that racism is ever-present. We often define racism as an explicit belief that one racial group is inferior, along with words and actions that stem from that belief, but structural and systemic racism are far more insidious. They are a blend of policies, ideas, norms, and institutional practices that are deeply woven into the fabric of society and reinforce inequities between racial groups. The so-called risk factors termed social determinants of mental health are direct sequelae of historical structural and systemic racism. Regardless of our own identities, we are all affected by the elements of racism embedded in our lives and bodies. The essence of racism-related trauma is the gross violence and injustice we experience, our strong emotional responses, and their profound impact on our collective mental health. While there is a broad range of posttraumatic reactions to the ongoing

intergenerational complex trauma of racism, oppression, and colonialism, many of these responses go unrecognized as such. In addition, by the act of other-ing, we limit our opportunities for connection and our understanding of the breadth and depth of human experience. As physicians, we took an oath to do no harm. Most of us reject explicit racism and would never think of ourselves as racist. But implicit bias is not conscious. It is an automatic association between an attitude, idea, or stereotype and a group of people, activated without intention or conscious control. It operates outside of our awareness, meaning stereotype-confirming thoughts pass through our minds unnoticed to affect our decisions and behavior. This allows systemic racism to influence us, leading us to perpetuate disparities even if we are consciously opposed to racist ideology. Given the history of racism in medicine and the physician-patient power dynamic that is especially salient for patients of color, we can enact and perpetuate systemic racism regardless of our identity or intent. As psychiatrists, we must examine the influence of racism on our own practice. It is imperative for us to be able to discuss these issues with our patients in a realistic, respectful way. We must also engage our colleagues in open dialogue about the role of racial bias in our clinical thinking and behavior. In doing so, we better serve our patients and further our growth as clinicians and as people. This session provides context for racial disparities in mental health by reviewing the true source of so-called risk factors that disproportionately impact communities of color. Grounded in principles of social justice and racial harmony, clinicians will understand the influence of racism and related trauma and be encouraged to examine their role in our field and their own clinical practice. Presenters will discuss strategies for coping with racial trauma and talking with patients and colleagues about race and identity, as well as ways to help promote racial healing.

Reconsidering Conversations Between Ezra Griffith and Chester Pierce: Dr. Cynthia Turner Graham

Interviews Dr. Ezra Griffith, Author of *Race and Excellence: My Dialogue With Chester Pierce*

Introduction: Vivian Pender, M.D.

Chair: Constance E. Dunlap, M.D.

Presenters: Ezra E. H. Griffith, M.D., Cynthia Turner-Graham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be familiar with the history of the Black Psychiatrists of America and the circumstances of its inception; 2) Identify modern day manifestations of structural racism in academic and clinical settings; 3) Know how racial aggression manifests in clinical settings; and 4) Develop more effective tools for securing one's own emotional safety.

SUMMARY:

In 2017, the APA Human Rights Award was renamed to honor Chester M. Pierce, MD and, in 2021, the award was endowed by the APA Foundation with the generous support of his colleagues, friends and family. Dr. Pierce was a pioneering clinician, human rights advocate, and visionary with great ambitions for humankind. He was always focused on the possibilities for excellence. The term "microaggressions" grew out of his research experience and since the 1970s has been a part of the American lexicon. The average psychiatrist should know more about Dr. Pierce's life and work. He was the founding president of the Black Psychiatrists of America (BPA), an organization whose formation and history are closely tied to that of the American Psychiatric Association (APA). Protégé, former BPA President, and Professor Emeritus of Psychiatry and African American Studies at Yale, Dr. Ezra Griffith, penned a unique biography, *Race and Excellence: My Dialogue with Chester Pierce* in 1998. A pioneering psychiatrist himself, Dr. Griffith has given us a unique gift, the result of a series of conversations between himself and Dr. Pierce. Here is a brief comment on the text: In *Race and Excellence*, Ezra Griffith, also an African American professor of psychiatry, engages Pierce in a dialogue with the goal of clarifying the inter-connection between the personal and the professional in the lives of both black scholars. The text melds the story of Pierce's life and his achievements, with particular attention to his theories about the predictable nature of racist behavior and the responses of oppressed groups.

Having earned his doctorate a generation after Pierce, Griffith approaches his conversation with Pierce as a face-to-face meeting between mentor and student. Retelling Pierce's life story ultimately becomes for Griffith an exercise in conceptualizing his own experience. As he writes, "I never just wanted to tell Chet's story; I wanted to work his story out, to measure it, to try it on, to figure out which parts are good for me and other blacks so earnestly seeking heroes." Dr. Cynthia Turner Graham, a Distinguished Life Fellow of the APA and current president of the BPA, interviews Dr. Griffith in this session. Together they will explore and elaborate on poignant aspects of Dr. Pierce's life and work. The timing of this dialogue coincides with current sociohistorical events. The gains of the 20th century seem to be eroding quickly and racial aggression is less often experienced as being "micro" in nature. In this conversation, they will focus on several themes: 1) Lessons to be gleaned from Dr. Pierce's journey as a psychiatrist; 2) APA's role in this most recent iteration of racism that we are experiencing and witnessing; 3) Steps toward dismantling structural racism in medicine; 4) Current relevance of Dr. Pierce's concept of microaggressions; 5) Reconsidering Dr. Pierce's candor about protecting himself in predominantly White environments such as Harvard – current significance

Wednesday, May 25, 2022

International Social Determinants of Health as Displayed in Psychiatric Emergency Services: Relevance to Patients

Chair: Tsuyoshi Akiyama, M.D., Ph.D.

Presenters: Mary Jo Juneau Fitz-Gerald, M.D., Masaomi Iyo, M.D., Ph.D.

Discussant: Vivian Pender, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn the social determinants of health displayed in psychiatric emergency rooms in the United States, Japan, and other countries.; 2) Learn that the role of the psychiatric emergency department may be affected by community mental health care systems, health insurance system, substance use/misuse, and economic conditions.;

and 3) Learn the relevance of the social determinants to the usage of psychiatric emergency services by the patients..

SUMMARY:

Japan, the number of patients who receive psychiatric emergency services has been decreasing. This may be because patients, including those under social welfare, can easily access psychiatrists, there being many psychiatric clinics and more than 1,000 psychiatric hospitals. And Japanese health insurance allows up to a mean length of nearly 60 days of stay at a psychiatric emergency hospital. Therefore, patients may see psychiatrists before becoming emergency cases and can stay at the psychiatric hospital until the symptoms improve substantially once admitted. This helps to avoid revolving-door phenomena. The number of people who experience substance use in Japan is only about 3% of those in the U.S. However, there exists a shortage of child psychiatrists. Also, the treatment for patients with physical complications has been an issue. This may be because most psychiatric emergency hospitals do not have substantial services for physical complications, and most general hospitals do not have enough psychiatric staff. In the United States, emergency rooms have become the *de facto* treatment facility for psychiatric patients who cannot locate a psychiatrist or psychiatric inpatient care due to a lack of insurance and a lack of inpatient psychiatric beds. As the emergency departments become overwhelmed with psychiatric patients, care of the medically ill in the emergency department may suffer because all emergency beds are utilized by psychiatric patients. Some emergency rooms may not have access to a psychiatrist in the community. The patient may not be able to afford appropriate medications or find an outpatient psychiatrist in a timely manner. In other countries, a lack of psychiatrists for a large population may lead to overwhelmed emergency resources. Culture, including religion and the stigma of mental illness, also influences the utilization of psychiatric emergency care. One survey in America reports that the consumers stressed the importance of the treatment with respect, the collaborative approach, the oral medication use guided by the consumer's problems, the development of alternatives, more comfortable physical environments, and increased

use of peer support services. One-fifth attributed their emergency contact to a lack of access to more routine mental health care. In Japan, at the government council on psychiatric emergency service, the patients stressed the diminution of the involuntary nature, provision of outreach type of emergency services, and regular inclusion of patient-members in the council. In Singapore, NGOs provide services so that the patients can decrease the unnecessary usage of emergency services. In Canada, patients complain that their physical complaints are not taken seriously in the emergency room. The influence of social and clinical determinants on the usage of psychiatric emergency services seems universal.

Methamphetamine Use Disorder and Treatment Updates in the Context of COVID-19 and the Opioid Epidemic

Chair: Larissa J. Mooney, M.D.

Presenters: Frances Rudnick Levin, M.D., Helena B. Hansen, M.D., Ph.D., Dominick DePhillippis, Ph.D.

SUMMARY:

Methamphetamine use is a growing public health concern in the U.S., producing increasingly severe consequences including use disorder and overdose deaths (Twillman et al., 2020). Fewer than 32% of at least 1.6 million individuals who need treatment each year for methamphetamine use disorder receive any treatment (Jones et al., 2020), and a significant proportion have co-occurring psychiatric disorders or symptoms (Glasner-Edwards et al., 2009). The intersection of methamphetamine use with the U.S. opioid epidemic presents a specter for clinicians and policymakers struggling to address the growing consequences of these mutually deleterious conditions; inadvertent or intentional co-use of methamphetamine with opioids including fentanyl (and its analogues) yields potentially dangerous consequences (Ciccarone 2021; Jones et al., 2020). Comprehensive approaches are needed to reduce harms associated with methamphetamine use, including among individuals with OUD (Tsui et al., 2020), but significant barriers to treatment remain and are impacted by health disparities. Reduced healthcare services and other limitations resulting from the COVID-19 pandemic have exacerbated the

difficulty of treating individuals with methamphetamine use disorder and other comorbidities. This symposium will first present the epidemiology and scope of the methamphetamine problem in the U.S. and its increasing prevalence among persons who use opioids, with additional impacts on the opioid crisis. It will then discuss evidence-based treatment approaches for methamphetamine use disorder, including behavioral and pharmacological treatment interventions. It will review social determinants of health (SDoH) that impact SUD treatment access and overdose deaths. Specifically, (1) Dr. Larissa Mooney will provide an introduction and overview of methamphetamine use in the context of the U.S. opioid epidemic and the COVID pandemic, medical and psychiatric consequences of co-use of methamphetamine and opioids, and provision of integrated treatment for both disorders. (2) Dr. Frances Levin will review medications that have been studied for the treatment of methamphetamine use disorder, those that have shown promise, and practical clinical recommendations using pharmacologic interventions. (3) Dr. Dominick DePhilippis will present the evidence supporting Contingency Management (CM) for treating stimulant use disorder, including CM for individuals on medication treatment for OUD. He will discuss the potential utility of digital healthcare delivery techniques (i.e., apps) in making CM readily accessible and the role they can play in customizing schedules of CM reinforcement. (4) Dr. Helena Hansen will then review the role of social determinants of health in the methamphetamine+opioid crisis and how addressing social determinants may improve treatment outcomes and reduce health disparities related to SUDs and overdose.

The Psychedelic Revolution in Psychiatry

Chair: Richard Doblin, Ph.D.

Presenter: Julie A. Holland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) learn the mechanism of action of various psychedelics, such as MDMA and psilocybin; 2) learn how psychedelics would be

regulated, post-FDA approval; 3) understand the latest data for Phase 2 and Phase 3 studies of psychedelics; 4) review the risks of using psychedelics as tools for psychotherapy; and 5) understand the training options for psychedelic therapists.

SUMMARY:

Psychedelic-assisted therapies warrant serious consideration for treatment of mental health conditions with substantial impact on daily functioning. Previous research has led to the U.S. FDA's Breakthrough Therapy Designation of 3,4-methylenedioxymethamphetamine (MDMA) as for treatment of PTSD and psilocybin for treatment of Major Depressive Disorder (MDD) and Treatment Resistant Depression (TRD) when administered as an adjunct to therapy. This workshop will cover recent findings from modern Phase 2 and Phase 3 trials assessing the efficacy and safety of psychedelic-assisted therapies administered under direct observation for treatment of PTSD, TRD, MDD. Risk management procedures supporting the safety profile of these studies before, during, and after dosing sessions will be elucidated. Adverse events (AEs), concomitant medications, and suicidal ideation and behavior will be summarized. Generally, psychedelic-assisted therapies were well tolerated in a complex patient population with high background event rates, with some treatment emergent AEs occurring after dosing sessions. The panelist will present important considerations for development of clinical practice guidelines for psychedelic-assisted therapies and their placement within the treatment journey of these patients. If Phase 3 results confirm that psychedelic-assisted therapies significantly attenuate symptomatology of serious mental health diagnoses, these results will form the basis for marketing authorization applications worldwide. Risk/benefit considerations and cost effectiveness analyses will be presented. Training requirements for risk mitigation by prescribers and other healthcare providers developed during the Clinical Development Program will be discussed.