

AMERICAN  
PSYCHIATRIC  
ASSOCIATION



# IPS: THE MENTAL HEALTH SERVICES CONFERENCE

October 4-7, 2018 • Chicago



Syllabus and Proceedings

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Courses

Thursday, October 04, 2018

**Buprenorphine and Office-Based Treatment of Opioid Use Disorder**

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

Faculty: *Petros Levounis, M.D., Andrew John Saxon, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss the rationale and need for Medication-Assisted Treatment (MAT) of opioid use disorder; 2) Apply the pharmacological characteristics of opioids in clinical practice; 3) Describe protocols of treatment for buprenorphine and other forms of MAT and protocols for optimal patient/treatment matching; 4) Describe the legislative, logistical and regulatory requirements of office-based opioid pharmacotherapy; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women and patients with acute and/or chronic pain.

**SUMMARY:**

The course will describe the resources needed to set up office-based treatment with buprenorphine and naltrexone for patients with opioid use disorder and will review 1) DSM-5 criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality regulations related to treatment of substance use disorders; 3) Drug Enforcement Administration requirements for prescribing opioids for the treatment of OUD and for record keeping; 4) staffing requirements, billing, and common office procedures; 5) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, ADHD, and how to distinguish independent psychiatric disorders from substance-induced psychiatric disorders; and 6) common clinical events associated with addictive behavior, including relapse, medication diversion and disruptive behavior. Special treatment populations, including adolescents; pregnant women; and geriatric, HIV positive, and chronic pain patients will be addressed, and small-group case discussions will be used to reinforce learning.

Friday, October 05, 2018

**2018 Psychiatry Review and Clinical Synthesis**

Directors: *Philip R. Muskin, M.D., M.A., Tristan Gorrindo, M.D.*

Faculty: *Ilse R. Wiechers, MaryBeth Lake*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify gaps in knowledge in psychiatry and neurology through self-assessment; 2) List key diagnostic and treatment strategies for major disorders in psychiatry; 3) Create individual learning plans for addressing knowledge gaps; and 4) Convey a working knowledge of the various topical areas likely to be encountered during lifelong learning activities.

**SUMMARY:**

Using a “flipped classroom” design, participants will engage in a multi-week self-study exercise designed to increase knowledge and critical reasoning of essential psychiatric and neurology topics. The first book, Study Guide for the Psychiatry Board Examination, consists of several hundred self-study multiple-choice questions (MCQ) including answers and explanations. The second book is a curated compendium of review articles from FOCUS: The Journal of Lifelong Learning, which have been compiled to summarize current diagnostic and treatment approaches for major disorders in psychiatry. The third text is Approach to the Psychiatric Patient, a case-based exploration of psychiatric topics. Course participants are encouraged to use these materials to review major topics in psychiatry prior to attending IPS: The Mental Health Services Conference. During the live portion of this course, participants will work in small groups and with expert faculty in general psychiatry, geriatric psychiatry, child psychiatry, and consultation-liaison psychiatry to complete a series of case-based vignettes that have been designed to illustrate high-yield and key learning points for major disorders in psychiatry. This four-hour clinical synthesis session is designed to help learners integrate and apply knowledge through clinical vignettes and to reinforce key principles in psychiatry.

## **Good Psychiatric Management for Borderline Personality Disorder**

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

Faculty: *Victor Hong, M.D., John Gunder Gunderson, M.D.*

### **EDUCATIONAL OBJECTIVES:**

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

### **SUMMARY:**

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

## **Pediatric Psychopharmacology**

Director: *John T. Walkup, M.D.*

Faculty: *Thomas K. Cummins, M.D., Julie Sadhu, Rachel R. Ballard, M.D., Nicholas M. Hatzis, M.D.*

### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss the assessment of aberrant behaviors associated with Autism Spectrum Disorder and the evidence base for their psychopharmacological treatment; 2) Describe the diagnostic assessment of attention deficit hyperactivity disorder and its treatment with stimulants and non-stimulant medications; 3) Recognize the developmental stages and ages of risk for anxiety and depressive disorders in children and adolescents; 4) Recognize elements of treatment of anxiety and depression in children and adolescents that differ from treatment of these disorders in adults; and 5) Discuss the presentation, evaluation, differential diagnosis and treatment of psychotic symptoms in younger people including similarities and differences when compared to adults.

### **SUMMARY:**

With respect to autism spectrum disorder, this course will review the evidence for the use of psychopharmacological interventions in treatment of aberrant symptoms associated with ASD that include attentional symptoms, hyperactivity, anxiety, depression, and transdiagnostic symptoms including social communication and thinking, irritability, repetitive behaviors, and insomnia. With respect to ADHD, the course will describe how a proper ADHD assessment requires sensitivity to the age and developmental status of the child, teen, or young adult and the translation of the assessment into treatment selection and monitoring of stimulant and non-stimulant medications. With respect to anxiety disorders, the course will describe the cognitive and behavioral aspects of anxiety and depression as they appear in children and the role of family interactions in reinforcing or mitigating symptoms. Evidence-based treatments for anxiety and depression in children and adolescents, highlighting distinctions from adult practice, will be discussed. With respect to new-onset psychosis, the course will review the similarities and differences in presentation in

adolescents as compared to adults, the diagnostic assessment and medication treatment selection, and adverse event monitoring.

### **Transgender Mental Health 101**

Director: *Eric Yarbrough, M.D.*

Faculty: *Sarah C. Noble, D.O., Amir K. Ahuja, M.D., Gilbert A. Smith, D.O., Angeliki Pesiridou, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the gender spectrum and gender diversity; 2) Understand gender dysphoria as a diagnosis and when to use it; 3) Review gender-affirming psychotherapy; 4) Review hormone treatment options with detailed instruction; and 5) Review gender-affirming surgeries and how to screen for them.

#### **SUMMARY:**

Transgender and gender non-conforming people (TGNC), for better or worse, are now in the midst of national political and social spotlights. For the first time in history, large portions of the world population are aware gender diverse people exist. Those who don't fit neatly into the gender binary are marginalized and shunned from public society. Most cultures have little tolerance for those who don't follow general social gender norms. The growing number of gender diverse people in the world is something of a misconception. Gender diverse people have existed as long as people have existed. Greater society now being aware of them is mostly due to increasing safety and acceptance by communities. This was partly accomplished through advocacy organizations educating policy makers, research and scientific organizations educating clinicians, and, to a greater extent, the media of movies and television educating the general public. Regardless of the reason, gender diverse people are now feeling more comfortable to come out and express their gender identity. Now that so many people are aware of the TGNC population, they are having more reactions to being around those who are gender diverse. Seeing people who are not like ourselves makes us question our own sense of self. The presence of TGNC people has encouraged others to examine their own gender and the gender of others. Ideas about what is masculine and feminine

are being called into question, and even those who do not necessarily identify as gender diverse are still bending gender with the way they dress, how they talk, and the activities they participate in. Society is being forced to look at the historical institution of gender now more than ever. Despite the growing presence of gender diverse people in the media, the medical and mental health communities' responses have been lacking. Gender clinics sparsely populate large urban areas, and those tend to be over capacity with referrals of gender diverse people seeking care. The great majority of patients needing treatment either get poor treatment from those who are not TGNC-competent or simply don't seek services out of frustration and an inability to connect with clinicians who work with and understand gender diversity. It is now time to train all mental health clinicians to understand and work with gender.

Saturday, October 06, 2018

### **Emergency Psychiatry: The Basics and Beyond**

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

Faculty: *Leslie Zun, M.D., M.B.A., Jon Scott Berlin, M.D., Scott L. Zeller, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand key elements of the medical workup for behavioral emergencies; 2) Understand key elements with psychiatric evaluation to help determine risk; 3) Learn ways to develop engagement--even in an emergency setting; 4) Understand the thoughts behind when to give versus hold meds; and 5) Learn ways--pharmacologic and non-pharmacologic--to treat agitation.

#### **SUMMARY:**

No matter in what type of environment you practice psychiatry, you will experience patients who are in crisis. Behavioral emergencies may occur in any setting—outpatient, inpatient, and emergency departments, as well as in the community. When psychiatric emergencies do occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes

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

### **Marijuana and Mental Health**

Director: *Thida Myo Thant, M.D.*

Faculty: *Marc W. Manseau, M.D., M.P.H., Erica Kirsten Rapp, M.D., Taylor Mac Black, M.D., Laura F. Martin, M.D., Matthew R. Shirazi, M.D., M.S.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify various dispensary and pharmaceutical formulations of medical marijuana as well as synthetic cannabinoids; 2) Describe how cannabis use impacts psychiatric illnesses including

mood disorders, anxiety and psychosis; 3) Understand differences between some medical marijuana programs as well as the current state and implications of current legislation; and 4) Know treatments for acute cannabis intoxication and cannabis use disorder.

#### **SUMMARY:**

Marijuana use is a controversial topic across the United States. Opinions about marijuana can range from it being a harmless natural plant with medicinal value while others view it as a substance of abuse with overstated benefits and understated risks. Despite the classification of marijuana on a federal level, marijuana use is becoming legalized by states across the U.S. and highlights the ambivalence about marijuana in our society. Research currently suggests increased teenage and adult use of marijuana in states with legalized medical marijuana with noted harmful effects for adolescents and those with psychotic spectrum disorders. With the increasing prevalence and availability of marijuana products, medical providers will need to become more informed and well-versed about marijuana beyond the scope of addiction. This course will familiarize attendees with this new culture of legalized medical marijuana and its implications for psychiatry and will feature presentations on 1) an overview of why it is important for psychiatrists to understand marijuana; 2) medical marijuana, including pharmaceutical and dispensary formulations, brief overview of the relevant neurobiology, dosing, interactions, and monitoring; 3) synthetic cannabinoids, including physiological, physical, and psychiatric effects; 4) psychiatric complications of cannabis use, including impact on anxiety and mood disorders; 5) marijuana and psychosis; 6) legislation and policy related to medical marijuana; and 7) the treatment of cannabis use disorder, including psychotherapeutic and pharmacological interventions.

#### **Forums**

Thursday, October 04, 2018

### **Do Organized Minority/Underrepresented Groups Make a Difference in Promoting Health Equity and Diversity in Leadership?**

Chair: *Ramaswamy Viswanathan, M.D., D.Sc.*

Presenters: *Ranna I. Parekh, M.D., M.P.H., Christina V. Mangurian, M.D., Ubaldo Leli, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Know the history of minority and under-represented (MUR) groups in the APA, and know about the components addressing MUR needs in the APA; 2) Know the diversity leadership and mentoring opportunities provided by the APA; 3) Know the challenges for inclusion faced by various MUR psychiatrists and patients; 4) Develop ideas for reducing health disparities; and 5) Develop ideas for fostering professional, academic and organizational growth of MUR psychiatrists.

**SUMMARY:**

The United States is a nation of immigrants which owes its economic strength and leadership in innovations to the diversity of its population. However in many organizations including the APA, historically the diversity of members was not reflected in the leadership. The APA recognized this and has taken several initiatives over the years to mentor ethnic minority and other underrepresented (MUR) groups into leadership positions. This has borne some fruit as exemplified by the Association's election of its first black president, and we are privileged to present during the first major meeting of our organization under her presidency. We have witnessed the election to presidency of women, and psychiatrists from Gay, Hispanic, International Medical Graduate (IMG) and Asian American groups. We have seen psychiatrists from various MUR groups in several other leadership positions, in the APA and in several other professional, clinical and educational organizations. The APA has also tried to address disparities in access to healthcare among MUR patients. A major way the APA has tried to address the above has been through formation of a Council on Minority Mental Health and Health Disparities, and seven MUR caucuses with representation in the APA Assembly: Asian American, Black, Hispanic, IMG, LGBT, Native American, and Women. In this workshop we will review the history of diversity development in the APA and its fruits. The APA and the APA Foundation have also provided mentoring Fellowships to trainees with emphasis on diversity in awardees and

the patient population served. In this workshop we will discuss the history and structures described above, and explore the following: How effective the above measures have been in promoting health equity in MUR patient populations, and equity in career development for MUR psychiatrists? Do MUR group members feel sufficiently included in the APA and in its district branches (DBs)? Do all MUR group members relate well with the APA and the DBs, or are there differences? How included do MUR psychiatrists in the public sector feel in main stream psychiatric organizations? What do MUR leaders need to do to improve MUR caucus participation, help educate MUR psychiatrists, and help them be more proactive in their own career development and inclusion, and to improve minority health and women's health?

**Law Enforcement-Mental Health Interactions and the Crisis Intervention Team (CIT) Model**

Chair: *Abhisek Chandan Khandai, M.D., M.S.*

Presenters: *Amy Watson, Ph.D., Michael T. Compton, M.D., M.P.H., Philip G. Janicak, M.D., Antoinette Ursitti*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the acuity and complexity of mental health-related police calls, and the experience of both police officers and persons living with mental illness in such encounters; 2) Discuss the history and structure of the Crisis Intervention Team (CIT) law enforcement-mental health collaboration model; 3) Review existing research on the efficacy of CIT for patients and police officers; and 4) Discuss various ways providers can collaborate in law enforcement-mental health interactions, including research, education and advocacy.

**SUMMARY:**

The fractured mental healthcare system and continuing degradation of the social safety net underscore the importance law enforcement interactions with persons with mental illness. This is further complicated by increased media attention. In response, the Crisis Intervention Team (CIT) model was developed as a specialized police-based program to enhance officers' interactions with

individuals with mental illness and ultimately reduce law enforcement involvement by partnering with mental health services to develop a more comprehensive crisis response system. Its aims are to improve officer and patient safety, enhance access to mental health services, and reduce unnecessary arrest and incarceration. The CIT model is increasingly utilized by departments across the country, including the Chicago Police Department (CPD). CIT training provides officers with 40 hours of classroom and experiential de-escalation training during mental health crises. Officers then serve as specialized front-line responders for mental health police calls in the community. CIT can increase police officers' knowledge of mental health topics and de-escalation techniques, decreasing the likelihood of arrest and increasing referrals of patients with mental illness to appropriate treatment venues (1,2,3). This forum will discuss the law enforcement-mental health interface, including subjective experiences of both police officers and patients living with mental illness. In this context, we will provide an overview of CIT's history and structure, and a critical appraisal of the research on the benefits of CIT for police officers, patients, and the community. During a panel discussion with researchers, professionals who have taught in CIT programs or undergone CIT training themselves and law enforcement members, we will discuss opportunities for mental health providers to collaborate with CIT programs in their communities.

Friday, October 05, 2018

**Creating Your Voice: A Guide to Publishing in Psychiatric Services and the Community Mental Health Journal**

Chair: *Lisa Dixon, M.D.*

Presenter: *Jacqueline M. Feldman, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) To understand the different types of Psychiatric Services submissions and the Community Mental Health Journal and their requirements; 2) To be able to match different types of article ideas to the appropriate submission category; and 3) To have greater knowledge and skills in creating publishable articles.

**SUMMARY:**

Writing for professional journals and other outlets can increase your professional impact and reputation. Clinicians who adopt a scholarly and empirical approach and who are astute observers can publish successfully. Research articles have one set of fairly standard requirements. However, many journals, including Psychiatric Services and the Community Mental Health Journal (CMHJ), publish papers with different demands and review criteria. For example, Psychiatric Services also publishes columns in a wide variety of areas, from financing and policy issues to integrated care to research and services partnerships. Frontline reports showcase innovative new programs. Understanding the criteria and how to adapt and present your ideas within different formats will increase your success in publishing. In this workshop, the editors of Psychiatric Services and of the CMHJ will present the parameters of the different types of articles published in the respective journals. In Psychiatric Services, regular articles and brief reports present the results of original research. In general, regular articles should not exceed 3,000 words, excluding abstract, references, and tables and figures. Brief reports should be a maximum 1,800 words (excluding abstract, references, and table), plus no more than 15 references and one table or figure. If you do not conduct research, other types of submissions may be appropriate. Provocative commentaries of 750 words maximum are invited for Taking Issue. Authors may also submit commentaries of 1,200 to 1,600 words and no more than 15 references for the Open Forum section. Psychiatric Services columns should not exceed 2,500 total words, including text, no more than 15 references, and an abstract of no more than 100 words. The CMHJ does not have specific columns, but often publishes themed issues related to public and community psychiatry, and is working to enhance submissions from international authors. The workshop will review several examples of the evolution and review process of different article types. The workshop will then allow small group discussion of participants' publication ideas. The workshop will teach attendees how to determine what is the best fit for their publication idea and what steps are needed to publish successfully.

Workshop attendees will have the opportunity to meet members of the Psychiatric Services editorial board, and with the Editor of the CMHJ.

**Physician Wellness and Burnout: A Town Hall Discussion With APA Leadership**

Chair: *Richard Fredric Summers, M.D.*

Presenters: *Saul Levin, M.D., M.P.A., Altha J. Stewart, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Assess their own degree of wellbeing and/or burnout; 2) Recognize the primary drivers of burnout for psychiatrists; 3) Identify potential interventions for enhancing wellbeing in their work setting; and 4) Increase their sense of participation in a community of psychiatrists through sharing personal experiences of wellbeing and burnout with colleagues.

**SUMMARY:**

This interactive session will provide members with an opportunity to engage the APA Leadership and APA Administration to discuss ways in which the APA can assist members in promoting workplace change to enhance psychiatrist wellbeing and reduce burnout. Data in APA member wellbeing and burnout from the APA Wellbeing Online Assessment Tool will be presented for discussion. There will be an opportunity for members to express their own personal experiences with wellbeing and burnout and to provide feedback on APA efforts in this area, including the APA Wellbeing Ambassadors Toolkit, the PsychPRO registry that can help meet quality reporting requirements, and the recent changes in payment reform that allow for the use of new collaborative care codes. Attendees will be encouraged to share concerns and provide feedback to panelists.

**The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)—Transforming the U.S. Mental Health System Through Federal Leadership: Next Steps**

Chairs: *Kenneth Minkoff, M.D., Saul Levin, M.D., M.P.A.*

Presenters: *Brian Matthew Hepburn, M.D., Joseph John Parks, M.D., Clayton Chau, M.D., Ph.D., Anita Everett, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand ISMICC, why it is important, what it has recommended and how it works; 2) Learn how interdepartmental leadership is making progress to transform the US delivery system for adults with SMI and children with SED, and to identify steps to be involved; 3) Become familiar with the elements of an ideal crisis continuum and how federal/state collaboration can make it happen in every community; 4) Understand how federal/state/local/provider collaborations are beginning to improve access to an effective integrated recovery-oriented continuum across the nation; and 5) Recognize how federal interdepartmental efforts can improve integration of behavioral health services within the health continuum, to improve outcomes and save lives.

**SUMMARY:**

The US system of care for adults with SMI and children with SED is dysfunctional. While there are pockets of excellence, there are many places where the system has dramatic gaps, leading to tragic outcomes (incarceration, homelessness, early death), even more for people who are culturally diverse. Many past efforts at transformation (e.g., New Freedom Commission) resulted in reports and recommendations but little action. Now there is reason for hope. Improving the lives of people with SMI/SED is one issue in Congress for which there has been bipartisan support, as marked by the passage of the 21st Century CURES Act. Congress recognized that one reason for poor performance of the MH system is because the capacity for meaningful interdepartmental Federal leadership has not been developed. Congress created a new position, the Asst Secretary for MH and SUD Services, within HHS, to not only lead SAMHSA but also to have capacity and authority to convene multiple departments to create a coordinated national strategy for change. To help operationalize this, Congress created a new entity, ISMICC, which includes representation from multiple federal departments AND a diverse group of non-federal members. ISMICC is tasked over the



next 6 years to work with the Asst Secretary to identify recommendations for change, help to implement them, and regularly report to Congress on progress. Psychiatrists have a powerful role at the table. The Asst Secretary is a psychiatrist (Dr. McKance-Katz), who works with the SAMHSA CMO, Dr. Everett, who is current APA President. There are two non-federal psychiatry representatives (Dr. Chau and Minkoff) on ISMICC, and opportunities for key partners, including NASMHPD, led by Dr. Hepburn, and National Council (Dr. Parks – Medical Director) to be involved in both recommendations and actions. The first report from ISMICC was issued in Dec, 2017. During 2018, Dr. Everett is tasked with developing an action plan to implement the 45 recommendations in that report. This forum is designed to educate attendees about this important process, and to engage everyone in building a strong collaboration for change. In the forum, Dr. Minkoff will describe ISMICC and review major findings and recommendations in the ISMICC report. Dr. Hepburn will discuss federal/state collaboration and focus on recommendations for developing a national crisis continuum that is effective and responsive. Dr. Parks will discuss partnership with providers for implementing recommendations to improve ACCESS to effective SMI/SED community-based services. Dr. Chau will discuss the integrated continuum of culturally responsive and trauma informed health and BH services to support recovery for those with complex needs. Dr. Everett will describe current implementation progress, and how participants can contribute to success of the transformation. The whole panel will engage participants in discussion about next steps.

Saturday, October 06, 2018

#### **Inside the APA Town Hall**

Chair: *Altha J. Stewart, M.D.*

Presenters: *Saul Levin, M.D., M.P.A., James Robert Batterson, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe initiatives within the APA that are designed to assist members address issues related to payment reform; 2) Describe initiatives within the APA that are designed to assist

members address physician well-being and burnout; and 3) Examine initiatives related to the PsychPRO registry.

#### **SUMMARY:**

This interactive session will provide members with an opportunity to engage members of the APA Leadership and APA Administration to discuss ways in which the APA can assist members in improving their practices, addressing administrative burdens, and addressing issues among physicians related to burnout and well-being. Panelists will discuss how the APA's PsychPRO registry can help meet quality reporting requirements, the efforts of the APA's Workgroup of Psychiatrist Well-Being and Burnout, and recent changes in payment reform that allow for the use of new collaborative care codes. Attendees will be encouraged to share concerns and provide feedback to panelists.

#### **SAMHSA Town Hall: Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) Updates**

Chair: *Anita Everett, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in; the community; 2) Demonstrate and apply new skills that will be useful in public psychiatry settings; 3) Examine how the current health care system affects patient care; 4) Describe how to transform systems of care; and 5) Recognize how to bring new innovations into a variety of treatments to improve patient care.

#### **SUMMARY:**

The ISMICC reports to Congress and federal agencies on issues related to serious mental illness (SMI) and serious emotional disturbance (SED). The ISMICC is composed of senior leaders from 10 federal agencies including HHS, the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, Education, and the Social Security Administration along with 14 non-federal public members.

#### **Supporting Medical Directors in Behavioral Health Clinics**

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

**EDUCATIONAL OBJECTIVES:**

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

**SUMMARY:**

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

Learning Labs

Thursday, October 04, 2018

**Releasing the Voice Within: Storycatchers Theatre's Musical Performance and Workshop**

Chair: *Tory Davidson, B.A.*

**EDUCATIONAL OBJECTIVES:**

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

**SUMMARY:**

Storycatchers Theatre presents musical stories and a workshop by its Changing Voices Ensemble, a post-release employment program for 17-24 year-olds navigating reentry. The Ensemble members document and develop their personal stories into musical theatre productions while receiving case management services and job skills training. During

this interactive session, attendees will have an opportunity to collaborate with the ensemble and participate in a discussion.

Friday, October 05, 2018

**Ethics in Real Time: Learning Through Simulation**

Chair: *Rebecca Weintraub Brendel, M.D., J.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Learn various theories, frameworks, and approaches to making ethical decisions in simulated cases; 2) Appreciate the contributions of theory, method, science, and social science to moral judgment; and 3) Develop skills and strategies to identify and engage ethical challenges that arise in medical practice.

**SUMMARY:**

Psychiatric ethics requires knowledge of theory, frameworks, and approaches to ethics as well as development of skills to practically engage challenges in research and practice. In this innovative learning lab session, teams of participants will function as ethics committees to make a series of decisions with broad ethical (and at times life and death) consequences. This dynamic simulation will push participants to state their positions and then unpack the reasoning and other factors that contributed to their individual and group positions. The three-hour activity will be divided into two roughly equal sections: first, the interactive group activity, and second, a focused debrief eliciting participant self-reflection as well as didactic engagement of participant perspective and fundamental theory and perspectives on ethics and moral decision-making. Specifically, participants will come to understand major philosophical approaches to ethics, as well as critiques and frameworks addressing narrative, gender, race, and disparities (social determinants). In addition, the didactic portion will engage contemporary neuro and social science research on moral decision-making to inform and deepen appreciation of the complexity of ethical inquiry and application in psychiatry. Due to the interactive and participatory nature of this activity, full participation from each participant is necessary for the group learning experience. Therefore,

participants will be asked to stay for the entirety of the session.

Saturday, October 06, 2018

### **Microaggressions, Macroeffects: Navigating Power and Privilege in Psychiatry**

Chairs: *Kimberly A. Gordon-Achebe, M.D., Michaela Y. Beder, M.D.*

Presenters: *Megan Elizabeth Baker, M.D., John F. Chaves, M.D., Bhinna Pearl Park, M.D., Shadé Miller, M.D., Cassandra Raphaël, M.D., M.P.H., Neal Evan Goldenberg, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand microaggressions and implicit bias, and provide examples of how they affect patient care; 2) Identify the ways in which microaggressions and implicit bias influence both patients and clinicians; 3) Engage colleagues and patients with new communication skills after practicing exercises that teach techniques that can be incorporated into a clinician's daily routine; 4) Develop a self-awareness of our own privilege and/or oppression to better understand how we may impact others; and 5) Understand how racial and power dynamics intersect in complicated ways and can affect the quality of the psychiatric services our agencies provide.

#### **SUMMARY:**

Implicit bias and microaggressions affect all levels of medical care. Far from being subtle or small, an emerging literature suggests these phenomena can have big effects on access to care, care effectiveness, and even stigma. Manifestations can range widely, from assumptions about patient socioeconomic status or personality to recommending a different treatment depending on a patient's ethnicity, gender, or disability status, not to mention countless mental health-related disparities among racial and sexual minority and underrepresented groups that suggest these populations have worse prognoses. These injustices are not new and can have a significant impact on health, both physical and mental, at the individual and population levels. They are among the forces that contribute to burnout and compassion fatigue

among so many in the health professions. This can erode patient trust, undermine therapeutic alliances, discourage patients from seeking care, and potentially worsen outcomes. A recent study found that a black, working-class man would have to call 16 times as many therapists before finding care. This is unacceptable. Providers also experience these biases and microaggressions, which undermine their ability to provide excellent care. Interestingly, minority and underrepresented psychiatrists may self-select to work in underserved community clinics, and even there find discrimination from their peers and patients due to the subtle microaggressions of an oppressive health system. Experiences of discrimination based on gender, race, or identity may contribute to burnout and worsen provider well-being. Indeed, many academic institutions struggle to foster diversity at the highest levels of their organizations. An understanding of these factors is essential to increasing access to care, providing quality care, and fostering well-being among providers and patients. This highly interactive workshop will involve participants engaging in exercises to understand power, privilege, and microaggressions that occur on a daily basis in our offices, clinics, and hallways. A panel of facilitators will lead group discussion regarding the types of microaggressions, common reactions, and how they might affect our interpersonal interactions. Participants will be provided with resources to examine their own implicit biases, and we will conclude with strategies both individually and systemically to combat microaggressions and implicit biases in our daily practices and become allies with those who are oppressed. Questions and discussion will be encouraged.

### **You Are Human: Addressing Burnout Through Improv**

Chair: *Ashley Whitehurst*

Presenter: *Tristan Gorrindo, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify major factors leading to burnout; 2) Understand the balance of physician needs and patient needs; 3) Utilize techniques from improv to combat burnout through better

communication, self care, and personal connection; and 4) Let go and have a little fun.

#### SUMMARY:

Beep Bop Boop, guess what? You are not a robot that is expected to endure the same task over and over or expend all of your energy without release, recovery, and relaxation. Professional burnout can impact physicians' health, quality of life, quality of care they provide, and their productivity. There is substantial evidence of burnout and vulnerability among psychiatrists. The helpers and healers who treat those who need help are becoming more isolated, burnt out, and, more than ever, are at an increased risk of depersonalization, depression, and suicide. What can we do to address this alarming trend and bring wellness to psychiatrists? Improv. Improv? Yes! Improv! By applying the basic fundamentals of improv, we can move from isolation to more connection. We will learn to drop our barriers and guards and be comfortable with doing so. We will take care of ourselves so that we're better equipped to take care of others. Using basic improv techniques allows every individual to overcome self judgement, drop pre-conceived notions to serve the situation/circumstances and not our own agenda, and be more comfortable about collaboration, communication, and connection with others.

Lectures

Thursday, October 04, 2018

#### **Psychiatric Services Achievement Award Winners: Innovation in Service Delivery**

Chair: *Altha J. Stewart, M.D.*

Lecturers: *Andre Sturkey, Elizabeth M. Fitelson, M.D., Cherie Castellano, C.S.W., M.A.*

#### EDUCATIONAL OBJECTIVES:

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

#### SUMMARY:

Since 1949, the Psychiatric Services Achievement Awards have recognized creative models of service delivery and innovative programs for persons with mental illness or disabilities. This year, APA is pleased to announce the recipients of the 2017-2018 awards: Gold Award (academic program): Meeting the Challenges of Domestic Violence: A Partnership for Research and Treatment; Gold Award (community-based program): Chesapeake Connections Silver Award: Reciprocal Peer Support

#### **Transforming the Criminal Justice System in the Cook County State's Attorney Office**

Chair: *Glenda L. Wrenn, M.D.*

Lecturers: *Kim Foxx, Kim Foxx*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in the community; 2) Demonstrate and apply new skills that will be useful in public psychiatry settings; 3) Examine how the current health care system affects patient care; 4) Describe how to transform systems of care; and 5) Recognize how to bring new innovations into a variety of treatments to improve patient care.

#### SUMMARY:

Reform in the criminal justice system is an issue prevalent in public discourse in recent years, particularly as it pertains to equity in practice. Disparities exist in the way racial and cultural minorities are treated in the criminal justice system around the country, with African-American and Hispanic populations often suffering the most under draconian civil and criminal penalties. Kim Foxx, elected Cook County State's Attorney in December 2017, has spent her career working toward a fairer and more transparent criminal justice system. Despite significant obstacles to reform during her first year, including a large existing staff uninterested in reform and severe budget cuts in her office, Foxx worked diligently to rebuild the public trust and enact necessary reforms to the justice system in Cook County, including the overturning of wrongful convictions by previous administrations. In this lecture, Foxx will discuss her background and personal experiences related to the innovative work

she has done with the Cook County State's Attorney Office. She will share her vision for her community, including the fair treatment of minority offenders and those struggling with mental health or addiction issues. Her story is a testament to how we can all advocate and fight for equity, progress, and reform, bringing the promise of justice for all to all people.

Friday, October 05, 2018

### **Clinicians and Managers in Structural Conflict: How Can We Share the Triple Aim?**

Lecturer: *Hunter L. McQuiston, M.D.*

Discussants: *Kenneth Stewart Thompson, M.D., Barbara Linder, Ashley M. Overley, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate economic, social, and humanitarian complexities while pursuing the Triple Aim; 2) Understand structural role tensions in evolving healthcare systems challenging quality service; and 3) Acquire tools that help them bridge clinician - administrator gaps in pursuit of mutual satisfaction and professional success.

#### **SUMMARY:**

The Triple Aim --population health, improved outcomes, and lower cost --is a goal both line clinicians and management share. Simultaneously, systems flux in healthcare transformation is so great that there is an emerging crisis between manager and clinician. Senior leadership experiences frustration, particularly as it pursues key outcome metrics, while focusing on fiscal viability. Clinicians are increasingly alienated and demoralized as they struggle to maintain healing relationships among a wide range of patients, especially those who may experience social disaffiliation, while working under increasingly relentless time pressures, with a feeling that management is disconnected from patient care practice. One symptom is burnout. Presenters represent clinicians, clinical administrators, and systems managers from different communities and phases in their careers. We will discuss how transformation is affecting clinical care and how the management-clinician worlds can be closer, addressing burnout structurally -- promoting concrete ideas to help healthcare organizations,

especially those serving the public sector, modify and mature as they transform, keeping the patient at the center, and encouraging satisfaction of the line worker. Problem solving will be actively elicited from and discussed by all workshop participants.

### **From Cultural to Structural Competency: Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism**

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

Lecturers: *Enrico Guanzon Castillo, M.D., Nichole I. Goodsmith, M.D., Ph.D., Isabella Morton, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe at least three exemplary cases of clinical practices and training programs that intervene on social determinants of mental health; 2) Identify four common elements of their successful implementation; 3) Describe at least one technique for identifying structural causes of common clinical patient presentations that will apply to their own clinical practice; and 4) Describe at least one potential structural intervention for the common clinical patient presentations that will apply to their own clinical practice.

#### **SUMMARY:**

Structural Competency is an emerging approach to clinical training and practice that enables practitioners to intervene on the structural and social determinants of patients health -- through collaboration with community organizations, non-health sectors such as schools, housing and law enforcement, and with policy makers to promote mental health. This talk will present cases of successful structural competency interventions in psychiatric training and in clinics. These include Vanderbilt University's Medicine, Health and Society curriculum as well as its Structural Foundations of Health Survey for pre-health students, New York University's PRECEPT (Program for Residency Education, Community Engagement, and Peer support Training), in which psychiatry residents partner with mental health peers to generate community resource maps and to engage community organizations in patient care, Yale psychiatry residency's Structural Competency

Community Initiative (YSCCI), which increases PGY2 psychiatry resident awareness of the structural challenges to health of the people who reside in the neighborhoods of New Haven, including poverty and job opportunities, food insecurity, education inequality, social exclusion/isolation, housing instability, the criminal justice system, and violence/trauma. UCLA's psychiatry residency training combines "Critical Thinking Skills" in classroom learning informed by the social sciences and humanities, with Structural Vulnerability oriented exercises in clinical care including ethnographic field notes and supervision focused on identifying and remediating structural inequality. The roles of physicians and clinical social workers in intervening on social determinants, through political and community advocacy (Indigenous and immigrant mental health in Canada), development of policy innovations (LA County Housing for Health), specialized mental health teams (supportive housing, Assertive Community Treatment, Assisted Outpatient Treatment), and direct screening and action through structurally competent patient care will be discussed.

### **Mental Illness and Gun Violence in the United States: Facts and Messaging Tips for Psychiatrists**

Lecturer: *Marc W. Manseau, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) understand the relationship between mental illness and violence; 2) understand the relationship between mental illness and suicide; 3) learn how firearm access increases the risk of violence and suicide; 4) learn about laws that prevent psychiatric patients from owning or purchasing firearms; and 5) learn how to intervene when risky patients have access to firearms.

#### **SUMMARY:**

The epidemic of public mass shootings in the United States has brought the issue of gun violence and mental illness into the spotlight of public debate. The perception that mass shooters must be mentally ill is reinforced by media speculation about or reporting on the mental health histories of the shooters. In fact, research consistently shows that people with mental illness have only a slightly

elevated risk of committing violence, with variation in risk depending on diagnosis, stage of illness, and co-morbid substance abuse. Additionally, the overall contribution of mental illness to community violence is very small. And research has shown that when media reporting of public violence highlights even minor or irrelevant mental health histories, this increases public stigma against people with mental illness. Firearm violence is a serious problem in the United States, and various statutes have attempted to prevent people with risk factors for violence from possessing firearms. People with mental illness are often the focus of such violence-prevention legislation, despite evidence that they are not necessarily a high-risk group. People with mental illness are, however, at a significantly increased risk of suicide as compared to the general population, and suicides comprise twice as many firearm deaths as homicides. Attempts made with firearms are much more likely to be lethal than attempts made with other methods, and restriction of access to lethal means like guns is one of the few suicide prevention strategies proven to be effective. Current firearm prohibitions aimed at people with mental illness are varied in their effectiveness at preventing suicides. Clinicians who do violence and suicide risk assessments should be aware of how access to firearms affects their risk-assessments for violence and suicide, which laws affect their patients' ability to legally own or buy firearms, and what they can do to separate dangerous patients from their guns.

### **Overcoming Disparities in Mental Health Services by Making Culture Count**

Chair: *Grayson Swayze Norquist, M.D.*

Lecturer: *Roberto Lewis-Fernández, M.D.*

Discussant: *Sonya Gabrielian, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the various levels at which culture shapes the utilization, delivery, and organization of mental health services; 2) Explore interventions and instruments designed to enhance the cultural competence of mental health services to reduce care disparities; and 3) Consider how these interventions can be applied in routine clinical care.

#### **SUMMARY:**

Culture shapes the utilization, delivery, and organization of mental health services. Structures of meaning and social organization exert their influence at every level: that of the individual seeking care (e.g., the impact of a person's and family's cultural views of illness on treatment choice and level of engagement), the provider (e.g., the role of implicit biases related to race, ethnicity, and gender identity on diagnostic and treatment practices), the program (e.g., how local socioeconomic and organizational factors influence treatment guidelines and the package of services offered at a health facility), and the mental health system (e.g., how political forces affect reimbursement structures that determine availability of services). Identifying and addressing these cultural forces is necessary to overcome disparities in access to and quality of care across cultural groups. This presentation reviews research conducted with my colleagues in the New York State (NYS) Center of Excellence for Cultural Competence at NYS Psychiatric Institute. Our work aims to develop interventions and instruments that enhance the cultural competence of mental health services to reduce care disparities. Projects include the development and testing of the DSM-5 Cultural Formulation Interview, a patient-level cultural assessment tool; the development and efficacy trial of Motivational Pharmacotherapy, an approach to enhance treatment engagement in pharmacotherapy that integrates motivational interviewing; the development of Web-based Interpreter-Negotiated Services (WINS), a triadic (patient-interpreter-clinician) approach to verbal interpretation that addresses communication, relational, and structural barriers that interfere with patient-centered care of persons with limited English proficiency; and other cultural competence initiatives involving services for first-episode psychosis, integrated physical-mental health care, and suicide prevention.

### **The Balancing Act: Women Psychiatrists**

Chair: *Carolyn Bauer Robinowitz, M.D.*

Lecturer: *Carol Ann Bernstein, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify key factors contributing to the challenges specifically impacting women in

medicine, and contributors to stress, burnout and wellbeing which affect women; 2) Describe the complex interrelationships between external and internal workplace and personal factors which contribute to finding the delicate balance between professional and personal development; and 3) Identify potential approaches to these challenges at both the individual and systemic levels.

#### **SUMMARY:**

This presentation will focus on the key factors contributing to challenges specific to women especially as they relate to stress, burnout and wellbeing in the context of leadership roles in psychiatry. Data will be presented on the demographics of women in medicine and psychiatry, AAMC information on faculty workforce and roles as well as information from the workplace outside of medicine. The program will identify such issues as performance evaluation bias, penalties for success and social penalties for women who violate gender stereotypes in addition to overt sexism, discrimination and harassment. The program will also describe the complex interrelationships between internal and external factors such as the culture of medicine, lifestyle and partnership issues, societal and psychological stereotypes and second generation gender bias which contribute to difficulties for women in finding the delicate balance between professional and personal development. Finally, the presentation will highlight potential approaches to these challenges at both the individual and systemic levels.

### **The Psychiatrist's Role in Addressing the Opioid Crisis**

Lecturer: *Elizabeth Salisbury-Afshar, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the epidemiology of the opioid crisis in the United States; 2) Describe which public health interventions have been shown to reduce mortality; and 3) List at least 3 activities a psychiatrist can take on to address the opioid crisis within their practice.

#### **SUMMARY:**

Dr. Salisbury-Afshar will describe the trajectory of the opioid crisis nationally and the public health interventions that are being implemented in response. She will focus on public health interventions that have been shown to reduce mortality and then describe the potential role of physicians, and specifically psychiatrists, in being part the solution to this national crisis.

Saturday, October 06, 2018

### **Health Economics 101**

Lecturer: *Patrick S. Runnels, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss and conceptualize how the United States compares with other systems in developed countries around the world; 2) Discuss and understand that concept of Moral Hazard; 3) Discuss and understand the concept of Willingness to Pay; and 4) Understand and discuss multiple paradigms for healthcare payment reform.

#### **SUMMARY:**

Given that healthcare consumes nearly 1/5 of our economy, a reasonable emphasis has been placed on reducing healthcare costs. Yet, while physicians maintain tremendous influence over the systems in which we practice, few fully understand how basic principles of economics inform both what the system currently does and what the system is capable of doing. Like it or not, having a basic understanding of healthcare economics has become increasingly important for physicians, including psychiatrists, who wish to shape how our system evolves. In transitioning to a system that emphasizes value over volume, psychiatrists can wield tremendous influence. Psychiatry not only provides tremendous value in terms of reducing costs, but also informs a patient-centered approach that can improve the value of all healthcare services. In this lecture, participants will get an overview of the basic concepts of health economics, consider facts related to the economic and value based performance of our healthcare system, and consider how different payment models and reforms might improve both cost and performance.

### **Influencing Health Outcomes With Trauma-Informed Care: Healing IN Communities**

Lecturer: *Brian R. Sims, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand how language can escalate or heal, and be able to cite at least 2 strategies using language to enhance connection; 2) Use SAMHSA's Six principles of Trauma informed Care to enhance the development of collaborative and non re-traumatizing environments; 3) Appreciate the profound short and long-term effects of high ACE scores and their effect not only on the individual, but the subsequent effects on the community if left unaddressed; 4) Understand how language can escalate or heal, and be able to cite at least 2 strategies to enhance connection with individuals; and 5) Practice comfort, rather than control.

#### **SUMMARY:**

This session entitled Influencing Health Outcomes through Trauma Informed Care, will focus on strategies utilized by SAMHSA's National Center for Trauma Informed Care in cooperation with the city of Baltimore, Maryland with resultant healing in communities and agencies there. At the time of our initial entry into Baltimore, there was significant violence with Baltimore reaching in one year the highest number of homicides in its history. Our goal upon entry was to assist the city in its healing process; a process involving the understanding and subsequent addressing of the extremely high prevalence of trauma interwoven in the communities. Add to this, the extensive Historical trauma, and the city was suffering, with no significant channel to relieve the agony or processes to address the pervasive traumas. In implementing trauma informed strategies, the attempt was to assist a city in crisis, stressing healing and subsequent beginnings of recovery. As the city sought emotional healing, it as well sought physical healing. The Adverse Childhood Experiences study will be discussed, to show the correlations of adverse experiences, many of which occurred in childhood and some even before the child had formed language to express, and how these experiences have profound emotional, physical and



physiological consequences, stressing the need for early intervention in treatment. When we began the work with Baltimore, we were excited to see the embracing of the concepts of trauma informed care through the Baltimore City Health Department and its Health Director, Dr. Leana Wen. Her visions led to the request that as many of the Baltimore City employees from the various organizations be trained in trauma informed practices. This led to a broad range of trainings in the city, totaling to date some 78 agencies and over 2600 people. With this collaborative, people all over Baltimore have been receiving assistance and education on strategies to not only help others but to help themselves, knowing that the prevalence of trauma in the general population remains quite high. The key to successful and sustained effects, is to embrace prevention. This discussion promotes the addressing of trauma on both ends of the spectrum. Many examples from the efforts within the city, with creation of unique, community-oriented programs will be discussed with the goals of producing long-lasting outcomes. Concepts that promote healing; communicating effectively; embracing the premise of "It's not what's wrong with you, but what happened to you" have become our mantra. With active collaboration, we have attempted to help individuals of all levels of expertise to understand that "you do not have to be a therapist to be therapeutic". Many communities and agencies have begun to emerge with strength, healing and resilience. While still a work in progress, the response from the city of Baltimore has displayed Baltimore's desire to heal.

**Problem Behavior in Autism Spectrum Disorder:  
What Is the Psychiatrist's Role?**

Chair: *Kelly McGuire Morton, M.D., M.P.A.*

Lecturer: *Agnes Whitaker, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Participants will be able to define and recognize Problem Behavior in Autism Spectrum Disorder (ASD) and understand its clinical, public health and forensic significance; 2) Participants will become familiar with a multidisciplinary systematic approach to evaluating and treating Problem Behavior; 3) Participants will

become aware of the critical role of psychiatry in addressing problem behaviors in ASD and how to integrate this awareness into clinical care, training, public policy and research; and 4) Participants will become familiar with current and emerging initiatives in the area of problem behavior and autism spectrum disorder.

**SUMMARY:**

Problem behavior in ASD is a term that usually refers to aggression and self-injury, behaviors that are not part of the core features of ASD, but which play an outsized role in terms of determining quality of life and destiny for these patients and their families. Although more common in persons with ASD who may also be language and/or cognitively impaired, problem behavior can also occur in persons with ASD having fluent spoken language and normal intelligence. Problem behavior in ASD is the most common reason for which persons with ASD are prescribed neuroleptics, is the most common reason for out-of-home placement (often at great distance from their family of origin), and is a cause of encounters with law enforcement, arrest and imprisonment. When first encountered, problem behavior in ASD can often be confusing and frightening to families and providers. This already complex picture is complicated by the fact that the causes of problem behavior are almost always multiple. Where to begin? A systematic approach to rapidly assessing the possible causes of problem behavior can give confidence to the provider and family. A psychiatrist, often the first professional consulted for problem behavior, has a key role to play in a) ruling out treatable medical conditions that may be causing pain or dysregulation b) conducting a preliminary assessment as to the role of communication impairment, psychosocial stressors and maladaptive reinforcements in the onset and maintenance of the behavior c) determining whether any diagnosable psychiatric disorder is contributing to the behavior and treating accordingly e) determining whether irritability that is not part of a psychiatric disorder but may be part of ASD as a brain disorder is a contributor to the problem behavior and treating accordingly. Neuroleptic medications may be indicated in situations where problem behavior is an imminent threat to the safety of the patient or others, when psychosis is

present, or when irritability that is not part of a diagnosable psychiatric disorder is contributing to the problem behavior. However, other approaches not involving neuroleptics or even medication at all, may be even more effective and carry less risk for individuals for whom those specific indications are not present; in these cases, professionals specializing in functional communication and professionals with expertise in using environmental manipulations to change behavior patterns are invaluable allies to the patient, family and psychiatrist. Unfortunately, these resources are not available or overburdened in many communities. Adult and child psychiatrists caring for adults and children with ASD can play an important advocacy role for improving the full range of community services, and for improving training in ASD, not only in our own specialty, but among the medical profession generally, as well as employers and law enforcement. Several important initiatives in this area will be described.

### **Road to Wellness: An African American Female's Journey**

Chair: *Ranna I. Parekh, M.D., M.P.H.*

Lecturer: *Lauren Carson*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the status quo and statistical considerations of Mental Health of African-American females; 2) Identify the unique stressor factors and aid in boosting protective factors of mental health of African-American females; and 3) Recognize the racially and culturally sensitive treatment considerations, approach, and alternatives when working with African-American females.

#### **SUMMARY:**

African-American middle age women and older women have some of the highest rates of mental wellness, however, young African-American females between the ages of 12-19 have the highest rate of suicidal ideations. How do we get from Point A to Point B? Additionally, how do we ensure that African-American women and young females curb stressor factors and bolster protective factors to promote positive mental health? This session will explore the current state through statistics and

personal stories of African-American female's mental health journey. Attendees will have the opportunity to learn more on how to identify African-American female patients with addressing risk and stress factors for mental health difficulties and bolster positive protective factors through self-care techniques, treatment, and self-advocacy. While stigma still persists in society and especially in the African-American community this session will help explore how to help ensure the "backbones" of society's mental health is addressed and cultivated.

### **Women's Mental Health: News You Can Use**

Lecturer: *Nada Logan Stotland, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Structure mental health services so that they address the real-life concerns and needs of women patients; 2) Differentiate valid from biased research on reproductive health care; 3) Critically compare the impact of female hormones with the impact of male hormones; 4) Treat women patients affected by workplace inequities and harassment; and 5) Advocate for improvements in access to care and social supports for women.

#### **SUMMARY:**

There is so much news these days that is crucial to women's mental health: news about sexual harassment, gender discrimination in pay and advancement, gender differences in clinical research, the impact of female hormones on mood and behavior, the use of psychotropic medications during pregnancy and lactation, gender differences in brain structure and function, the impact of identity and sexual orientation on health, access to reproductive health services, family leave and child care. Polls and election results often focus on the attitudes and behaviors of women voters. There has been a successful effort to increase the number of women running for public office. All this news has implications and applications for psychiatric education, the structure of psychiatric services, the provision of clinical care. Mental health expertise is critical to government policies, for prevention as well as treatment of psychopathology. This interactive session will present data on these issues, followed in each case by practical applications for

mental health practice, administration, and advocacy—and questions for audience consideration and discussion. We will analyze the news and use it to inform our work improving women’s mental health.

Sunday, October 07, 2018

**Disparities Faced by Individuals With Mental Health Problems: Creating Tools and Forging Pathways for Change**

Lecturers: *Adrienne Kennedy, M.A., Keris Jän Myrick, M.B.A., M.S., Paul M. Grant, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Articulate disparities that affect people living with Dx of serious mental illness (race, geography, access to care, low expectations, differential treatment, negative impact on social determinants); 2) Identify impact on caregivers, what they must learn, understand, reconcile and practice to become positive contributors, effective collaborators and engaged partners in treatment and recovery; 3) Describe practices that promote caregiver, consumer and practitioner collaborations to increase parity, re-balance relationships or improve social determinants of mental health and recovery; 4) Prioritize Policy targets that disrupt disparities (e.g., expand provider codes, expand recovery-oriented cognitive therapy, integrate and reimburse peer and family education and support services); and 5) Recognize critical components with potential high-impact to affect health care, social determinants and strategic communication, including innovations for effectively-integrated, collaborative teams.

**SUMMARY:**

People living with mental health problems, especially those with diagnoses of serious mental illnesses, experience multiple disparities that impact social determinants of health, up to and including early mortality from preventable and treatable conditions. This session will explore multiple disparities from diverse perspectives: family, consumer/peer and provider/researcher. Each expert panelist will present tools and pathways to disrupt disparities and create parity for those with the most needs via

innovative policy, programs, and payment pathways for better short-term and long-term outcomes, effective reduction of crises or relapses, improved recovery and robust resiliency outcomes.

**Multicultural Psychiatrists at Work: The Art of Storytelling: The Human Experience of Being a Psychiatrist**

Chair: *Francis G. Lu, M.D.*

Presenter: *Michelle L. Furuta, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the importance of the psychiatrist drawing on one's own cultural identity to enhance physician well-being and resilience; 2) Understand how the; and 3) Enhance multicultural patient care by viewing *The Art of Storytelling*, which reveals treatment approaches used by three generations of psychiatrists from diverse cultural backgrounds.

**SUMMARY:**

*The Art of Storytelling: The Human Experience of Being a Psychiatrist* is a 65-minute 2016 documentary film about the human experience of being a psychiatrist as told by 3 generations of multicultural psychiatrists (by gender, sexual orientation, country of origin, race/ethnicity, age, among other cultural identity variables) in Southern California. This project was conceived by the Art of Psychiatric Medicine Committee of the Southern California Psychiatric Society. This film premiered at the 2016 American Psychiatric Association Annual Meeting and has been shown at the Annual Meetings of the California Psychiatric Association (2016) and the Central California Psychiatric Society (2017) and the World Congress of Psychiatry in Berlin (2017) among other venues. The current perceptions of who psychiatrists are, what their intentions are, and what is important to them has largely been distorted through the mainstream media and other groups. This film is the first of its kind by highlighting the importance of psychiatrists taking a proactive stance in telling their own stories grounded in their own cultural identities, and in doing so conveying the human element of who and what Psychiatry is - as told by those on the film. The same questions are asked of each psychiatrist in

such a way that personal narratives of each interviewee, as well as a cohesive narrative of the diverse group can coalesce. The differences in life experiences and cultural backgrounds of the psychiatrists interviewed are vast. Their stories are personal, inspiring, and moving. Emerging from the diversity of experience is an unexpected thread of commonality - a deep love for connection with others, incredible courage in the face of adversity, and an unmatched level of personal resilience. The film demonstrates vividly the importance of understanding the psychiatrists' own cultural identities to assess and treat diverse patients.

Information:

<https://artofstorytelling.squarespace.com/#theartofstorytelling> Trailer:

<https://www.youtube.com/watch?v=EED2zKx9P74>

Director: <http://www.furutamd.com/art-of-storytelling-film/>

Thursday, October 04, 2018

#### Poster Session 1

No. 1

##### **What Is "Complexity" in Mental Health and Why Does It Matter? A Review**

Poster Presenter: *June Sing Hong Lam, M.D.*

##### SUMMARY:

Complexity or "complex patients" in health care has been conceptualized in different ways, including those with more than one chronic illness, high-cost users of services, and those who have ongoing psychosocial vulnerabilities (Schaink et al. 2012). Complexity in mental health care is poorly understood. A recent study of high-cost mental health users found that they incur more costs than other high-cost patients, and their demographics differ in significant ways (de Oliveira et al. 2016), which suggests complexity in mental health care deserves separate attention. Many models of complexity have been developed, but how it is understood and applied depends on the stakeholder perspective (e.g., governmental institutions, healthcare providers, community organizations). The patient perspective has not been incorporated into this discussion. A consistent understanding of complexity is important because it helps determine

funding allocation and service delivery. In Toronto, the Local Health Integrated Network (LHIN) has developed a definition of complex mental health patients used to help allocate resources. This presentation reviews existing literature on complexity and identifies the gaps in understanding mental health complexity, the multiple existing stakeholder perspectives, and the need for a better conceptualization. We also describe and identify participatory action research as a methodology to address these knowledge gaps. We describe our process in partnering with community organizations to develop a study to examine complexity from patient perspectives as a unique lens to identify existing gaps in meeting the needs of "complex clients". We will use their perspectives to clarify mental health complexity and integrate existing perspectives.

No. 2

##### **Walk-in Wednesday: An Open Access Psychiatry Model Developed From Lessons Learned Working With LGBTQ Patients**

Poster Presenter: *Eric Yarbrough, M.D.*

Co-Authors: *Angeliki Pesiridou, M.D., Erin Black*

##### SUMMARY:

Callen-Lorde is a federally qualified community health center in the heart of Manhattan. It focuses on the treatment of LGBTQ+ patients who also have chronic and persistent mental illness. Because of appointment adherence concerns, Callen-Lorde has developed a walk-in/open access treatment model to offer continued care to patients who have difficulty making appointments and to help prevent hospitalization with frequent walk-in visits. Since starting the open access model, Callen-Lorde has experienced relatively few inpatient hospitalizations and is managing patients with severe symptoms in outpatient treatment. The goal of this workshop is to introduce participants to the benefits of an open access model and help identify patients who would be suited for this type of treatment. Ultimately, participants will take away basic requirements to making an open access model successful.

No. 3

##### **Perspective of Patients With Serious Mental Illness on Reverse Integration: A Qualitative Study**

Poster Presenter: *Rachel Melissa Talley, M.D.*  
Co-Authors: *Stephanie Alexia Rolin, M.D., M.P.H.,*  
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**SUMMARY:**

Background: Previous research has demonstrated that individuals with serious mental illness (SMI) have two to three-fold increases in mortality rate as compared to individuals in the general population (1, 2, 3, 4), with leading causes including medical comorbidities such as cardiovascular disease, pulmonary disease, and cancer (5, 6, 7,8). Quantitative evaluation of integrated care models designed to address this disparity have demonstrated positive results (9, 10, 11, 12). While perspectives of individuals with SMI on access and barriers to primary care have been qualitatively studied (13, 14, 15), less is understood about patient perspectives on integrated care models specifically, and whether patients view these models as improving their primary care resources. This qualitative study utilized semi-structured interviews to examine perspectives of patients with SMI on a reverse integrated Methods: A purposive sample of adult English and Spanish-speaking subjects with SMI was recruited from two state-funded outpatient clinics for individuals with SMI in Northern Manhattan. A semi-structured interview guide was used to conduct 60-minute audio-recorded interviews exploring subject views both on their current resources to manage medical issues and on whether a hypothetical reverse integrated care model, described in a vignette, would impact management of their medical issues. Interviews were transcribed and analyzed by two coders per grounded theory methodology to elucidate common themes. Outpatient medical charts of subjects were reviewed to collect basic demographic data. Results: Thirty subjects (mean age=47.4; 53% male; 50% Spanish-speaking), were interviewed. Patient comments in response to the vignette describing reverse integration of care were generally positive. Common themes included an expectation of increased access to care and a belief that this model would facilitate frequent collaboration and communication between mental health and primary care providers, thereby allowing all providers to have a holistic understanding of the patient's health

needs. Conclusion: This qualitative analysis of perspectives of patients with SMI in a diverse urban setting demonstrated an overall optimistic view of reverse integration of care as a resource for management of medical issues, with an emphasis on improved access to care and an expectation that this model should generate frequent communication and coordination between primary care and mental health providers. These results add to the understanding of patient viewpoints on emerging treatment models. Research reported in this publication was supported by the National Institute of Mental Health of the National Institutes of Health under Award Number R25MH086466

No. 4

**Frostbite Injuries in Patients With Mental Illness**

Poster Presenter: *Victoria J. Tann*

**SUMMARY:**

Frostbite is a serious injury that causes tissue damage and may require intensive care and life altering surgical intervention in severe cases. Statistics linking frostbite to psychosocial instability and mental illness have been so compelling that previous papers have suggested that frostbite injury should trigger an in depth psychosocial screening process. To further gather information on the demographics and circumstances surrounding frostbite injury and mental health, a retrospective chart review was performed. Using Trinetx software, 160 patients were identified with a documented mental health diagnosis and a frostbite injury who presented to The University of Iowa Hospitals and Clinics over approximately the last 10 years. Patients were more likely to be male and white with a mean age of 46. 75% of patients had a diagnosis underneath the ICD-10 codes F10-F19 for mental and behavioral disorders due to psychoactive substance use. While many patients only required supportive cares, some did require skin grafting and/or amputation because of their injuries. Previous studies have noted the high cost of treating patients with frostbite, who may also be more likely to lack the resources to pay for their care. Frostbite, therefore, is not only a personal issue for patients, but one that should concern society at large.

No. 5

## **Increasing the Impact of IMPACT on Preventable Health Conditions**

Poster Presenter: *Shea M. Jorgensen, M.D.*

Co-Authors: *Michael Jorgensen, Jess Fiedorowicz, Nancy A. Williams, M.D.*

### **SUMMARY:**

**INTRODUCTION:** People with serious mental illness (SMI) die 15-20 years earlier than those without SMI (1). Up to 60% of this increased mortality is due to preventable health conditions, such as cardiovascular disease (CVD) and diabetes (2). Medication-induced weight gain, increased smoking prevalence, and limited contact with primary care providers likely contribute to the 2-3 times greater risk of cardiovascular morbidity and mortality of people with SMI (3,4). Psychiatrists can play a vital role in improving the physical health of these patients by monitoring and treating variables that impact CVD. The goal of this QI project was to reduce risk of CVD, cancer, and infection in an SMI patient population through a practical and sustainable intervention. In this analysis, we will evaluate the extent to which patient risk of these illnesses was reduced. **METHODS:** An Integrated Multidisciplinary Program of Assertive Community Treatment (IMPACT) implemented a quality improvement project from 1/1/2012 to 10/31/2016 with a goal of systemizing the team process to reduce patient risk of CVD, cancer, and infection. The intervention consisted of offering five interventions to 77 people with SMI enrolled in IMPACT. Interventions were as follows: 1) mammography screening in which patients were educated, offered screening, and scheduled with assistance; 2) motivational interviewing that included assisting each patient to identify one goal to reduce their overall CVD risk every six months; 3) measured and recorded variables needed to calculate Framingham Risk Score every six months; 4) educated patients on value of influenza vaccine and assisted with scheduling and; 5) colonoscopy screening in which patients were educated, offered screening, and scheduled with assistance. Statistical analysis software will be used to analyze the above interventions. **RESULTS:** Preliminary data show mean/median SD decrease in BMI of 0.48/0.25 kg/m<sup>2</sup>, Wilcoxon signed rank  $S=203.5$ ,  $p=0.22$ , indicating no significant weight gain over time.

Additionally, there was a mean/median (SD) decrease in total cholesterol of 8.0/5.5 (31.2) mg/dL, Wilcoxon signed rank  $S=-212.5$ ,  $p=0.06$ , indicating a marginally significant decrease in total cholesterol. Further data analysis to be completed includes the proportion of participants who underwent age-appropriate mammography and colonoscopy screening, change in Framingham Risk Score, and proportion of individuals receiving influenza vaccination. **CONCLUSION:** Individuals with SMI who are prescribed antipsychotic medications are prone to significant weight gain. Following implementation of this QI Program, 77 people with SMI experienced no significant weight gain over a period of 4 years, as well as a marginally significant reduction in total cholesterol. This study demonstrates that implementing evidence-based interventions in an SMI population is a feasible and effective means to manage preventable health conditions.

No. 6

## **Adherence to Psychiatric Care After Compulsory Admission: A Five-Year Longitudinal Study in a Psychiatric Center**

Poster Presenter: *Chu Wei Tsai*

### **SUMMARY:**

**Background:** Compulsory admission is a mandated admission without patient consent after a formal psychiatric assessment. The common patient factors leading to compulsory admission were psychosis, aggression, lack of insight, care avoidance, and unauthorized reduction or cessation of medication. Being compulsorily admitted may have negative impact on patients, and can be a traumatic experience. However, to date there are limited data regarding the adherence to psychiatric care in patients who were discharged from the detention orders. **Methods:** This is a retrospective cohort study, using database from one of the two appointed psychiatric centers for psychiatric emergency services. Between 2013 to 2017, patients who were involuntarily committed to hospital were recruited. The major outcome was the discharge disposition. The secondary outcomes were the mean and median duration of follow-up, the proportion of readmission, and repeat compulsory admission. Trend analysis was performed to examine the

proportion of compulsory admission over the past five years. Results: Between 2013 to 2017, a total of 373 patients were recruited, constituting 453 compulsory admissions. Among the 373 patients, 54 patients were involuntarily committed more than once. The mean number of compulsory admission was 2.2, with maximum of 5. The mean length of hospital stay was 51.1 days. Long acting injection (LAI) was administered to 132 patients during their involuntary commitments. Considering both voluntary and involuntary admissions, 119 patients were re-admitted, composing 617 admissions during the five years. Most of patients (n = 338) were followed up in outpatient clinic, and 81 patients were transferred to home health care service. There were six patients being referred to department of day care. Interestingly, 21 patients were transferred to chronic ward. The mean period of followed up was 13 months (with max 60 months, median 6 months). Conclusions: After discharge from the detention orders, 61% of patients voluntarily visited the outpatient clinic, and 24% of patients were transferred to home care. The mean period of followed up was 13 months. These findings suggest that compulsory admission might be not a stigmatized treatment but an insight enhancement treatment.

No. 7

**Outcomes Related to Mental Health, Public Service Utilization, and Employment Stability Among Iowa City Fairweather Lodge Program Participants**

Poster Presenter: *Emily E. Morse, D.O.*

Lead Author: *Thad E. Abrams, M.D.*

**SUMMARY:**

Background: Homelessness is often the result of inadequately managed mental illness, and examination of the correlations between the two often reveals that the mental health problems predate periods of homelessness. Frequently, mental illness, substance use and homelessness result in a lack of social support, elevating the need for emergency service use and hospitalizations. Models rooted in the community, such as the Fairweather Lodge (FWL), seek to provide supportive housing using a recovery-oriented model for persons experiencing mental illness and co-occurring conditions. The model's primary intent is to

eliminate homelessness through provision of: 1) permanent supported housing, 2) low-barrier access to mental health care, 3) employment, and 4) peer support. The Fairweather Lodge was initiated in Iowa City, Iowa in 2011 as an extension of the community's primary service provider for individuals with mental illness facing homelessness and ultimately expanded to include 3 houses with capacity for 18 clients. Review of published literature reveals a limited number of recent studies that report on this model's impact on outcomes such as 1) emergency service use, 2) inpatient mental health utilization, 3) stable employment, and 4) public service use (e.g., jail). Methods: 38 participants have completed the Iowa City FWL program. Using retrospective, longitudinal analysis triangulating data from client entrance interviews, administrative collected data, and validated vulnerability risk index we examined the impact of the Iowa City FWL on the 4 outcomes listed above. Data were hand extracted by trained individuals hired by the homelessness service provider. Analyses compared service use in the 5 years before entry in the program and through a minimum of 12 months or until completion, whichever occurred first, for 20 participants for whom complete data were available. Services provided in the program included biweekly visits with a board-certified psychiatrist, peer support, individual and group counseling by graduate psychology students with supervision, supported employment, and medication reminders. Results: Preliminary analyses of 3 service-utilization outcomes indicate marked reductions (90-100%) for all 3 measures among the 20 completers. Notably, participants totaled 1060 law enforcement encounters in the 5 years preceding program entry but had 0 encounters following entry. All completers, by nature of the program, were able to sustain at least part-time employment, which was the fourth measure. Conclusion: This report illustrates the promising impact of supported housing and employment programs, and specifically of the FWL model, for individuals with mental illness and co-occurring disorders who are homeless. While access to this type of program is limited in most communities, the outcomes described support the expansion of this model of service delivery to address a growing population of individuals with mental illness facing homelessness.

No. 8

**Toward a Home Sweet Home: Provider Perspectives on Improving Services for Homeless Families**

Poster Presenter: *John Horton*

Co-Authors: *Kayleen Ports, Michelle Quan, Lillian Gelberg, M.D., M.S.P.H., Sheryl Kataoka, M.D., M.H.S., Gery Ryan, Roya Ijadi-Maghsoodi, M.D.*

**SUMMARY:**

Background: The burden of substance use disorders (SUDs) and trauma significantly affect homeless families. Exposure to risk factors including poverty, SUDs, and trauma can result in negative mental health outcomes for homeless youth. While family-based resilience interventions can improve youth health outcomes, few are designed specifically for homeless families and, in particular, homeless families with parental SUDs. As such, an unmet service need exists for family-based interventions for families experiencing homelessness and impacted by parental SUDs. We conducted qualitative interviews with homeless services providers to better understand the stressors, family needs, and recommendations for improving services and implementing a trauma-informed family intervention. Methods: We conducted qualitative semi-structured interviews with service providers (n=25) to explore the family experiences, needs, and feasibility and acceptability of providing a family intervention to homeless families with parental SUD, and how to best engage families. A component of the semi-structured interview focused on perceived parenting strengths and challenges and family communication. Participants were recruited from transitional housing facilities in Los Angeles County. Interviews were audio-recorded, transcribed, and analyzed using in-depth content analysis. Results: Service providers described the profound impact homelessness, parental SUDs, trauma, and separation/reunification processes have on relationships in families. Perceived challenges to family communication and functioning included inadequately treated or untreated parental SUDs, stressors associated with finding affordable/stable housing, and limited case management resources and time to complete transitional housing program requirements. Providers perceived a key opportunity to improve services focusing on parental

communication and help families cope with reunification/separation and the impact of parental SUDs. Providers felt a family intervention delivered in transitional housing facilities could improve family coping and youth mental health. Conclusions: Homeless families with parental SUDs who are living in transitional housing experience remarkable stressors related to finding permanent housing and coping with the impact of parental SUDs. Our findings can inform housing and mental health services and highlight the need for increased understanding of the impact of parental SUDs and housing stressors on family functioning and communication among homeless families, and for delivering a family-based, trauma-informed intervention in transitional housing facilities. In addition to addressing housing instability, homeless service providers and mental health providers can play a critical role in helping with coping, communication, and family functioning, in order to best help this important population.

No. 9

**Using the Cultural Formulation Interview to Guide the Treatment of a Geriatric Latino Patient With Bipolar II Disorder**

Poster Presenter: *Victor Manuel Gonzalez, M.D.*

Co-Authors: *Pamela Lopez, M.D., Erica C. Garcia-Pittman, M.D.*

**SUMMARY:**

Cultural competency has become an important practice in the mental health field. The recent incorporation of a cultural formulation interview in the DSM-5 further goes to show the essential role that culture has in a patient's mental health care. Cultural competence is important in helping provide the patient with the best care possible by understanding the views/interpretations of their mental illness, their cultural interpretations of stressors propagating their illness, and their understanding of treatments, along with their expectations of resolution of symptoms. This case report focuses on a Latino geriatric patient with Bipolar II disorder and the associated complexities in treatment that arise in large part due to the patient's cultural beliefs regarding his mental illness. Patient was seen in outpatient psychiatry clinic for initial complaint of recurrent mood episodes. He had



previously been treated by providers in Mexico and more recently in the US, who had trialed him on several medications including SSRIs, SNRIs, mood stabilizers, and benzodiazepines. Patient received ECT early in our care given the severity of his mood symptoms, which seemed to improve after several trials of treatment. However, the patient's condition was never stabilized long term due to barriers such as language differences, medication non-adherence, and a lack of patient insight. The patient ended up seeking outside care in his native country of Mexico, which led to interference with our care plan and a subsequent hypomanic episode. In an effort to improve patient care, we focused on bridging cultural gaps by developing an understanding of the patient's belief towards his illness, providing him a Latino/a Spanish-speaking provider when possible (allowing for easier communication), and managing expectations of treatment and illness course. We leveraged the findings obtained through a cultural competency formulation to help contextualize cultural barriers and better address them in our assessment and treatment plan.

No. 10

**Intellectual Disability in Indian Cinema: A Narrative Review**

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

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

**SUMMARY:**

Introduction: Cinema is well known medium for portraying psychiatric disorders including intellectual disability. They help in understanding the views of general population towards mental illness. We review films portraying intellectual disability in Indian Cinema. Methods: Films were identified after discussion with various experts in person, telephone and email correspondence Results: 20 films portraying lead characters with intellectual disability were identified. They lead characters range from child to adult age group with balanced and unbalanced portrayal. Various themes including stigma, relationship issues and ability to possess empathy and have emotions have been portrayed. Conclusions: The portrayal of intellectual disability in the films in our study can be used as a medium to understand cultural issues related to intellectual

disability in India. They can be an excellent resource for movie clubs as a part teaching in post graduate and undergraduate training in psychiatry.

No. 11

**Correctional Mental Health in California and San Diego County: Models of Treatment and Community-Based Recovery**

Poster Presenter: *Benjamin Carron, M.D.*

Co-Author: *Stephanie Martinez, M.D.*

**SUMMARY:**

The number of mentally ill concentrated in correctional settings has increased dramatically in the United States since the Community Mental Health Centers Act in 1963. Prisons, jails, and diversion programs, such as mental health courts and drug courts, are often operated by varying entities with different approaches to care. Inadequate mental health resources in the community are partly responsible for why this population ends up incarcerated rather than treated. The Sequential Intercept Model has shown to be an effective approach for improving mental health care delivery in the community as a means of reducing incarceration and recidivism among the severely mentally ill. The State of California and San Diego County have enacted legislation and services that aim to strengthen community mental health treatment and promote recovery. Proposition 63, the Mental Health Services Act (2014), increased funding and support services for community mental health programs across the state of California. An example of a crucial service being delivered to this population is the Parole Outpatient Clinic, which the California Department of Corrections and Rehabilitation (CDCR) provides to individuals recently released from prison into San Diego County to ensure continuity of care while transitioning to the community. Assembly Bill 109 allows non-violent, non-serious and non-sexual offenders to serve time in a county facility rather than a state prison, while allowing direct county supervision rather than being under state parole. This is a method of reducing recidivism, as county-run jails have more community reentry resources compared to prisons. The UCSD Re-Entry Treatment Program that which provides clinical treatment programs to individuals deemed appropriate for early community

re-entry. It targets those with co-occurring disorders at risk of re-offending. Within Richard J. Donovan Correctional Facility (RJD) there are an array of programs to assist an individual's recovery including the Striving To Achieve Rewards (STAR) program built around behavioral activation and positive reinforcement, programs dedicated to teaching healthy alternatives to violence, a behavioral health unit focused on education around medical needs, and initiatives paired with the Parole Outpatient Clinic that prepare inmates for pre-release and reentry back into the community.

No. 12

**A Grassroots Approach to Health Equity Awareness and Education Through Community Academic Partnerships**

Poster Presenter: *Carlos Fernandez, M.D.*

**SUMMARY:**

Background Reducing disparities and establishing health equity has become a national priority. Minority groups underutilize and often are apprehensive when accessing medical and mental health services. As a result, a significant number of community members with behavioral health issues and medical comorbidities go without diagnosis and treatment; frequently leading to potentially negative outcomes. The UCLA -Kern Medical, psychiatry program has identified these alarming trends and initiated a grassroots approach to health equity awareness and education through community academic partnerships. The research study will promote inclusion of ethnically diverse populations of Central California providing health equity education. Methods A study will be carried out at several community centers within central California. Participants will be made up of adult community members who are interested about learning about health equity topics relating patients mental and medical health by being provided educational lectures at community sites. Literacy scales will be used in a pre-and post survey to assess general mental and medical health knowledge, stigmatizing attitudes, and treatment modalities. At the completion of data gathering, the study will incorporate final data collection and statistical analysis and presented on a national academic platform. Results The study's primary focus is to

increase the communities' knowledge concerning health equity. The use of a community academic partnership will aim to reduce stigmatizing attitudes, allow participants to become informed community members giving them to tools necessary to recognize common mental health conditions and preventative health strategies. We anticipate that during the study participants will learn how to access mental and medical health services, become familiar with different treatment modalities. Conclusions Reducing health barriers and eliminating disparities is crucial in empowering patients. By utilizing a community academic partnership model, we intend to have a reduction in stigmatizing attitudes in under resourced communities, and increase community health literacy by fostering open lines of communication and addressing individual's concerns relating to their physical and mental health.

No. 13

**Exploring Exits From Homelessness Among Persons With Serious Mental Illness**

Poster Presenter: *Sonya Gabrielian, M.D.*

Co-Authors: *Gerhard Hellemann, Alexander Stehle Young, M.D.*

**SUMMARY:**

Background: About a third of persons who have experienced homelessness (homeless-experienced persons) have a serious mental illness (SMI). Our prior work established three longitudinal housing outcomes for homeless-experienced persons: stable housing; sheltered housing (e.g., long-term engagement in residential settings); and street homelessness. To inform intervention development, we sought to identify factors strongly associated with group membership in these housing outcomes. Methods: We collected two-years of housing history from homeless-experienced persons (N=86) with SMI at the VA Greater Los Angeles. We identified the setting persons lived in for >50% of the past two years: stable housing (n=28); sheltered housing (n=29); or streets (n=29). We reviewed medical records and conducted assessments to capture potential predictors of housing outcomes, including demographics, diagnoses, service utilization, neurocognition, social cognition, and symptoms; we hypothesized that cognition would strongly predict housing outcomes. We used chi-square and ANOVA

to determine how potential predictors varied by housing outcomes. Classification and regression trees (CART) were used to identify the best predictive subset of variables that classified persons by housing outcome. Results: Demographics, diagnoses, symptoms, and social cognition were similar between groups; among nine neurocognitive domains, only verbal learning and visuospatial memory had between-group differences ( $p < .05$ ), with highest performance in the sheltered group and similar scores in the other groups. Among service utilization variables, only duration of engagement in VA Supported Housing (VASH) differed by group; duration of VASH engagement was highest in the stable group, followed by the street and sheltered groups ( $p < .05$ ). Using CART, two variables--visuospatial memory and income--were sufficient to capture information provided by 37 potential predictors to classify persons by housing outcomes. Persons who scored  $\geq 19.5$  (17% percentile in normative samples) on the Brief Visuospatial Memory Test-Revised (BVMT-R) were predicted to be sheltered. Among persons with  $BVMT-R < 19.5$ , those with monthly incomes  $< \$221$  were predicted to be street homeless, while those with higher incomes were stably housed. However, this model only explained 39% variance in this sample (relative error=0.61). Conclusion: Though cognition predicts functional outcomes (work, social relationships) among persons with SMI, it did not predict housing outcomes in this study. Though we found between-group differences in two neurocognitive domains, the sheltered group performed the best, which is poorly aligned with our conceptual model of factors associated with housing outcomes. These data suggest that engagement in supported housing--an evidence-based practice to address homelessness--may supersede person-level factors in influencing exits from homelessness in this population. VA HSR&D supported this study.

No. 14

**Remarkably Vulnerable: Comparing Homeless Veterans Who Use Homeless-Specialized Versus Mainstream Primary Care**

Poster Presenter: *Sonya Gabrielian, M.D.*

Co-Authors: *Young-il Kim, Aerin deRussy, Lillian Gelberg, M.D., M.S.P.H., Ann Elizabeth Montgomery,*

*Adam Gordon, April Hoge, Sally Holmes, David Pollio, Erika Austin, Audrey Jones, Stefan Kertesz*

**SUMMARY:**

Background: Homelessness is a social determinant of health and is highly prevalent among persons with psychiatric illness. In VA, Homeless Patient-Aligned Care Teams (HPACTs) began providing primary care (PC) tailored to homeless Veterans in 2012. However, we do not know if HPACTs serve a particularly vulnerable subset of homeless Veterans, which may influence service needs. We compared demographics, diagnoses, service utilization, and social determinants among three groups: homeless Veterans in HPACTs, homeless Veterans in mainstream PC, and non-homeless Veterans in mainstream PC. Methods: Using VA administrative data, we identified 27 VA facilities operating the largest HPACTs (panel sizes 200-2500). We compared HPACT users at these sites ( $n=10,713$ ) with homeless Veterans in traditional primary care clinics (HMAIN,  $n=70,990$ ), and Veterans in traditional primary care without a history of homelessness (MAIN= $71,610$ ). Inclusion required: 1)  $>2$  PC visits in 2 years; 2) a PC panel assignment. History of homelessness was determined by the presence vs. absence of  $>1$  homeless ICD9/ICD10 code or use of a VA homeless service within 24 months. ANOVA and chi-square assessed between-group differences in demographics, diagnoses, and use of Emergency Department (ED) and inpatient hospitalizations. Logistic regression assessed independent predictors of HPACT vs. HMAIN membership, excluding non-homeless Veterans. Results: Demographically, half of HPACT patients were very poor (income  $< 50\%$  of federal poverty level), compared to 36% of HMAIN and 25% of MAIN. HPACT and HMAIN groups were disproportionately African American (44%, 48%) compared to MAIN (24%). HPACT were less likely to be  $>65$  years (14%) than HMAIN (25%) and MAIN (53%). HPACT was less likely to be female (5%), compared to the HMAIN (13%) and MAIN (10%). Some psychiatric diagnoses were more prominent among HPACT and HMAIN users compared to MAIN, including PTSD (28%/32%/17%), depression (60%/58%/27%), alcohol use disorder (48%/33%/9%) and drug use disorder (45%/30%/5%). General medical diagnoses were similar between groups.

Greater Emergency Department use (>4 visits) was seen in the HPACT and HMAIN (27% for both) vs MAIN (8%) groups. Independent predictors of HPACT as opposed to HMAIN panel membership were mostly social/financial indicators, as opposed to diagnostic factors. Conclusions: Veterans using HPACTs differed from homeless-experienced mainstream primary care Veterans in their social vulnerabilities (e.g. income), addiction, and some psychiatric--but not general medical--diagnoses. Compared to non-homeless Veterans, the HPACT and HMAIN groups were disproportionately African American and used more acute care. While clinical vulnerabilities were notable among all studied homeless Veterans, greater vulnerability in the realms of housing and social determinants of health characterized HPACT users. VA HSR&D supported this study.

No. 15

#### **An Analysis of Five Facet Mindfulness Among Veterans: A Pilot Study**

Poster Presenter: *Jeremy Ramirez*

##### **SUMMARY:**

Background: The preferred method of treatment for patients with Post-Traumatic Stress Disorder (PTSD) receiving care in the VA healthcare system is Cognitive-Behavioral Therapy (CBT), however, this form of therapy is effective in treating only two of the three hallmark symptom clusters associated with PTSD. Purpose: We investigate the effectiveness of art therapy as a supplemental treatment for military veterans diagnosed with PTSD. Material and Methods: Current standard practice and research studies for art therapy among populations with PTSD are summarized and critiqued and placed within the literature context examining military and veteran unique needs and challenges to treatment. Results: The majority of selected articles suggest that through the practice of art therapy, patients with PTSD experienced at least three outcomes: 1) the ability to express thoughts which could not previously be verbalized, 2) improved social relationships which led to reduced social detachment, and 3) a general reduction in all three symptom clusters. Conclusion: Given the effectiveness art therapy has in treating the avoidance/ emotional numbing symptom cluster, it

is not meant to replace CBT, but rather, it is meant to be offered in addition to CBT in order to produce a greater comprehensive care package offered to veterans with PTSD.

No. 16

#### **Rethinking Violence Prevention in Rural and Underserved Communities: How Veteran Peer Support Groups Can Be Leveraged to Process Trauma**

Poster Presenter: *Jeremy Ramirez*

##### **SUMMARY:**

Purpose: Access to mental healthcare can be a challenge for veterans residing in rural and underserved areas. A growing number of trauma affected veterans are now returning to rural areas upon completion of their military service. The Palo Alto VA Health Care System has piloted a program known as the Peer Support Program (PSP) where certified peer support specialists hold group sessions for their fellow veterans in remote, community based outpatient clinics. Methods: Ethnography in program evaluation seeks to understand patients from their own frame of reference, which we used to better understand how patients diagnosed with PTSD experience peer support services. Our team conducted a qualitative evaluation of 29 peer-support group participants and one certified peer specialist. Semi-structured interviews lasted between 30 and 90 minutes and began with open-ended questions regarding participant personal experiences of the support groups. These were followed by direct questions that addressed the role of the PSP, expectations for the PSP, as well as benefits and limitations of the program. We performed a domain analysis using the Spradley ethnographic method on 325 pages of compiled narrative data. Following domain analysis, a preliminary list of codes and code categories was generated to serve as our codebook. A team of four trained research staff members then coded transcripts using Atlas.ti qualitative analysis software. One primary coder was designated as responsible for coding all transcripts, while the remaining coders evenly divided the 29 transcripts to ensure double coding of transcripts. Coding agreement was monitored via Kappa testing. Findings: The participants in this study report that

overall, peer support groups create a safe space where violence can be processed that is distinct from the typical clinical encounter with medical professionals. In addition, four notable key themes emerged, including: 1) Violence in Military Training Not Acceptable in Civilian Life, 2) Peer Support Creates the Trust to Freely Speak, 3) Skills are Taught to Defuse Violence, and 4) The Veteran Peer Support Specialist Relationship is Multi-Dimensional. Conclusions: The VAPAHCS pilot peer support program is an opportunity for veterans to share their experience with service-related trauma in a supportive environment with fellow veteran participants and a certified peer specialist. These emergent themes illustrate how trauma-focused assistance rendered by peer support specialists can be adapted and employed within the VA to benefit trauma affected individuals. Protocols for delivering such programs need to consider interplay of emergent themes found in this study, which may guide facilitation appropriately.

No. 17

**Stockholm Syndrome in a Battered Woman With Schizoaffective Disorder: A Case Report**

Poster Presenter: *Felix Oscar Priamo Matos, M.D.*

Co-Author: *Amina Hanif, M.D.*

**SUMMARY:**

Introduction Stockholm syndrome is a psychological response in which the victim shows signs of empathy, loyalty, or voluntary compliance with the victimizer (1). Victims live in enforced dependence and misinterpret acts of kindness in the midst of terrible conditions as good treatment (2). There is little published academic research on Stockholm syndrome. No validated diagnostic criteria have been described but as per to the literature and published research, the most widely proposed and quoted one is Graham's (1995) criteria based on a study of nine different victimized groups. Stockholm syndrome simulates battered woman syndrome (BWS) where women are victims of domestic violence, fear for their lives and are isolated, but patients with Stockholm syndrome do not have body image disturbances, somatic complaints or sexual intimacy issues, in contrast with BWS (3). Case Report We present this case of a 27 year-old African American married woman, with a psychiatric history

of schizoaffective disorder that was brought to the psychiatric emergency department due to suicidal ideation, bizarre posturing, selective mutism and negativism in the context of medication non-compliance. According to collateral information obtained from family members the patient and her daughter were physically and sexually abused by the patient's husband. During the hospital course, the patient showed cognitive and personality distortions, denying the above events on multiple occasions, rationalizing and protecting her abuser while displaying an indifferent and hostile attitude towards the treatment team. She used to call her husband on a daily basis and used to display a docile attitude during his visits. Conclusion The aim of this case report is to systematically review the existing published literature on Stockholm syndrome and identify and describe any existing diagnostic criteria and differentiating it from BWS. This patient meets Graham's criteria for the diagnosis of Stockholm syndrome as she is bonded with the offender, denies the episodes of violence, perceives her family and medical doctors as the enemy and the offender as the protector, and she views the world from offender's perspective (4). Existing literature does very little to support the existence of Stockholm syndrome yet case studies demonstrate a possible pattern in the behavior and experiences of people labeled with it.

No. 18

**Male-to-Eunuch Gender Dysphoria With Self-Castration Attempt in a Young Male With Cluster B Personality Organization**

Poster Presenter: *Liubov Leontieva, M.D., Ph.D.*

Co-Author: *Eric R. MacMaster, M.D.*

**SUMMARY:**

Background: Both male-to-eunuch gender dysphoria and self-castration are rare phenomenas that was described in the literature with the latter in the context of the desire to be a eunuch as well as a self-harm attempt. Method: we described a 19-year-old male without prior psychiatric history who attempted to self-castrate by removing one of his testicles with a pair of shears. He was admitted to the acute psychiatric inpatient floor after medical stabilization. Findings: the patient presented with contradictory information on his self-castration act:

initially stating that he dissociated during it; subsequently claiming that he was unhappy with his secondary male sexual characteristics and wanted to stop his hormonal development to remain looking like a boy. The patient denied psychiatric problems and endorsed attraction to females. The patient was evaluated with a MMPI-2 and the results showed long-term adjustment problems in his gender role, a pattern of disinhibition, high risk-taking and impulsive behavior, and propensity to act out without regard for others and be less bound by moral restraints. He also acknowledged alcohol and drug problems. Subsequent outpatient medication management and psychotherapy treatment revealed a borderline dynamic with likely identity confusion in the context of Cluster B personality traits with the attempts to devalue the psychiatrist and create parity among the two. Soon after establishing outpatient care, he began requesting the psychiatrist write him a letter of support to start estrogen therapy, despite continuing to deny being transgender. Additionally, he began to endorse "existential depression" for which fluoxetine was initiated and shortly discontinued as he felt it caused cognitive issues. A trial of bupropion followed which was discontinued after the patient reported fantastical psychotic imagery while at work. Choosing to work only in therapy, he would frequently no-show his appointments or arrive so late that little could be accomplished. He would frequently leave jarring and ambiguous messages on the psychiatrist's voicemail only to deny making these calls when confronted during therapy. Patterns of narcissistic behaviors as well as identity diffusion/confusion were noted. The seriousness of the case escalated after his girlfriend contacted the psychiatrist with text messages from the patient expressing his desire to impregnate her and then kill the baby and her. When questioned, he denied sending these messages and the girlfriend decided not to pursue legal action. Soon after, he was referred to a DBT skills group, but never started as he fired the psychiatrist unannounced and abruptly stated he was moving to California. Conclusion: a rare case of male to eunuch gender dysphoria could represent the identity confusion of a male with borderline personality. Intensive psychotherapy focusing on non-integrated images of self and others is warranted for such condition.

No. 19

**Conversion Symptoms in the Emergency Room:  
Diagnostic Challenges and Polypharmacy**

Poster Presenter: *Allyson J. Kemp, N.P.*

Co-Authors: *James L. Megna, M.D., Ph.D., Liubov Leontieva, M.D., Ph.D.*

**SUMMARY:**

Background: Features of serotonin syndrome and conversion disorder overlap requiring thorough neurological and psychiatric evaluations in order to make a salient diagnosis. There is also diagnostic overlap in conversion disorder symptoms and substance use disorders with episodes of intoxication and withdrawal. Both conversion disorder diagnoses as well as opiate and benzodiazepine use disorders are made from a medical and psychiatric history while serotonin syndrome is a diagnosis made on clinical grounds solely. Conversion disorder, however, requires incompatible evidence between symptoms and neurological and medical findings. Method: We recount a case of a 49-year-old female with a history of unspecified anxiety, depression, and migraines. Pertinent daily medication dosages prescribed by her primary care provider include sertraline 200 mg, venlafaxine 225 mg, and duloxetine 60 mg, as well as alprazolam 0.5 mg up to 6 times daily as needed and oxycodone-acetaminophen 5-325 mg up to 6 times daily as needed. Results: The patient presented to the ED for dysarthria consisting of slowed and slurred speech which progressively fluctuated. A stroke code was initiated resulting in a National Institutes of Health Stroke Scale score of 0, in addition to a non-actionable chest x-ray, a computed-tomography head scan, and an electrocardiogram. Neurology found no abnormalities other than dysarthria and mild depersonalization for alertness. Vital signs remained within normal limits throughout. The urine toxicology result was negative for all tested substances including benzodiazepines and opiates. Blood levels were taken for sertraline (28 ng/ml; low), venlafaxine (286 ng/ml; normal), and duloxetine (25.3 ng/ml; normal) resulting in low and normal plasma levels respectively. Psychiatry found the patient to be euthymic and anxious. Conclusion: Various factors contribute to transient somatic

symptoms making a diagnosis in the ED difficult. Based on findings from emergency medicine and neurology, psychiatry was able to rule out serotonin syndrome, concurrent opiate and benzodiazepine use disorder, opiate and benzodiazepine withdrawal syndrome, and to diagnose conversion disorder with speech symptoms. A sub-therapeutic blood level of 1 SSRI and normal levels of the other 2 SNRIs suggest either rapid psychotropic metabolism or poor medication adherence. This case report builds evidence towards further understanding an easily misdiagnosed clinical presentation of conversion disorder; a diagnosis which often leads to frustration of emergency staff with subsequent low priority placed psychiatric diagnoses and follow-up. Emphasizing on psychotherapy rather than polypharmacy for this patient, and similar patients, would be preferable.

No. 20

**Community Behavioral Health: Standardization of Depression and Substance Use Assessments, Interventions and Referrals in the Medicaid Population**

Poster Presenter: *Mollie Judd, M.S.W.*

Co-Authors: *Lorena Garcia, Neil Pessin, Ph.D.*

**SUMMARY:**

New York State's Delivery System Reform Incentive Payment Program (DRSIP) is one vehicle for Medicaid redesign which seeks to transform delivery of care with innovate integrated care models to improve the health of populations while reducing per capita costs. To this end, Visiting Nurse Service of New York (VNSNY) and twelve other community based organizations have entered into a collaborative with Bronx Partners for Healthy Communities (BPHC), the Performing Provider System (PPS) led by St. Barnabas Hospital (SBH). This collaborative, known as the Community Behavioral Health Initiative (CBHI), is a two-year program that provides resources, training and tools to support behavioral health provider agencies in developing standardized approaches to screening, referral and follow up practices. The initiative is part of BPHC's community-driven work of building an integrated delivery system in the Bronx that is aligned with performance targets that have a high potential for improving health outcomes for Bronx residents and

for making care delivery more efficient through DSRIP. It also provides behavioral health providers with the tools, knowledge and resources to support their transition from volume-based payment to value-based payment. This poster will describe the DSRIP program, the CBHI initiative, and present screening, brief intervention and referral data from our programs which have standardized the use of the Fagerstrom (tobacco dependence), PHQ (depression), AUDIT (alcohol use) and DAST 10 (drug use) assessments, conducted by bachelors and masters level clinicians and case managers, in their Medicaid population. We will compare pre and post implementation screening, intervention and referral rates to demonstrate the efficacy of assessment, intervention and referral standardization in promoting positive clinical outcomes in a community based behavioral health setting.

No. 21

**The Impact of Autism and Intellectual Disability on the Need for Restraint and Seclusion in Pre-Adolescent Psychiatric Inpatients**

Poster Presenter: *Elizabeth O'Donoghue, B.A.*

Co-Authors: *David Pogge, Philip Harvey*

**SUMMARY:**

Background: Manual restraint and seclusion (R/S) are last-resort methods used in psychiatric hospitals to manage aggressive and disruptive behaviors. Prior research suggests that the need for R/S is higher in pre-adolescents than in adolescents, although these incidents tend to be very brief and may be qualitatively different from those involving adults or adolescents. In particular, it appears that this intervention may be required by children whose behavior is less responsive to the kinds of environmental controls provided by the therapeutic milieu of the hospital. Two groups of children who may require more of these brief physical interventions are those who are intellectually disabled (ID) or suffer from Autism Spectrum Disorder (ASD). The purpose of this study is to investigate the role ID and ASD may play in the use of R/S with children in an inpatient setting. Methods: The records of 5-12 year olds (N=777; mean age=9.71) consecutively admitted to an acute inpatient hospital between July 2016 and June 2017 were reviewed by a multidisciplinary treatment

team and assigned a consensus DSM-5 diagnosis ID and/or ASD on the basis of all available information. Each case was then examined for the number and total duration of R/S events during their episode of inpatient care. Results: In this sample 48 children were determined to meet DSM-5 criteria for ASD (6.2%), 295 met criteria for ID (38.0%), 73 met criteria for both ASD and ID (9.4%), and 361 did not meet criteria for either condition (46.5%). Of these, 410 experienced at least one R/S event (52.8%). One-way ANOVA of these four patient groups (ID, ASD, Both, Neither) indicated that they were significantly different ( $p < .000$ ) on both number of R/S incidents and total duration of R/S. Planned comparisons ( $p < .000$ ) revealed that ID and ID/ASD patients required significantly more of these interventions than ASD patients without ID or patients with neither condition. Multiple regression analysis indicated that the effect of ID on R/S remained significant even when age is controlled. Conclusion: Previous research has indicated that R/S events involving pre-adolescents occur much more frequently but they are of much shorter duration than those involving adolescents or adults. These data suggest that a major factor contributing to the need for this intervention is intellectual disability (ID). Since prior studies suggest that the admission of ID children to psychiatric settings is on the rise, these data suggest the need for specialized programs to address the unique challenges of treating ID children in psychiatric settings, in the hope that this may reduce the need for this sort of intrusive physical intervention.

No. 22

**WITHDRAWN**

No. 23

**WITHDRAWN**

No. 24

**Demographics of Patients With ADHD and Non-Suicidal Self-Injury Behavior Requiring Seclusion and Restraints in an Inpatient Child Psychiatric Hospital**

Poster Presenter: *Marwa Badawy, M.D.*

Co-Authors: *Neetu Nair, Garima Singh, M.D., Ravi Shankar*

**SUMMARY:**

Seclusion and restraints (S&R) in pediatric psychiatric hospitals are often used to maintain the safety of the patient and others. Prolonged use of S&R has been found to have negative physical and psychological consequences with no long term benefits. S&R use is highly regulated and is only used in extreme circumstances when there is an imminent risk of harm to patient or others. There is a paucity of research on S&R use in the pediatric population. Most research currently discusses the harmful effects of S&R use and alternative strategies for reducing its need. A retrospective analysis of children admitted to Missouri Psychiatric Center at the University of Missouri, an acute inpatient facility, from January 2011 to December 2014 was conducted to examine predictors of S&R use. After IRB approval was obtained, patients (N=92) with at least one S&R event (N=305) were identified. An extensive chart review through electronic medical records (EMR) was conducted gathering data into a database. The Chronic Behavioral and Affective Dysregulation Syndrome (CBADS) questionnaire was used to gather data from the EMR. With the help of this instrument several demographic and historical clinical variables were collected including age, gender, race, reason for admission, and treatment history. Additionally, every S&R incident was documented with cause, type of restrictive measure(s), length of time, and any medication(s) that were administered. In a previous study using the same sample, we looked at possible risk factors that may predict duration of S&R. Our analysis revealed that attention deficit hyperactivity disorder (ADHD) and history of non-suicidal self-injury (NSSI) were strong predictors for duration of S&R. In the current study, we examined how demographic variables (such as age, gender and ethnicity) of subjects with ADHD or NSSI varied across different duration groups of S&R. Duration of S&R was divided into three groups for analysis: less than 60 minutes, 60-120 minutes and more than 120 minutes. Within each of the S&R duration groups, subjects with a history of ADHD and/or history of NSSI were identified. Frequency distributions were then obtained for demographic variables for the subjects identified. All analyses were performed using SPSS (IBM Corp, Ver 24). Patients with ADHD or NSSI behavior are known to have impulsive behavior



which may lead them to be more predisposed to S&R. The objective of this study is to define the demographic distribution of the two significant risk factors (ADHD and NSSI) that were determined in the previous study. Since there is limited research and data available regarding restrictive interventions, more research is necessary to determine whether findings observed are universally applicable. Understanding risk factors for S&R use in the pediatric population will diminish its need and ameliorate safety.

No. 25

**The Michigan Peer-to-Peer Depression Awareness Campaign: School-Based Prevention to Reduce the Impact of Depression Among Adolescents**

Poster Presenter: *Danielle Samantha Taubman*

Co-Authors: *Lizelle Salazar, M.P.H., Stephanie Salazar, M.P.H., Sagar Parikh, M.D.*

**SUMMARY:**

Objectives: Depression among adolescents is associated with significant disruption in school, relationships, and social roles. The mental health of adolescents (10 to 19 years as defined by the World Health Organization) has emerged as a priority over the last decade. In response, the University of Michigan Depression Center and the Ann Arbor Public Schools in Washtenaw County, Michigan launched the Peer-to-Peer Depression Awareness Program (P2P) in 2009. Since the start of the program, over 700 students have served as Peer Mentors; these students have delivered over 150 awareness-themed events and projects to thousands of peers across 22 schools and two counties. The goals of the project were to: 1) educate middle and high school students about depressions and related illnesses; and 2) support them in finding creative ways to convey this knowledge to their peers in order to raise awareness, reduce stigma, and ultimately, help promote the early detection and prevention of depression. Methods: The intervention involved a one-day conference to teach student educators about broad mental health issues and prepare them to provide peer-to-peer instruction as a team. Each P2P team then developed and implemented a depression awareness campaign featuring activities tailored to fit their school. Both P2P student educators and a

convenience sample of non-P2P students completed baseline and post-test questionnaires. Results: Campaign activities included school assemblies, displays around school, and giveaways. Following campaign rollouts, students were more knowledgeable about depression, more confident in their ability to identify and refer peers who may be depressed, more willing to seek help for themselves, and reported lower mental illness stigma in their schools. Conclusions: The P2P program is designed to maintain a continuous presence in school systems in order to reach incoming students each year and have an ongoing impact in the school and broader community. Findings indicate that the P2P intervention results in greater awareness and earlier detection of depressive disorders among adolescents. This in turn may translate to lower levels of depression-related academic problems, social difficulties, substance use, other psychiatric disorders, and suicide. For nearly a decade, the P2P program has reduced barriers to early identification and treatment among thousands of adolescents.

No. 26

**The Role of Extracellular Matrix Regulation in Synaptic Plasticity and Behavioral Deficits Associated With *Cyfp1* and *Fmr1* Mutations**

Poster Presenter: *Shivanshu Vijaykumar Shrivastava, M.B.B.S.*

Co-Authors: *Ozlem Gunal, Azadeh Kamali Tafreshi*

**SUMMARY:**

Background: Changes in cytoplasmic FMRP interacting protein 1 (CYFIP1) dosage may exacerbate several neuropsychiatric brain disorders. To examine whether mutations causing CYFIP1 and FMRP deficiency interact on common molecular targets, and lead to an exaggerated phenotype, we crossed *Cyfp1* +/- and *Fmr1* -/y mice. Method: We used electrophysiological recordings for hippocampal synaptic plasticity, and inhibitory avoidance test for cognitive behavior in young adult mice from wild type, *Cyfp1* +/-, *Fmr1* -/y and *Cyfp1* +/- /*Fmr1* -/y double mutant groups. We have previously showed that the proteolytic activity of MMP-9, an extracellular matrix gelatinase, is associated with synaptic plasticity in the hippocampus. To test if *Cyfp1* and *Fmr1* interaction regulates the gelatinase activity associated with

hippocampal synaptic plasticity we used gelatin zymography, which is an assay for gelatinase activity in which tissues are exposed to a specific substrate that is recognized and cleaved by gelatinases. For gelatinase assay hippocampal slices from all four genotypes were subjected to DHPG (50  $\mu$ M for 5 minutes), an mGluR agonist, and snap-frozen at 15 min after the treatment. Results: Double mutant mice show significantly diminished LTP (induced by a single 100 Hz stimulation) and display decreased NMDA receptor-dependent LTD (induced by low frequency stimulation), phenotypes that are not seen in either single mutant. In the inhibitory avoidance task, latencies at training, 24 hours and 48 hours show that there's an additional deficit in Cyfip1 +/- /Fmr1 -/y double mutant mice at 24 and 48 hours. We have found that gelatinase activity is regulated with DHPG in all wild type, Cyfip1 +/- , and Fmr1 -/y mice, but there is no regulation of gelatinase activity with DHPG in Cyfip1 +/- /Fmr1 -/y double mutant mice, which confirms the additional phenotypes by Cyfip1 and Fmr1 interaction. Conclusions: Our data support that CYFIP1 shares some roles with FMRP, and may have an interactive effect with FMRP in the regulation of synaptic function in mature synapses, which suggests a mechanism by which altered levels of CYFIP1 could increase disease severity. This study was supported by Rutgers NJMS and NIMH.

No. 27

### **Introducing EMR/EHR Prompts for Timely Diagnosis of Autism Spectrum Disorder**

Poster Presenter: *Ayesha Saleem Adil, M.D.*

#### **SUMMARY:**

Autism Spectrum Disorder is a growing epidemic within the United States. Currently, about one in every 68 children are diagnosed with ASD, with boys being 4.5 times more likely to have the disorder. Despite growing awareness of the disorder via organizations like the National Autism Association, the average age of diagnosis remains at around 5.7 years old. With the advent of seminal studies like the Early Start Denver Model, it is critical for an autistic child as young as 18 months to receive appropriate behavioral therapy to better prepare themselves in becoming eventual independent and productive members of society. Delayed diagnosis of ASD could

prove highly detrimental to a child's behavioral and social growth necessary to function in society. While some studies suggest that a pediatrician could confidently diagnose a child with ASD as early as 2 years of age, other studies suggest that diagnosis of the disorder when a child is 18-30 months old is often very difficult. One major reason is that 1 in 4 children could develop normally but then regress in their behavior during this critical period. Another recent study suggested that even psychologists well trained in diagnosing the disorder had missed properly diagnosing almost 40% of children with ASD, mainly because brief observation of a child (i.e. 10 minutes) is insufficient to truly assess whether a child may have ASD symptoms. If the child is "fortunate" in having received an early diagnosis during this critical 18-30-month period, oftentimes necessary tests of exclusion such as an audiology evaluation and proper networking with local autism resources is still delayed by as much as 7 months. With the recent increase in usage of electronic health record systems amongst pediatricians since the passage of the Affordable Care Act in 2009, we believe that there is an interesting possibility to help pediatricians in diagnosing ASD during this critical period. Very much like the EMR prompts for immunizations and Hepatitis C screenings, which have shown improved rates of vaccinations, early Hepatitis C diagnosis and treatment interventions; we believe that appropriate EHR prompts reminding physicians to check for typical ASD symptoms (i.e. no response to name calling) during the 18th, 24th, and 30th month well child visits would serve as key reminders that will potentially decrease the overall age of diagnosis. In having a simple EHR prompt system in place, pediatricians could increase referrals of potential children with ASD to get Neurodevelopmental evaluation done by Neurodevelopmental Pediatricians or Child and Adolescent Psychiatrists to confirm the diagnosis. Earlier diagnosis will in turn lead to early behavioral intervention from professionals, as well as appropriate networking and financial assistance to families of children with ASD. The hope is that with a simple prompt, more children with ASD will be better prepared to tackle their world and live by societal standards by adulthood.

No. 28

## **The Clinical Significance of Unexplained Symptoms**

Poster Presenter: *Brett Kramer*

### **SUMMARY:**

AG, a 6-year-old Caucasian male, came to Dr. Holsten's office on 08/01/2017 accompanied by his parent with a referral for diagnosis. Mrs. Wiggs, the referring practitioner, suspected a comorbid diagnosis of Autism Mild Level I, generalized anxiety disorder, and ADHD based on both AG's presented behaviors and families account. The referral was made for a differential diagnosis, to determine the goals of treatment, and to identify evidence-based treatments for AG. The Wechsler Intelligence Scale for Children-Fifth Edition estimated his intelligence to be within the 55th percentile. Mrs. G., AG's biological mother, completed the Vanderbilt ADHD Diagnostic Parent Rating Scale where she reported clinically significant symptoms such as inattention, hyperactivity/impulsivity, oppositional defiant behavior, and conduct behavior. Ms. K., AG's teacher, reported the same clinical symptoms in the Vanderbilt ADHD Diagnostic Teacher Rating Scale. AG reported multiple clinical significant symptoms in the BASC-2 Self-Report such as social stress and generalized anxiety. While multiple clinical symptoms came back positive via the Autism Diagnostic Observation System-Second Edition (ADOS-2), overall there was not enough symptoms to meet DSM-V criteria for Autism Spectrum Disorder. Final diagnosis made was generalized anxiety disorder and attention deficit hyperactive disorder. While these diagnoses fit multiple clinical symptoms that AG presents they still do not account for his other symptoms, such as: sensory overstimulation, an obsession with firearms, and predisposition for repetitive behaviors. Even though the symptoms stated above meet Categories B, C, and D for autism spectrum disorder, according to the DSM-V, he still does not qualify for the diagnosis of Autism Spectrum Disorder. This is because patients must have both social communication impairments (Category A) and repetitive behaviors to qualify for the diagnosis. Patients who have isolated social impairment with lack of repetitive behaviors can be diagnosed with Social Communication Disorder. On the other hand, there is no separate diagnosis for patients with the sole combination of repetitive behaviors and altered sensation that leads to

emotional outbursts when disrupted. An elevated awareness and focus on isolated restricted interests and repetitive behaviors can improve treatment options for patient's like AG.

No. 29

## **Outcomes in Older Adults With Schizophrenia**

Poster Presenter: *Maria Elena Correa, M.D.*

### **SUMMARY:**

Outcomes in Older Adults with Schizophrenia

Authors: Maria E. Correa M.D., Carl I. Cohen M.D.

Background: The study of outcomes in Schizophrenia has shifted over the years in tandem with changes in our perspectives on the disease structure, progression and management. The post-deinstitutionalization era created more optimism and a more nuanced view of how we perceive outcome. As the number of older adults with schizophrenia has dramatically increased it has become important to appreciate the outcome of the disorder in later life. Therefore, our aim is to examine cross-sectional and longitudinal data from a community sample of older adults with schizophrenia (OAS) with respect to 4 outcome measures: clinical remission, community integration, clinical recovery, and successful aging. Methods: The sample was recruited from outpatient programs, day programs and supportive residencies. It consisted of 250 persons aged 55 and over, who developed the disorder prior to age 45, living in New York City. The mean age was 61 years, 52% were male and 55% were white, 34% were black, 9% were Latino and 2% other. Of the original sample 104 participated in the follow up interview (mean follow-up period was 52 months with a range of 12 to 116 months). Clinical remission was measured using the PANSS scale and defined as a score of 3 or below on each of 8 symptom domains and as well as no history of hospitalization within the previous year. To assess community integration, 12 item Community Integration Scale was developed consisting of 4 components: independence, psychological integration, physical integration and social integration. Scores of 9 or higher were defined as successful community integration. Subjects who met the criteria for both clinical remission and community integration were deemed to have attained "clinical recovery., To evaluate successful

aging we developed a scale (range 0-6) comprising 3 domains: Avoiding disease and disability, High cognitive and physical function and engagement with life. Results: Cross-sectional data revealed a prevalence rate of 46% for clinical remission, and 37% prevalence of community integration;. 22% of the participants achieved criteria for clinical recovery; only 2% achieved criteria for successful aging. Longitudinally, we found 25%, 26%, and 12% maintained persistent clinical remission, community integration, and clinical recovery, respectively. There was also considerable flux between categories with 40%, 45%, and 70% for clinical remission, community integration, and clinical recovery, respectively. Conclusions: • Cross-sectional data may provide an overly optimistic view of outcomes among OAS and the prospective data suggests a more variable course with individuals fluctuating between favorable and non-favorable outcomes. • Persistent clinical recovery and successful aging remain elusive for most OAS. • Heterogeneity persists later in life; consequently, proactive care must continue

No. 30

### **Delusional Parasitosis in the Setting of Restless Legs Syndrome**

Poster Presenter: *Danny Tran, D.O.*

#### **SUMMARY:**

**INTRODUCTION:** Delusional parasitosis (DP) is a somatoform disorder where one exhibits monosymptomatic hypochondriacal psychosis believing they are infested by parasites or insects. DP is a rarely diagnosed (0.83% (1)) disorder and there is an estimation that practicing dermatologists may see an average of one patient with DP over a span of 7 years in practice (2). In this case we look at a patient's DP with co-morbid restless leg syndrome and present drug interactions that may arise. **CASE:** We report a 70 year old Caucasian female who presented to the geriatric inpatient psychiatric unit for insomnia along with visual, auditory, and tactile hallucinations over the course of the past month. The patient believed that her house was overfilled with insects, stating that she sees, feels, and hears them crawling all around her home as well as her body. She aggressively picked at her own skin to remove the bugs, resulting in numerous skin lesions. The patient was discovered by her husband washing

her entire body and hair with borax detergent and Listerine. Baby powder was spread all around her home so it would "smother and kill the insects". She presented pictures on her cellular phone of various places in her home believing she captured the bugs, however pictures showed small specks of fiber. She believed there were bugs in her ears, when removed, were pieces of thread. She had her primary care physician observe these threads under the microscope and nothing was found. The patient was diagnosed with provisional Delusional Parasitosis (DP) with Morgellons Disease, a subset diagnosis of DP. Her history was significant for Restless Leg Syndrome (RLS), which she was having significant difficulty with sleep over the last several weeks. She reported sleeping at most 1-2 hours a night secondary to leg discomfort. It was discovered that the patient was recently started on Mirapex for her RLS around the same time her delusions began. She also had a concurrent urinary tract infection which she was started on Macrobid on admission. Her urine drug screen was negative and all other lab work was unremarkable. We discontinued her Mirapex and started the patient on Gabapentin and Klonopin for her RLS and Risperdal for psychoses. The patient's RLS and sleep markedly improved with these changes and her delusions and hallucinations were resolved at time of discharge. **DISCUSSION:** This case demonstrates a patient with RLS whom was treated with a dopamine agonist resulting in psychotic symptoms presenting as delusional parasitosis. The patient responded well to the discontinuation of her Mirapex with appropriate replacement for treatment of her RLS. We illustrate the importance of considering contributing factors to patients' symptomatology.

No. 31

### **WITHDRAWN**

No. 32

### **Promoting Mental Health Awareness in the Christian Community Through Collaboration**

Poster Presenter: *Claudine Elaine Jones-Bourne, M.D.*  
Co-Authors: *Melissa Arbuckle, Benjamin Miller*

#### **SUMMARY:**

**Background:** Efforts have grown to improve knowledge and awareness of mental health illnesses

in order to decrease stigma and improve outcomes of mental illness. Christian churches are of particular interest because people in religious settings are more likely to have better outcomes with certain mental illnesses. However, stigma towards mental illness within the Christian community may limit this potential benefit. Collaboration between mental health professionals and religious leaders may be useful in addressing some of these issues. The aim of this study was to assess the feasibility of developing and implementing a mental health educational series in collaboration with a church community and to assess the impact of the program. Methods: The pastor and a congregation member (a psychiatrist) at an Orthodox Presbyterian church in New York co-developed six educational sessions focused on mental health. The sessions were offered weekly after the main services to high school students and adult attendees. The topics covered in the sessions included depression, anxiety, schizophrenia, bipolar disorder, substance use disorders, eating disorders, and personality disorders. Each session presented the illnesses using the themes: Recognition, Recovery, Renewal, and Response. The psychiatrist presented symptoms of various illnesses and treatment options (Recognition and Recovery), while the pastor led a discussion of religious aspects and the ways congregants can support to people with these illnesses (Renewal and Response). The participants participated in a post-survey which assessed how they would have described their opinions about mental illness and people with mental illness before the series, how their opinions about mental illness and people with mental illness has changed since attending the series, how their opinions about getting treatment for mental illness has changed since attending the series, and which aspects of the series was most impactful in changing their opinion. The institutional review board of the New York State Psychiatric Institute reviewed this study and determined that it did not meet the definition of human subjects research. Results: Interest in the series was evidenced by the fact that about 51 of the 100 members who attended worship also participated in the series. Our hypothesis is that the series promoted positive change in the congregation's opinions about mental illness as well as their thoughts about seeking treatment for such illnesses. Survey collection and data analysis is still

underway. Conclusion: The format and collaboration techniques employed in the mental health series could serve as a model which can translated to other community outreach efforts.

Friday, October 05, 2018

## Poster Session 2

No. 1

### **Telepsychiatry Assisted Follow Up Engagement of Treatment Dropout Substance Users**

Poster Presenter: *Raju Bhattarai*

#### SUMMARY:

**BACKGROUND** Opioid Substitution Treatment (OST) is a harm reduction approach for Intravenous drug users to shift them to oral Buprenorphine or Methadone. After a period, many of these clients drop out facing an increased likelihood of relapse. In such individuals a comprehensive approach right from the beginning of substance use treatment is essential. In India, OST is run by National AIDS Control Organization (NACO) and due to a nationwide shortage of mental health professionals, integrated treatment approach is unaccomplished in the majority of centers. Existing literature supports the role of economic methods such as telepsychiatry to facilitate mental health professionals' reaching out to substance-using clients. Brief intervention is useful in substance use population during different phases of drug treatment. Given the low psychiatrist/population ratio in India, telepsychiatry assisted brief intervention could be a viable alternative for drop-out population. By linking the psychiatrists to substance users in remote locations, telepsychiatry could enhance treatment adherence and promote follow up. **METHODOLOGY** NACO counselor at every OST center regularly visits the non-adherent clients' homes to report the reasons of treatment drop out. Sixty client clients from the OST program at Gorakhpur, North India, who had treatment drop-out history of preceding 3 months were contacted by phone. Every week 10 clients were contacted and home visits were made to 4 willing clients in each week. Altogether, 32 clients consented to meet over a period of 2 months. The meeting was conducted at home in presence of at least one family member as well as on a one to one

basis. A 20 minutes session was conducted by the counselor. It began with detailing the family about the purpose of the visit followed by obtaining an informed consent. Demographic details were noted and instructions were given for self-administration of 'Reason for Leaving Treatment Questionnaire' (RLTQ). After this, the facilitator connected the client to the psychiatrist through the medium of a tablet device for one to one brief intervention session. This was followed by the closure which included a group session with the client and the family members to address their queries. Clients were suggested to follow up at the OST center and restart the treatment at the earliest convenient date. The attendance frequency in the following 1 month after the telepsychiatry session was assessed and analyzed. RESULTS Twenty-eight out of 32 clients approached the OST center within 3 days of the home visit session and 22 clients remained in treatment until 1 month period following the intervention. Most common reason for leaving the treatment was logistic problems. Twenty-nine clients were using some form of substance, alcohol being the most common; 18 reported to be using their substance of choice: heroin.

No. 2

**Substance Abuse and Antipsychotics, an Inpatient Rehab Retrospective Analysis of Patients Who Sign Out Against Medical Advice**

Poster Presenter: *Charles Rodolphe Odom, M.D.*

Co-Authors: *Frozan Walyzada, M.D., Rachel Schoolcraft*

**SUMMARY:**

Background: "Comorbid substance abuse is known to blunt response to treatment for underlying psychiatric disorders,"(Star et al; 2017). It is also known that many second generation antipsychotics are being abused recreationally. Studies have been done which analyze the most commonly abused second generation antipsychotic and demonstrate preventative methods to decrease the amount of hospitalizations due to substance abuse. Quetiapine is one of the more commonly abused second generation antipsychotics, but there are others that are starting to rise in popularity. Methods: We will review retrospectively the charts from an in-patient rehab setting in an underserved area between July

2015 to June 2017 for patients who sign out Against Medical Advice (AMA) to identify any correlations between different antipsychotics and substance abuse. Conclusion: This retrospective analysis aims to examine prescribing patterns in our facility and determine if any changes could be implemented that could lead to better outcomes such as fewer admissions, and add to the literature about the increase in commonly abused second generation antipsychotics.

No. 3

**Positive Amphetamine Screen in a Credible Patient Who Strongly Denies Use**

Poster Presenter: *David M. Marshall, M.D.*

Co-Author: *Shannon Kinnan, M.D.*

**SUMMARY:**

Urine drug screens are commonly utilized when a patient presents with psychiatric symptoms as his/her chief complaint, regardless of whether the patient presents to an Emergency Department setting or an inpatient psychiatric hospital. The goals of the screen can be to confirm use of illicit drugs and/or non-prescribed medication, provide objective information, confirm use of prescribed medication, and facilitate doctor-patient communication. The screens are widely available and generally cost-effective, but are prone to false positives. Many clinicians fail to recognize potential causes of false positive and false negative results seen on the screen. Here we present the case of a 50 year-old Caucasian male with a history of depression and alcohol use disorder (a "functional alcoholic"), who presented to an ED in the Midwest following an intentional overdose of Lamictal. He admits to drinking alcohol heavily daily, presenting with a BAL of 74. His urine drug screen is positive for amphetamines. Following medical clearance he is admitted to a psychiatric hospital, where he strongly denies any recent history of illicit drug use and any history of using an amphetamine-containing drug. He offers a possible explanation for his positive test – while bingeing on alcohol in the past few days, patient consumed cough syrup, which he thinks contained all of the following ingredients: dextromethorphan, guaifenesin, and pseudoephedrine. In this poster, the authors will present general urine drug screen false positives and

negatives, information regarding the testing analytical techniques, further information on confirmatory testing, and the conclusion to the presented case.

No. 4

#### **Pitfalls in Transplantation for Alcoholic Hepatitis**

Poster Presenter: *Beth Zell, D.O.*

Co-Author: *Paula Marcus*

#### **SUMMARY:**

Introduction: The majority of liver transplant programs in the U. S. require patients with alcoholic liver disease be free of alcohol for at least 6 months before they can be listed. [1] However, because the survival for patients with acute alcoholic hepatitis is less than 30%, several transplant centers have begun transplanting select patients with shorter periods of sobriety. [2,3] The two cases below demonstrate similar cases of alcoholic hepatitis, both transplanted after minimal periods of sobriety, but with drastically different trajectories. The cases illustrate how we can better screen our patients prior to listing for improved outcomes. Case 1: Mr. X, a 52 year old, was diagnosed with acute alcoholic hepatitis, had been drinking since he was a teenager, had past DUIs and participated in alcohol rehabilitation programs in the past. At the time of admission, he was employed as a bartender, and last drink was four days prior to admission. He endorsed drinking more than six beers daily. Patient had strong family support, and demonstrated motivation for long term sobriety. Patient underwent OLT, and has been compliant and sober since his transplant. Case 2: Mr. K, a 36 year old male, had also been drinking since he was a teenager, with several DUIs, and attendance at rehabilitation programs; however, he had several prior liver-related medical admissions. His insight was poor, but family support seemed adequate. He underwent OLT, but returned to drinking two weeks following discharge which precipitated non-compliance with his immunosuppressants and he developed chronic rejection of his graft. Discussion: Insight into the addiction as well as motivation for life-long sobriety, are key factors in determining candidacy for transplantation for Alcoholic Hepatitis. Patients must be able to take ownership of their problem-drinking and have strong family support. Patients with a history of prior

episodes of liver de-compensation, poor insight, comorbid substance abuse of any kind and inadequate family support are considered poor candidates.

Conclusions: Recently, there has been a call to provide equal access to liver transplantation for patients with severe alcoholic hepatitis [4]. Our cases illustrate that patients with alcoholic hepatitis can have favorable outcomes as long as strict criteria are met.

No. 5

#### **Missouri's Response to the Opioid Crisis: Implementation of a "Medication First" Treatment Model**

Poster Presenter: *Roopa Sethi, M.D.*

Co-Authors: *Angeline Stanislaus, Rachel Winograd*

#### **SUMMARY:**

Objectives: The State Targeted Response (STR) project to curb the opioid epidemic is funded by SAMHSA- Opioid STR grant. Using "Medication First Model" this project links rural primary care, psychiatrists and mental health professionals to facilitate treatment for Opioid Use Disorder(OUD). Methods: The Missouri Institute of Mental health/University of Missouri at Saint Louis has partnered with Missouri Department of Mental Health for the STR of the Opioid epidemic in the state of MO. The grant targets four areas as in 1.Prevention, 2.Treatment, 3.Recovery, 4.Sustainability and Community impact. The focus of the grant is on treatment as in the "Medication First" model. Prevention focuses on evidence-based primary prevention school programming in two high need areas. It is providing Telehealth on chronic pain management in primary care settings. It is also expanding implementation of overdose education and naloxone distribution(OEND). The treatment part of the grant is focussing on increasing access to medical treatment for uninsured individuals. This is being achieved by interdisciplinary provider training, direct service delivery, healthcare integration and improved transition of care. The providers trained in Medication assisted treatment (MAT), hold trainings, seminars and webinars for the physicians who do not have the waiver for buprenorphine. This training encourages primary care physicians, psychiatrists, nurse practitioners and other interested prescribers get their waiver to be able to prescribe

buprenorphine and or buprenorphine- naloxone in their outpatient settings. Free seminars are held at various rural settings and at community mental health centers and webinars are prepared for providers to have access to this information. They are also educated about naltrexone and long acting naltrexone. An online listserv called the Opioid STR list serv, is available for physicians for questions about MAT. They discuss their challenges in initiating buprenorphine and other unique situations in compliance with HIPPA regulations. The goals of the "medication treatment model" is to have 1. Increased number of buprenorphine prescribers, 2. Opioid use disorder being treated across various care settings including primary care, mental health and addiction professionals. 3. Changing the standard of care for OUD in substance use disorder settings- treat with medication first model. STR recovery support efforts provide recovery housing for 500 individuals per year, use peer support specialists, have recovery community centers in four areas of the state and provide recovery management checkups to keep individuals engaged in treatment. Final goal of the Opioid STR grant is sustainability through policy and practice change. These include but are not limited to MO health net policy and reimbursement structure changes. Results: The goal of the Opioid STR grant is to catalyze a culture and practice shift to address the Opioid epidemic.

No. 6

#### **Varenicline for Smoking Cessation and Reduction in People With Schizophrenia: A Meta-Analysis**

Poster Presenter: *Saeed Ahmed, M.D.*

Co-Authors: *Sanya A. Virani, M.D., M.P.H., Michael Esang, MB.Ch.B., M.P.H., Padma Kotapati, M.D., Ramya Bachu, M.D., Mahwish Adnan, M.D., Ali M. Khan, M.D.*

#### **SUMMARY:**

Objective: Smoking represents a major public health problem among patients with schizophrenia. To this end, some studies have investigated the efficacy of varenicline for facilitating smoking cessation in schizophrenia patients. The present review seeks to synthesize the results of these studies as well as document the reported side effects of using this medication. Methods: An electronic search was performed using five major databases: PubMed,

Scopus, EMBASE, Web of Science and Cochrane Library. Included in the current analysis were randomized clinical trials (RCTs) that have investigated the effect of varenicline in promoting smoking cessation in patients with schizophrenia. Risk of bias among included RCTs was assessed using the Cochrane Collaboration's quality assessment tool. Results: Among the 828 screened articles, only four RCTs, which involved 239 participants, were eligible for meta-analysis. In patients with schizophrenia, varenicline treatment relative when compared to placebo significantly reduced the number of cigarettes consumed per day [SMD (95% CI) = 0.89(0.57-1.22)] and expired carbon monoxide levels [SMD (95% CI) = 0.50 (0.06-0.94)] respectively. Conclusion: Despite the limited number of studies included in the meta-analysis, our results suggest that varenicline is an effective and safe drug to assist in smoking cessation in patients with schizophrenia. Future large-scale and well-designed RCTs are required to confirm this finding.

No. 7

#### **A Case of Forced Normalization With Emergence of Psychosis**

Poster Presenter: *Saeed Ahmed, M.D.*

Co-Authors: *Michael Esang, MB.Ch.B., M.P.H., Padma Kotapati, M.D.*

#### **SUMMARY:**

We present a case study of a 26-year-old female with a history of a seizure disorder and no past psychiatric history presented to the emergency room (ER) in an altered mental state, exhibiting psychotic symptoms, all of the acute onset. She was admitted to the medical unit, where she was co-managed by Consultation-Liaison Psychiatry and Neurology services. Her family revealed that she was diagnosed with the seizure disorder in late 2016 and had been treated with Levetiracetam 500mg BID until October 2017. However, in November 2017, she began to have frequent seizure episodes. Due to increased frequency of these episodes, her private neurologist added Phenytoin 100mg three times a day instead of titrating Levetiracetam 500mg BID. According to her family, after she began taking Phenytoin, she became more irritable, labile, and was in "rage all day long." which eventually escalated into aggression, agitation, and florid



psychosis, which led to the hospitalization. During her stay on the medical floor, therapeutic levels of phenytoin and levetiracetam were 18µg/mL (normal range: 10.0-20.0µg/mL) and 11.2µg/mL (normal range: 12-46µg/mL), respectively. The patient's electroencephalogram (EEG) was normal, her computed tomography (CT) head scan was unremarkable, and her pregnancy test, antinuclear antibody (ANA) and Lyme disease serologies were negative. Her erythrocyte sedimentation rate (ESR), and her folate and vitamin B12 levels were also within normal limits. During her hospitalization, agitation was treated with Haldol 5mg and Lorazepam 2mg, both given intramuscularly every 8 hours as needed. Levetiracetam was discontinued, and the patient was started on divalproex sodium ER 500mg BD. Intravenous fluid administration addressed the patient's elevated levels of creatinine kinase (10881/L to 3061 U/L) until they dropped to 420 U/L. When her aggression resolved, she was started on olanzapine 2.5 mg to address psychosis. Subsequently, the patient's condition stabilized, and she was discharged. She received follow-up care at the adult medicine, psychiatry, and neurology clinics. At the time of discharge, her medications were phenytoin 100mg t.i.d., olanzapine 2.5mg b.i.d., and divalproex sodium ER 500mg b.i.d. This case emphasizes the importance of appropriate selection of antiepileptic's and closely monitoring epileptic patients, who are at increased risk for neuropsychiatric complications [1]. Many clinicians may encounter such cases in their daily practice when a patient is already on one AED and continues to have seizures. So prescribers often tempted to increase the medication or add another AED. This is a point where forced normalization occurs because of continuous efforts to control seizures which may lead to psychosis. We will discuss in greater how to deal with such situations with appropriate alternate options.

No. 8

### **Survey of Physician Attitudes Toward Psychogenic Non-Epileptic Seizures and Driving**

Poster Presenter: *Saeed Ahmed, M.D.*

Co-Authors: *Michael Esang, MB.Ch.B., M.P.H., Umer Farooq, M.D., Padma Kotapati, M.D.*

SUMMARY:

Background: Physicians from various disciplines encounter patients presenting with psychogenic non-epileptic seizures as part of their routine clinical practice. Recommendations towards assessing fitness to drive and reporting are clearer for conditions such as neurocognitive disorders and epilepsy but such guidelines do not exist for patients with psychogenic non-epileptic seizures (PNEs). Here we assess physicians' attitudes towards driving for patients diagnosed with PNEs. Methods: Electronic questionnaires were sent to Neurology and Family Medicine physicians practicing at Creighton University Medical Centre, and Psychiatry physicians practicing at Creighton-Nebraska Psychiatry Residency Program to assess their opinion regarding driving risk when encountering PNEs. Results: The survey request was sent to 125 physicians, of which close to 60% completed the survey. 88% of participants encountered PNEs in their clinical practice and 69.1% agreed it was a difficult problem to assess, with only 8.3% endorsing a belief that these patients should drive without restrictions. 93% felt having guidelines would help them assess the driving risk in this population. Conclusion: PNEs are common across Neurology, Psychiatry and Primary Care, and most physicians find assessing driving risk in such individuals highly warranted yet difficult. Developing such assessment guidelines and recommendations is of great need for clinicians. Conclusion: Our survey examined major issues that physicians face while making recommendations. After a rule-out diagnosis of PNEs by Neurologists; patients are either referred back to primary care or to Psychiatrists. We included primary care physicians, psychiatrists and neurologists in our survey sample as these are the 3 most involved specialties. Some of those include limited knowledge on how to make driving decisions in this population; lack of resources, fear of legal implications and lack of experience in making such decision were highlighted. The need to have guidelines was a unanimous need identified among all specialties. Our study findings mimicked previous studies with 45.8% of responders endorsing those same restrictions should be applied to PNEs as with epilepsy. Making decision case-by-case causes significant variation and confusion in assessments and recommendations among providers. This is reflected by fear of legal implication in 47.9% of the responders, 54.9 %

reporting lack of experience in taking the decision and 93.1% reporting a need for specific guidelines.

No. 9

**We Miss 100% of the Questions We Don't Ask: Improving Chronic Traumatic Encephalopathy Outcomes**

Poster Presenter: *Alexander Ghobadimanesh, D.O.*  
Co-Authors: *Ronald Wauters, Herman R. Clements, M.D.*

**SUMMARY:**

Chronic traumatic encephalopathy is a debilitating disease that was initially recognized back in the 1920s, but only recently popularized by the American media as a result of Dr. Bennett Omalu's neuropathological autopsy findings from NFL players that he had suspected of having the disease. However, traumatic brain injuries that can lead to long-term cumulative neuropsychiatric symptoms such as those seen with chronic traumatic encephalopathy, are relatively understudied within the child and adolescent population. Mr. T is a 20-year-old white male with no documented past psychiatric history at time of evaluation, who presents with his mother at the outpatient psychiatric facility for evaluation and management after his mother witnessed that he was displaying bizarre behaviors. Mr. T's mother was concerned because Mr. T had exhibited behaviors that were not observed in the past. These behaviors included extreme paranoia, Mr. T admitting to auditory and visual hallucinations, as well as suicidal thoughts. Mr. T's history reveals that he played football from age 5 years on, sustaining multiple traumatic brain injuries (TBI). The first episode occurred in 6th grade, with loss of consciousness during that episode.. His second TBI episode occurred in the 11th grade without loss of consciousness. His third and most recent TBI episode reportedly occurred when he was in 12th grade and he experienced loss of consciousness. While Mr. T's presentation is further confounded by cannabis use, which he admits to starting after his last TBI, his exhibited psychiatric signs and symptoms are concerning for early onset of chronic traumatic encephalopathy. While this is usually a diagnosis made upon postmortem brain biopsy, and has been primarily studied in the adult population, the potential for previous traumatic

brain injuries occurring in childhood which lead to chronic traumatic encephalopathy, should be a point of emphasis when clinicians obtain information from patients. Preventative management can lead to improvements in academic, social, and occupational functioning.

No. 10

**Petit Mal or Thought Blocking? A Case of First-Break Psychosis in a Patient With Absence Seizures**

Poster Presenter: *Xavier Yang Diao, M.D.*  
Co-Authors: *Marta Lea Hoes, M.D., J.D., Lauren Lepow*

**SUMMARY:**

Ms. E, a 21 year old female with a past medical history of seizure disorder (absence and complex partial) and a past psychiatric history of reported borderline personality disorder and cannabis use disorder, was brought to the emergency department in restraints for worsening agitation and aggression in the setting of clobazam dose fluctuation. She had mistakenly taken twice the dose of her AED, clobazam, for approximately one month leading up to admission, followed by abrupt cessation when she discovered her error. She was admitted to the inpatient psychiatry service based on bizarre and aggressive behaviors, and neurology was consulted. From the patient's first interview on the unit, she was noted to have brief periods of staring, grimacing, loss of focus, and latent responses to questions. These episodes were initially thought to be absence seizures based on the characteristics observed and prior documented EEG findings consistent with absence seizures. However, the team was surprised to discover that repeat EEGs were negative for seizure activity during witnessed episodes. On further evaluation during a subsequent hospitalization, Ms. E was diagnosed with schizophrenia. She was started on an antipsychotic, and the episodes decreased in frequency and intensity. In a Pubmed literature search, neither cases of clobazam-induced psychosis nor peri-ictal psychosis associated with absence seizures could be found. Psychogenic non-epileptic absence seizures are also not well documented. Therefore, it was thought that the most likely etiology of her psychotic presentation was benzodiazepine withdrawal. Ultimately, when her symptoms did not improve on

a stabilized clobazam dose, it became apparent that the phenotypic architecture of her thought-blocking mimicked that of her previous seizures. When differential diagnoses fall between the fields of psychiatry and neurology, patients often suffer from delayed diagnosis and treatment. While the comorbidity of epilepsy and severe psychiatric illness has been studied, there is currently a lack of literature pertaining specifically to absence seizures. To this end, more research is needed to further elucidate the distinguishing features between absence seizures and frank psychosis, in order to improve diagnostic accuracy and offer targeted treatment.

No. 11

**Associations Between STS Gene Polymorphisms and Risk of ADHD: A Meta-Analysis**

Poster Presenter: *Yang Ao Roby, M.D., Ph.D.*

**SUMMARY:**

Background: Steroid sulfatase (STS) gene plays an essential role in the biosynthesis of steroid hormones. Aberrant level of steroid sulfatase enzyme has been linked to Attention deficit/hyperactivity disorders (ADHD) and is hypothesized to underline the development of brain and behavior. Previous studies investigating the role of STS polymorphisms in ADHD have yielded mixed findings, rendering it difficult to ascertain the exact genetic impact of STS in disease susceptibility. This meta-analysis aims to clarify the relationship between STS variants and risk of ADHD by combing all published data. Methods: We searched PubMed, MELINE, PyscINFO, Scopus and Google Scholar for relevant articles covering both case-control and family-based genetic association studies published through June 2017. Meta-analysis was performed on three STS polymorphisms (rs2270112, rs17268988 and rs12861247) under a random effect model. Odds ratios (ORs) for the allelic contrast model were aggregated to evaluate the strength of association. Between-study heterogeneity was explored using sensitivity test, and potential publication bias was assessed using Egger's test and Rank Correlation test. Results: A significant association was found between rs2270112 and ADHD (OR = 1.30, 95% CI = 1.01 – 1.69, P = 0.04). Furthermore, in stratified analysis, rs12861247 displayed a strong association

within family-based studies (OR=1.96, 95% CI = 1.38 – 2.78, P = 0.0002). Conclusions: The current meta-analysis suggests rs2270112 polymorphism of STS gene is a risk factor for ADHD. However, larger-scale studies are warranted to replicate these findings and further elucidate the genetic impact of STS has on ADHD.

No. 12

**22q11 Deletion Presenting as First Break Psychosis, Severe Hypocalcemia and Bilateral Basal Ganglia Calcifications**

Poster Presenter: *Ali Maher Haidar, M.D.*

**SUMMARY:**

We present the case of a 20 year old young woman in a first psychotic episode with paranoia, Capgras delusions and catatonic features. Laboratory investigation found her to suffer from hypocalcemia and hypothyroidism and head CT revealed bilateral calcification in her basal ganglia. Upon further inquiry, patient was found to have been diagnosed with hypocalcemia 3 years earlier with no further work up before being started on Calcium replacement therapy. Physical examination showed bradykinesia, gait shuffling and rigidity suggestive of Parkinsonism. Her original catatonic symptoms responded quickly to Lorazepam on a 2mg TID regimen. However she failed a 4 week Aripiprazole trial on maximum dose. She expressed EPS signs with a single dose of Olanzapine. Seroquel was started and tapered up with a dose of 800 mg daily on which she became stable. Patient's bilateral basal ganglia calcification and thyroid hormone anomalies were suggestive of possible congenital anomaly and Fahr's disease was highest on our differential given her bilateral calcification and calcium abnormalities suggestive of hypoparathyroidism despite relatively early onset considering patient's age. However genetic testing revealed a deletion on chromosome 22q11 indicative of DiGeorge syndrome. This case illustrates the importance of screening for undiagnosed medical illnesses in first break psychosis even if patients fall within the classical phenomenological age group. As one of the principal risk factors for developing schizophrenia, DiGeorges should always be on the differential in psychotic adults with other endocrinologic anomalies as several previous reports show that adults may go

under the radar without being diagnosed with the disorder. In this poster we discuss the importance and frequency of assessing for undiagnosed 22q11 deletions.

No. 13

**WITHDRAWN**

No. 14

**Barriers to Clozapine Use in the United States of America**

Poster Presenter: *Saad Wasiq*

Co-Author: *Muhammad Aadil*

**SUMMARY:**

Background: Clozapine is an FDA approved, atypical antipsychotic for use in treatment-refractory schizophrenia and suicidal risk reduction in patients with schizophrenia or schizoaffective disorder. Despite its proven efficacy, several barriers to clozapine use exist, and the drug remains underutilized across the US. Methods: Clinical practice guidelines, clinical trials, review papers, meta-analyses, and reports were reviewed off PubMed, Psychinfo, and Cochrane library. Keywords used included 'clozapine,' 'prescribing,' 'schizophrenia,' 'schizoaffective disorder,' 'underutilization,' 'barriers,' 'antipsychotics,' 'guidelines.' The search was restricted to articles published over the last ten years. Results: 10 articles were retrieved. Several barriers to clozapine use were highlighted in these articles. The most important barriers were lack of knowledge and confidence among physicians, negative perception about the drug's efficacy among physicians and patients, drug side effects, lack of resources, administrative burden and unprepared healthcare centers. Conclusion: There is a need to understand and overcome the barriers to clozapine use, especially for the drug's benefits in refractory schizophrenia and suicidal risk reduction. Patient and provider education, better guideline and policy implementation both within the hospital setting and at the administrative level can help overcome these barriers.

No. 15

**Lithium-Induced Bradycardia: Sinoatrial Node Dysfunction in an Elderly Muslim Woman With Syncope**

Poster Presenter: *Therese Woodring*

Co-Authors: *Britney Galantino, M.D., Amanda Vastag*

**SUMMARY:**

CASE: A 69-year-old South Asian Muslim woman with history of bipolar disorder was admitted from the emergency department with syncope and frequent falls for the past 3-4 months. Her dose of lithium had recently been modified from 300 mg twice daily to 600 mg nightly. Initial workup found serum lithium levels above therapeutic range, and EKG showed sinus bradycardia with junctional escape. As lithium was held, serum lithium levels decreased and bradycardia improved. The patient was discharged without symptoms on a reduced dose of 300 mg lithium daily. However, she was noted to have recurrent signs of dizziness at a follow-up echocardiogram 8 months later. She endorsed multiple syncopal episodes since discharge and was readmitted with bradycardia and sub-therapeutic lithium levels. Lithium was discontinued, and the patient was started on divalproex titrated to 500 mg daily. Despite this adjustment, her heart rate remained significantly lower compared to baseline on lithium 300 mg twice daily (55 vs. 67 beats per minute;  $P < 0.0001$ ). DISCUSSION: EKG abnormalities including T-wave inversion and sinoatrial node dysfunction are among the adverse effects of chronic lithium therapy [1]. At nodal cardiomyocytes, lithium is believed to reduce pacemaker automaticity by competing with sodium for slow voltage-gated sodium channels and attenuating the membrane hyperpolarization required for their activation [2]. Previous cases have described sinus bradycardia with serum lithium levels in toxic as well as therapeutic ranges, typically improving after discontinuation of lithium [3-6]. In our patient, however, sinus bradycardia persisted after the drug was stopped, suggesting more lasting alteration of cardiomyocyte function. A switch to an alternate mood stabilizer or lithium treatment with permanent pacemaker placement are options for continued management of bipolar disorder. Notably, our patient experienced several months of symptoms between changing her lithium dose and

seeking care, and despite ongoing syncopal episodes after discharge, her readmission rested on concerns voiced by her echocardiogram technician. Cultural factors, including a more passive role for female South Asian elders in medical interactions, may account for some latency initiating complaints [7, 8]. In addition, over half of American Muslim women report delay in seeking care when same-sex physicians are thought not to be available [9]. Providers should encourage healthcare utilization by soliciting physician gender preference. Ultimately, we recommend increased provider attention to heart rate and hypotensive signs in all patients on chronic lithium therapy.

No. 16

**Mindfulness Based CBT With Medication Is Probably More Effective in the Treatment of Generalized Anxiety Disorder in Female Adults (25–30 Years Old)**

Poster Presenter: *Debanjan Pan, M.D.*

**SUMMARY:**

Participants - Inclusion criteria: 1. Existence of Generalized Anxiety Disorder (Diagnosed by a psychiatrist and psychologist) according to DSM - V Criteria. 2. Hamilton's Rating Scale for Anxiety. (HAM-A): Value in between 18-24, classified as mild- "moderate anxiety severity" were selected. 3. Informed Consent of the Patient. Participants - Exclusion Criteria: 1. Psychiatric Illness other than Generalized Anxiety Disorder like, Depression, OCD, Bipolar disorder, Schizophrenia and related psychotic disorders. 2. Generalized Anxiety due to general medical condition or side effect of any medicine (Diagnosed by both Physician and Psychiatrist). 3. Any physical illness like Diabetes, Hypertension and other cardio-vascular disorders. 4. Deafness and blindness 5. History of substance abuse Methods: 1) Hamilton's Rating Scale for Anxiety (HAM-A) was administered upon 40 volunteers coming from similar socio-economical and educational background. 2) Out of them, 20 candidates, who were categorized as suffering from mild-moderate anxiety, were selected for the study. 3) These 20 subjects, were randomly assigned into Group A (who were going to be given mindfulness based CBT along with medicine) and Group B (who were going to be given yoga therapy with medicine),

each group having 10 candidates each. The medicine chosen was sertraline dose adjusted and titrated for each candidate. 4) Therapy for both the groups continued for 2 months at a frequency of 2 sessions per week. 5) After completion of the assigned treatment, the candidates of each group were assessed by HAM-A and their scores were recorded. Results: Mean of post-treatment anxiety score of Group A and Group B was calculated and student's t-test was performed to find out whether there is a significant difference between mean score of the two groups. It was found that mean of anxiety scores of Group A was significantly lower than the mean score of Group B. Conclusion: Yoga therapy has long been advocated in the treatment of GAD but candidates exposed to Yoga therapy along with Sertraline in this present study did not get the opportunity to correct their faulty cognition, which is perhaps the most important factor contributing to development of the disorder. On the other hand, in mindfulness\*1 based CBT, the participants learned how to concentrate with purpose, in each moment without judgement. In other words they learned mind management skills leading to heightened metacognitive awareness, acceptance of negative thought pattern and ability to respond in skillful way. So probably mindfulness based CBT\*2 along with medication is probably more effective for treating Generalized anxiety disorder in female adults than those candidates who received yoga therapy along with medication.

No. 17

**WITHDRAWN**

No. 18

**The Application of a Psychodynamic Model in Understanding and Treating a Diagnostically Ambiguous Patient**

Poster Presenter: *Noor Anabtawi*

Co-Author: *James L. Megna, M.D., Ph.D.*

**SUMMARY:**

Diagnostic formulation in psychiatry is challenging. While the DSM-V allows for diagnostic clarification in the vast majority of cases, at times its descriptive, symptomatic focus may limit a full understanding of a patient's psychopathology. There is utility, therefore, in utilizing psychological constructs for a

more complete understanding of a patient's diagnosis and level of functioning. The following discussion describes such an example of the combination of both approaches and how it informed the treating physician's diagnostic formulation process. Ms. B is a 42-year-old Caucasian woman with a poorly documented history of bipolar disorder, who was admitted to the inpatient psychiatric unit for depression after a initially presenting to the ED with complaints of vaginal bleeding. Review of the chart indicated that the patient had been hospitalized two weeks prior with what was deemed to be a manic episode. On arrival to the unit, the patient demonstrated shifting polythematic delusions, all in the absence of thought process abnormalities, manic, or hypomanic symptoms, save for mood lability. Collateral from family members indicated that the patient had been periodically impaired in the past, but that she had progressively become more 'delusional' over the last 6 months. During her hospitalization, the patient's evolving and demonstrably false claims appeared to be less consistent with delusions, which are typically fixed. While pseudologia fantastica was suspected, it is not recognized in the DSM-V and has little clinical utility without an underpinning psychological construct. While on the unit, the patient split amongst staff and peers, projected her thoughts, feelings, and past actions onto peers, exhibited limited reality testing, and did not respond to treatment interventions. After placing a letter requesting discharge, the patient could not be committed involuntarily, and was discharged prior to completing psychological testing. This poster utilizes Kernberg's model of personality organization in exploring the patient's psychopathology, and explores the challenges such a patient may pose to providers on an acute inpatient psychiatric unit. Such an approach has utility in dealing with diagnostically challenging patients, as it facilitates in maintaining objectivity in the treating physician, and thus improves treatment planning.

No. 19

**Case Report: Clinical Challenges in the Diagnoses and Management of Delirious Mania in a U.S. Veteran With a Mental Health History of Bipolar Disorder**

Poster Presenter: *Muhammad Ali Zaidi, M.D.*

**SUMMARY:**

A 46 year old Caucasian male veteran with a mental health history of Bipolar Disorder was admitted to the inpatient psychiatric unit following an episode of mania. He was re-started on his outpatient medication regimen for mood stabilization with Quetiapine, Lamotrigine, and Clonazepam. He improved initially, however, on hospital Day 3, the veteran was noted to have acute worsening of manic and psychotic symptoms including, decreased need for sleep, excess energy and responding to internal stimuli. Additionally, he developed symptoms which were atypical for mania, including unprovoked agitation, depersonalization, difficulty sustaining attention, and visual hallucinations. These mental status changes were associated with, excessive motor movement, walking with bizarre postures, squatting, laying taut on the ground, and standing still for several minutes in uncomfortable positions. At this time, Seroquel was switched with Olanzapine for management of mania and psychosis. On physical exam, his vital signs were notable for tachycardia and fever, his extremities were noted to have a normal range of motion; he also experienced loss of bowel continence. The treatment team initiated a medical work up for delirium which revealed no infectious, neurological, or metabolic cause. Of note, there was concern for benzodiazepine withdrawal; however, adequate management did not relieve the symptoms. The veteran was transferred to medicine and neurology was consulted to assist with medical workup. His neuroleptic and benzodiazepine medications were discontinued at that time, except for Lamotrigine. The veteran was then transferred back to psychiatry after medical stabilization, Lamotrigine was discontinued at that time. He was started on Haloperidol, Benztropine and restarted on Clonazepam. At this time, veteran experienced improvement on his mental status exam, with resolution of mania, psychosis, and delirium. However, after two days of treatment, he developed acute rigidity in his extremities. Intramuscular Benztropine and Lorazepam improved his rigidity. Haloperidol was discontinued because of side effects and the veteran was managed with Risperidone and Ativan. He continued to show improvement in his mental status examination and was discharged on a medication regimen of Risperidone, Clonazepam,

and Benzotropine. The veteran experienced signs and symptoms which were atypical in nature for Bipolar Mania, such as fever, movement disorder, and delirium. This presentation is consistent with a rare medical condition, Delirious Mania for which limited research is available. Delirious mania meets the criteria for mania and delirium without an underlying medical disorder. Delirious mania is a potentially life threatening but under-recognized neuropsychiatric syndrome. Early recognition and aggressive treatment can significantly reduce morbidity and mortality.

No. 20

**Empirically Derived Decision Trees to Model Risk of 30-Day Readmission for Bipolar Disorder**

Poster Presenter: *Juliet Edgcomb, M.D., Ph.D.*

Co-Authors: *Trevor Shaddox, M.D., Ph.D., John O. Brooks, M.D., Ph.D.*

**SUMMARY:**

Objective: Bipolar disorder is associated with an estimated total yearly cost of \$202.1 billion, corresponding to over \$80,000 per patient, a cost twice that of major depression. Repeated hospitalizations not only contribute significantly to healthcare costs in bipolar disorder, but also disrupt employment, social and family functioning. The goal of this study is to create a clinically useful algorithm to define risk profiles of all-cause 30-day psychiatric hospital readmission among patients with bipolar disorder and comorbid medical illness. This research utilizes empirically derived decision trees to hierarchically stratify clinical and sociodemographic predictors of 30-day readmission. Method: A total of 552 patients with bipolar disorder (ICD-10 F31.9; ICD-9 296.1, 296.4, 296.5, 296.6, 296.7, 296.80, 296.89) and comorbid medical illness were identified from a large multi-institutional electronic health record database (University of California, Los Angeles (UCLA), Clinical and Research Data Repository (xDR)) containing 206,129 encounters from 2006 to 2016. Data on clinical (e.g. comorbid diagnoses, chief complaint, pain, medications), sociodemographic (e.g. age, sex, race, ethnicity), and outcome (e.g. number of hospitalizations, clinic visits, emergency department visits) measures as well as financial charges were extracted for analysis. Encounter-level data was condensed to modal or

summative measures across one year from an index encounter. Classification and Regression Trees (CART) were implemented to produce hierarchical risk profiles of 30-day readmission. Two models were built via modulation of sensitivity thresholds for each predictor of readmission to obtain risk hierarchies correlated with patient-specific characteristics. Results: In the first model, patients with higher past use of inpatient care (defined as >6 hospital admissions in the past year), higher comorbidity burden (>5 comorbid disease category conditions), and older age (>64 years) predicted readmission at 30 days. In the second model, prior inpatient care utilization and comorbidity burden predicted readmission, and - among the highest utilizers of inpatient care - elevated modal pain score further differentiated risk of 30-day readmission. Conclusion: Our aim is to offer clinicians a strategy to tailor clinical practice based on patient's characteristics, thereby mitigating the cost and burden to health systems. Our study identified prior health care utilization, medical comorbidity, older age, and pain as hierarchically predictive of 30-day readmission amongst patients with bipolar disorder. Overall, in lieu of gestalt clinical decisions, these models illustrate the possibility of tailoring strategies to prevent readmission based on clinical characteristics, and point to the importance of developing and implementing innovative transitional care initiatives.

No. 21

**Repeat Hoarding Behavior in a 75-Year-Old Female Patient**

Poster Presenter: *Oscar Fernando Plata, M.D.*

Lead Author: *Claudia J. Chapa Garcia, M.D.*

Co-Authors: *Madeleine M. O'Brien, M.D., Raj V. Addepalli, M.D.*

**SUMMARY:**

Introduction: Hoarding behaviors are characterized by the excessive acquisition of, and unwillingness or inability to discard, large quantities of sometimes seemingly "useless" items. Severe hoarding can ultimately limit or even prohibit very basic activities of daily living such as cooking, food storage, toileting, bathing, sleeping and moving freely about the living space. Hoarding often leads to various health risks, worsening of pre-existing medical

conditions, forced removal of at-risk children or dependent adults from the home, an overall decline in functioning, social isolation, adverse effects on family members and friends, financial stress, public economic burden, increased risk of fires, increased risk of falls, increased risk for structural damage to the dwelling, poor sanitation, various infestations, cessation of utilities, condemnation of the dwelling, eviction and even death. Case report: Ms. T is a 75 year old Latino woman with a history of mild neurocognitive impairment, hoarding disorder, Congestive heart failure, Hypertension, Diabetes Mellitus, with limited history of treatment with psychotropic medications, Risperdal and Doxepin, no h/o previous psychiatric admission, no h/o alcohol or substance abuse. The patient had been referred to Adult Protective Services (APS) by a previous psychiatrist, was seen by APS staff and was subsequently referred to the local hospital-based Mobile Crisis Unit. Findings included a severely overpacked and cluttered apartment with piles of trash, objects, and papers that were blocking the entrance to the hall and bedroom, a packed bathroom and a tub full of fecal matter. There was a pungent and foul odor throughout the apartment. The patient was observed wearing knee high boots to avoid rat bites while sleeping on the couch as her bed and bedroom were no longer accessible. The patient was distrustful of allowing outsiders to help her reduce the clutter in view of self perceived loss of valuable possessions on prior heavy duty cleanings. On the second Mobile Crisis unit home visit, she voluntarily agreed to come in to the Emergency room for a wellness check. On examination, significant findings included a patient who was wearing multiple layers of clothing, emanated a strong smell of urine and feces, sunglasses and a hat. Her thought process was notable for tangentiality and circumstantiality, preoccupied with getting home to her son and grandchildren who were no longer in her home. She denied SI/HI. Discussion: This poster highlights the impact of hoarding disorder on the patient, family members and the eventual involvement of multiple city and social service agencies for a successful resolution. Issues at stake include difficulty in engagement in treatment, issues of autonomy vs paternalism and making the living situation safe and habitable and at times forced

removal of patients from the cluttered apartments to a safer setting against their will.

No. 22

### **Refractory Delusional Parasitosis**

Poster Presenter: *Anthony C. D'Auria*

Co-Authors: *Anjali M. Varghese, Taylor J. Wiseman*

#### **SUMMARY:**

Delusional parasitosis, or delusional infestation, is a rare disorder typified by the false belief that an individual is infected with insects or parasites. The infestation may manifest on the patient's skin and/or possessions (1). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies it as a delusional disorder, somatic subtype (2). Although a mental disorder, patients with delusional parasitosis are unaware their symptoms are delusions, and are therefore reluctant to see a psychiatrist (3). Case Report A 70 year old female presented to an outpatient Partial Psychiatric Hospital Program (PPHP) after an episode where the patient was reported missing, and subsequently found by police hiding under a tree with minimal clothing in freezing temperatures. Upon discovery, the patient agreed to attend the outpatient PPHP where she explained that she ran away from her home due to feelings of guilt and "feeling like a burden." The patient then revealed her feelings are primarily regarding a perceived parasite infestation, which she states has plagued her for decades. The patient states there are "little white bugs crawling in and out of my skin." The patient expressed fear that her family members will also become infected, prompting her recent episode of escaping her home. She became overwhelmingly embarrassed about the issue, particularly because she is from a rural town and feels "everyone will know." The patient admits seeing several healthcare providers including dermatologists, all reporting negative findings. While explaining, the patient became agitated and repeated "no one believes me, but I'm not crazy." Additional past medical history and physical exam was benign. However, in reviewing past medical records, we elucidated the patient was admitted to the Behavioral Health Unit two times previously with the complaint of parasite infestation. Toxicology screening was negative, and the patient's sole medication is Zyprexa. On completion of the



interview, the patient was observed in group therapy, and a decision was made that the patient was not a good candidate for the PPHP as her delusions were too severe and disruptive. She was then transferred to a free-standing private psychiatric hospital for further evaluation and treatment where she currently is undergoing treatment with psychotherapy and antipsychotics. Discussion We have determined that the patient meets the DSM-5 criteria for primary delusional disorder, somatic subtype (2). The mainstay of treatment for a patient carrying this diagnosis is developing a strong, caring relationship, as often times these patients have often have had inadequate treatment from their previous providers who dismiss their claims of infestation (11). It is widely debated whether health care providers should agree or disagree with the patient's delusions (12). Several authors propose a passive approach, using phrases such as "I don't see the parasites," rather than

No. 23

**National Survey for Mental Health in Egypt 2016–2017**

Poster Presenter: *Sally Ibrahim Noby, M.B.B.S.*

**SUMMARY:**

Introduction The General Secretariat of Mental Health and Addiction Treatment (GSMHAT) is a governmental body dedicated to the provision of mental health services and substance use treatment and rehabilitation including inpatient psychiatric hospital, outpatient mental health care center and primary health care services. A mandatory need is to render the services geographically and economically accessible to their recipients aiming to facilitate inclusion and participation of people within the community. The achieved improvement of the distribution and the variability of services according to modern trends would encourage deinstitutionalization of psychiatric patients, to be replaced by community care network. The ultimate goal of this national survey is to provide the general secretariat of mental health with the accurate data on the current status of mental health problems for fulfilling its primary aim of establishing "accessible" mental health services covering the whole population with mental health problems in balanced

way with proper geographical distribution.

Methodology: This is a cross-sectional survey of a random sample of adults residing in households in Egypt using a standard assessment. The study employs a one-stage design aimed at detecting common mental disorders and sub-clinical conditions that require care in addition to their demographic correlates. A. Sample design and selection: The sample of the survey was designed by the Central Agency for Public Mobilization and Statistics (CAPMAS). The estimated sample size was 22 thousand households distributed in the urban and rural governorates distributed proportionately with the size of families in the governorate. • The total number of clusters is 1000 (segments). The size of the cluster is 22 households in each segment. • The main idea of the design of the main sample is based on the preparation of a basic sample of urban and rural governorates of the Republic. This sample is large in size and spread throughout the site and represents the Egyptian society in terms of the main characteristics of individuals well represented. B. Sample size: The target sample size was 22,000 households (average 4 members). Study tools: Selection of tools and research designing was conducted through 2 workshops including experts in the field of psychiatry research. 1. General Health Questionnaire (GHQ-28) (Goldberg & Williams, 1988): The 28 item scaled version – assesses somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. In this survey the Arabic version (Okasha et al 1988) was used. 2. Mini- Plus International Neuropsychiatric Interview (M.I.N.I.) (Sheehan et al.1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.) is a short structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. The Arabic version (Ghanem et al, 2000) was used in this survey.

No. 24

**The Decentralization of the Ghanaian Mental Health System Through the Psychiatric Institution, Prayer Camp, and Non-Profit Sector**

Poster Presenter: *Opemipo Akerele*

**SUMMARY:**

Mental health services, with my research focus on the most prevalent disorders, schizophrenia and depression, are incredibly under-resourced. Ghana has just 18 practicing psychiatrists and only three psychiatric hospitals for the entire country. It is estimated that, “of the 24.3 million people living in Ghana, 2.4 million suffer from mental illness” (ACCA Global 2013). With less than 20 practicing psychiatrists, there is a 98% treatment gap in Ghana. Mental health services funding is nowhere near the level of funding concerning infectious diseases or reproductive health. The misconception that mental illness is contagious leads to the stigmatization of not only the mentally ill but also mental health professionals. Due to resource constraints and the stigma attached to mental illness, the majority of the population suffering from psychiatric conditions is not treated with modern medicine like psychotherapy or medication. Instead, they are sent to spiritual churches or prayer camps where they are sometimes severely mistreated. This includes being chained up (sometimes outside in poor weather conditions) or prevented from using adequate medical care (ACCA Global 2013). Furthermore, the dearth of research in mental health contributes to insufficient understanding of how the Ghanaian mental health system may influence the social differentiation, or “othering,” of the Ghanaian mentally ill and impact Ghanaian mental health care-seeking behavior or utilization of the Ghana mental hospital system. Those who are mentally ill are unfortunately ostracized from the rest of the community and perceived to be straying from what society considers normal. Through my ethnographic research with key actors in the Ghanaian mental health system, I analyze what “abnormal” means in this society and how the mental hospital and prayer camp may have different forms of othering the mentally ill. This study focuses on the following research questions: (1) How do Ghanaian mental health institutions influence the social “othering” of the mentally ill (primarily through confinement and social isolation)? (2) How does this not only impact the vulnerable population but also impact voluntary mental health care utilization and mental health care seeking behaviors in Ghanaian society? In my final analysis, I conclude that the roots of the issues behind mental health are education, resource allocation, awareness that mental health is on an

expansive spectrum, and the understanding that people must heed to their mental health and wellness as much taking care of their physical health. Thus, I argue, decentralization does not solve issues of stigma because the social and political body’s issues are so deeply ingrained in the culture and cannot be changed with a complete revolution of what it means to have a mental illness -- normal life can still be maintained, the mentally ill can still contribute to society, etc.

No. 25

### **Hospício De Pedro II: A Nineteenth Century Insane Asylum in First Person Accounts**

Poster Presenter: *Antonio Leandro Carvalho de Almeida Nascimento, M.D.*

#### **SUMMARY:**

Introduction: The Hospício de Pedro II (Pedro II Asylum) was the first psychiatric hospital built in Brazil. Comissioned in 1840 on the coronation of Emperor Dom Pedro II by the Emperor himself, the hospital was inaugurated 1852. From 1852 to 1944, the Hospício de Pedro II (or Hospício Nacional de Alienados – National Insane Asylum – as it was renamed after the proclamation of the republic in Brazil) was on the forefront of psychiatric assistance, teaching and research in Brazil. Objective: To describe the Hospício de Pedro II, its architecture, staff and treatments available using first person accounts. Method: PubMed and Scielo databases were searched with the keywords “Hospício de Pedro II”, “Hospício Pedro II” and “Hospício Nacional de Alienados”. The articles retrieved using this search process were selected if they presented first person accounts about the hospital. The references on these articles were also searched for other first person accounts. The Brazilian National Library archives were also searched using the same keywords. Results: Seven first person accounts related to the hospital have been found. These accounts have been written by four lay American visitors to the hospital (Daniel Parish Kidder and James Cooley Fletcher whose report was published in 1857 and Louis Agassiz and Elizabeth Cary Agassiz, whose report was published in 1868), two French psychiatrists who visited the asylum (Philippe Marius-Rey in 1875 and François Jouin in 1880), two Brazilian psychiatrists who worked at the hospital

during their internship years (and would later become full professors of psychiatry at the Federal University of Rio de Janeiro, Maurício de Medeiros who reports his experience at the hospital in 1904 and José Leme Lopes, who describes the hospital in the 1920s) and one patient who wrote a diary during his hospitalization at the Hospício Nacional de Alienados, the Brazilian writer Lima Barreto (hospitalized in 1920). All the seven accounts mention architectural aspects of the building and characteristics of the staff, five accounts describe occupational therapy activities and two accounts mention the diagnostics of the patients. Discussion: In spite of being the the first psychiatric hospital in Brazil, there are few first person accounts of the Hospício de Pedro II during its more than 90 years of functioning as a psychiatric hospital. All first person accounts mention the luxurious architecture of the building, but in contrast to the architecture, almost all accounts report that hospital was understaffed, considering the large number of patients hospitalized there. Five of these accounts mentions the several occupational therapy activities and how they were benefical for the patients (including the account written by a former patient), but very few accounts describe other methods of treatment.

No. 26

**After the Storm: Community Engagement in Puerto Rico**

Poster Presenter: *Alan Tomas Rodriguez Penney, M.D.*

Co-Author: *Nhut Giuc Tran, M.D.*

**SUMMARY:**

Disasters have both physical and mental health impacts. In the aftermath of Hurricane Katrina, epidemiological studies reported the prevalence of PTSD at 16% at 5-7 months which increased to 21% one year later. Hence, the impact of disasters on mental health is important, and the general consensus among mental health experts is that mental health should be integrated into emergency and medical disaster response. Norris and Rosen (2009) emphasized a disaster mental health system that provides psychoeducation and resilience-building while having more intensive services available. Reported here is the mental health response to Hurricane Maria by a group of

psychiatrists. Hurricane Maria struck Puerto Rico on September 20th, 2017. Sixty-four people died as a direct result of the hurricane, and an estimated 1,000 deaths were related to post-hurricane causes. Within three weeks, Crear Con Salud (“Creating With Health”), a group of Puerto Rican psychiatrists working/training in the United States, arrived to provide mental services. The basis of Crear Con Salud’s work involved an emphasis on community empowerment over being service-oriented in engaging with communities, facilitating the donation of basic necessities, collaborating with community-based clinics, and providing talks about resilience and mental health post-disaster. Systemic barriers the group faced pertained to the recovery process, which included inadequate food supplies, poor coordination of services, and lack of access to healthcare. The group has been giving workshops to communities and their leaders while expanding their community outreach. Their experience has taught them that communities have different needs based on their recovery phase, and that adaptability and responsiveness is necessary for community empowerment.

No. 27

**Mega-Interest in Meta-Analysis**

Poster Presenter: *Chandresh Shah*

**SUMMARY:**

Medical science has grown from folklore to an observation to an experiment. Diseases were believed to be a curse of an evil spirit. Alexander Fleming accidentally left an open petri dish and observed that a growth of mold stopped growth of bacteria. Edward Jenner made a community –based observation that milkmaids who previously had caught cowpox did not catch smallpox. Then he experimented by inoculating a young boy first with material from cowpox lesions and later with that from smallpox lesions to show that the boy did not develop smallpox as he had developed immunity from cowpox infection. Since second half of 20th century, there has been a greater emphasis on evidence-based science. This has led to randomized clinical trial as gold-standard of medical science, especially in field of therapeutics. Globalization is becoming more prevalent as the 21st century progresses. It is impacting science and technology,

politics and economy, social and cultural norms, and in general the ways and values of our life. Medical science is confronting these challenges and embracing this reality by embarking on meta-analysis/meta-analyses (MA). This tool has become accessible with readily available large data, advances in computer technology and better understating of statistics. To look at raising profile and promise of this new tool – MA – in contemporary Psychiatry, data was accessed from PubMed (National Library of Medicine). Publications with word MA in their titles were reviewed from two American journals, namely American Journal of Psychiatry (AJP) as well as Journal of American Medical Association – Psychiatry (JAMA-Psych) and its predecessor, Archives of General Psychiatry (AGP); and from two European journals, namely British Journal of Psychiatry (BJP) and Acta Psychiatrica Scandinavica (APS) from 2001 to 2017. There were 134 publications of MA in AJP, 84 in JAMA-Psych+AGP, 140 in BJP and 111 in APS. The interest in MA has spiked in recent years. 37.31% of citations of MA in AJP, 82.14% in JAMA-Psych+AGP, 57.07% in BJP and 62.16% in APS have been reported in recent years from 2011 to 2017. It is also noted that more than third (37.73%) of such publications of MA occurred in last 3 years. This signifies not only increasing interest, but also increasing impact of MA in medical science.

No. 28

#### **Treatment Over Objection: A Comparison Study**

Poster Presenter: *Sevie Kandefer*

Co-Authors: *Yogesh D. Bakhai, M.D., Raymond St. Marie, M.D.*

#### **SUMMARY:**

Background: In psychiatric inpatient facilities, it is a common occurrence for patients to object to receiving appropriate medical treatment with a reported mean daily rate of 1 incidence per day in an average acute psychiatric ward and approximately 2 to 13 instances per month per 100 admissions.<sup>1,2,3</sup> Often times, hospital providers will seek a court hearing in which the patient's competency is assessed according to constitutional due-process which includes judicial determination of treatment appropriateness while considering the best interests of the patients. Once a decision is made that the patient either lacks competency or has competency

to refuse medications, appropriate therapy may or may not be initiated against objection accordingly. Our study retrospectively examines all patients for whom the process of court ordered treatment over objection was initiated at the Erie County Medical Center's (ECMC) acute inpatient psychiatric units within the 2015 calendar year. From this group of patients, we will compare patients who went to court and subsequently received treatment over objection to those patients for whom the process of court ordered treatment over objection was initiated but who agreed to take their medications prior to their court dates. Method: Data was obtained from a retrospective chart review using the electronic medical record system at ECMC. The subjects consisted of all the patients above the age of 18 who were hospitalized at ECMC between the 2015-2016 calendar year who refused psychiatric treatment and who a court ordered TOO was sought (n=153). Data collected on these individuals were divided into three categories: demographic variables (age, race, gender), clinical variables (diagnosis, length of stay, TOO filing outcomes), and discharge variables (1 month and 1 year rates of readmission). Conclusion: In 2015, TOO papers were filed for 153 patients at ECMC. 83 of those cases went to court and TOO was granted in 79 of those cases, which is a 95.18% success rate. There was no relationship between Filing Outcome and Gender ( $\chi^2(1) = .327, p > .05$ ) or Filing Outcome and Race ( $\chi^2(2) = .262, p > .05$ ). Patients who were granted TOOs (M=40.7, SD=16.6) had a significantly longer hospital stay than patients who took their medication (M=22.6, SD=17.2);  $t(136) = 6.231, p < .001$ . There was a relationship between Filing Outcome and Readmissions within 30 days of the TOO filing ( $\chi^2(1) = 7.743, p < .01$ ). Patients who took their medicine were readmitted within 30 days at a higher rate than expected. Patients who were granted TOO were less likely than expected to be readmitted within 30 days

No. 29

#### **Factors Associated With Involuntary Commitment in the Acute Inpatient Unit of an Urban Academic Medical Center**

Poster Presenter: *Apoorva M. Polavarapu*

Co-Authors: *Vandana Doda, Chiadikaobi Okeorji, Mansi Shah, Najeeb U. Hussain, M.D., Cheryl Ann Kennedy, M.D.*

#### SUMMARY:

**Background:** Involuntary commitment raises an ethical dilemma between the principles of autonomy and beneficence. Early psychiatric institutions saw bleak patient autonomy, but today psychiatrists strive to identify when patients truly require psychiatric aid and carry out beneficial treatment. Patient satisfaction surveys can be a valuable means for involuntarily committed patients to give feedback to help improve quality and effectiveness in treatment. In this study at our urban academic medical center, we examined factors associated with patient satisfaction among patients after involuntary commitment in our acute inpatient psychiatric unit. **Methods:** A patient satisfaction survey was administered to consenting psychiatric inpatients on the day of discharge. The survey covers ratings of staff, family involvement, support option preferences, ratings of effectiveness of care and treatments, and general satisfaction. With consent, sociodemographic information and treatment history were obtained from the medical record. **Results:** This study included 849 participants: males were 57% (n=488); 23% (n=196) were 18-25 years old; 70% (n= 592) were African Americans. Of the participants, 47% (n=402) were involuntarily committed. 15% (n= 131) reported homelessness, while 85% (n=717) were domiciled. Almost three-quarters reported no drug history (65%; n=550), but 40% (n=342) had positive urine toxicology report on admission. Bivariate analysis showed that females are more likely to be involuntarily admitted ( $p=0.0055$ ); younger patients aged 18-25 are more likely to be involuntarily committed ( $p=0.0077$ ); patients with drug history are more likely to be involuntarily committed ( $p=0.0033$ ). Multivariate regression analysis determined gender and involuntary commitment have a statistically significant association ( $p=0.0028$ ) as do drug history and involuntary commitment ( $p=0.0030$ ). The overall average level of satisfaction is 8/10 and average length of stay of patients is  $10.1 \pm 7.4$  days. **Conclusion:** Overall, all patients regardless of legal status, had high levels of satisfaction (80%). In our cohort, women, young patients and drug users were involuntarily committed more than others. While there are gender/societal issues/policies not studied here that may discourage these individuals from self-

identifying as needing psychiatric care; stigma, lack of mental literacy and exacerbations in psychiatric symptoms that illegal drugs can cause, all demand more comprehensive education and training along with innovations in research. Our urban academic medical center is continuously studying ways to improve care and hope our practices ease ethical and legal tensions inherent with involuntary psychiatric commitment.

No. 30

#### **Behavioral Health—Virtual Patient Navigation: Results From a Pragmatic Research Study Among Patients With a Telepsychiatric Consult in the ED**

Poster Presenter: *Jason Roberge*

Co-Authors: *Christine Zazzaro, Timothy Hetherington, Wayne Sparks*

#### SUMMARY:

**Background** The number of patients presenting to emergency departments (ED) in the need of psychiatric care, continues to increase. With outpatient behavioral health resources and funding on the decline, oftentimes the attending ED physician must decide to admit a patient in lieu of discharge due to the lack of outpatient resources or the perceived inability of a patient to navigate a complex system. As a part of usual care, Carolinas HealthCare System currently offers 21 of its EDs 24-7 virtual access to licensed clinicians and psychiatrists who provide psychiatric evaluations and recommend dispositions (telepsychiatry). From a partnership with the Centers for Medicare and Medicaid we developed and are evaluating a Behavioral Health - Virtual Patient Navigation program (BH-VPN), which provides short-term follow up navigation to patients receiving usual care. A patient navigator connects with the patient virtually prior to leaving the ED and then communicates during regularly scheduled calls and assists as needed in obtaining services or overcoming any barriers to treatment, for up to 45 days post ED discharge. **Methods\Results** We designed a pragmatic, randomized research evaluation among patients in behavioral health crisis who present to an ED and receive a telepsychiatric consult. We describe team composition, design of the BH-VPN service, and enrollment status. The results herein focus on the effect this initiative has on the conversion from ED discharge to hospital

admission as well as post discharge utilization. Discussion Available evidence suggests that adoption and utilization of virtual care in tandem with wrap-around services may reduce utilization and improve health outcomes. However, variations in study designs limit our ability to draw definitive conclusions. By integrating virtual patient navigation into the existing telepsychiatry program, we expect to decrease the number of patients admitted for inpatient psychiatric treatment from the ED. The methods and results described here provide a template for conducting research to improve outcomes among behavioral health patients that present to an emergency department.

No. 31

**Improving Psychiatry Resident Knowledge and Patient Education Practices Regarding Safe Medication Disposal**

Poster Presenter: *Michael A. Strong, M.D.*

Co-Author: *Jess Fiedorowicz*

**SUMMARY:**

Background: Suicide remains a leading cause of death in the United States, with intentional medication overdose being one of the most common and accessible means. Furthermore, restricting access to common means of suicide such as firearms, toxic gas, pesticides, and medications has been shown to be effective in reducing deaths by suicide. However, the vast majority of patients report that they do not receive information about proper medication disposal. By improving psychiatry resident awareness and practices in the education of patients on the proper disposal of medications, it may be possible to reduce patient access to one of the most common methods of suicide. Although there remains some uncertainty regarding substitution of alternate means of suicide when access is restricted, current practice guidelines continue to advocate for the life-saving potential of restricting lethal means. Methods: An online, six-question pre-intervention survey was administered to PGY1-PGY5 psychiatry residents in the University of Iowa Hospitals and Clinics Psychiatry Program assessing familiarity with guidelines regarding proper disposal of medications, as well as patient education practices. Educational materials were then distributed to residents electronically for review, and

a nine-question, post-intervention survey was subsequently administered. Results: Significant differences were found between pre- and post-intervention in terms of familiarity with medication disposal guidelines, level of comfort discussing guidelines with patients, and reported frequency in which residents assessed patient access to over-the-counter or prescription medications. Overall, residents identified time-constraints during clinical encounters and lack of prior knowledge regarding medication disposal as the primary barriers to the discussions with patients. Conclusion: Psychiatry residents found educational materials on patient medication disposal practices and guidelines helpful. Brief, self-guided review of electronic educational materials was found to increase familiarity with current guidelines, comfort level in discussing with patients, and the frequency in which residents reported assessing patient access to over-the-counter and/or prescription medications, particularly those with elevated suicide risk.

No. 32

**Learning to Speak Truth to Power: Developing Advocacy Curricula Across the Spectrum of Psychiatric Training**

Poster Presenter: *Jacob Michael Izenberg, M.D.*

Co-Authors: *Colin David Buzzza, M.D., M.P.H., M.Sc., Haining Yu, M.D., M.P.H., Aislinn Bird, M.D., Katherine Koh, M.D.*

**SUMMARY:**

Faced with cuts to psychiatric services, political debates over the future of the Affordable Care Act, under-enforcement of mental health parity, the growing opioid crisis, and a breadth of other structural and political challenges, psychiatrists must not only serve their patients in the clinic, but must also serve their patients' interests as effective advocates. The importance of physician advocacy has been increasingly recognized by professional associations and within training competency frameworks, yet there remains a dearth of dedicated advocacy training at virtually every level of medical and psychiatric education. The authors of this proposed poster have significant combined experience developing and conducting educational activities focused on structural competency (understanding of the sociopolitical and economic

phenomena that shape health outcomes) and mental health advocacy. The poster will detail several key concepts in advocacy pedagogy for mental health providers, including the rationale for such efforts, a brief review of the literature on advocacy training in psychiatric education, approaches to teaching advocacy and related concepts, and lessons learned from evolving efforts to implement curricula at UCSF and Harvard/MGH, the institutions represented by the authors.

No. 33

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

Poster Presenter: *Meredith Clark, M.D.*

Co-Authors: *Nadia Gilbo, M.D., Madeleine S. Abrams, L.C.S.W.*

**SUMMARY:**

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

Examples of ethical clinical and systems issues with which we have been confronted will be included.

No. 34

**Interdisciplinary and Experiential Learning Within the Homeless Community**

Poster Presenter: *Craig P. Kaufmann, M.D.*

Co-Authors: *Pranav Aurora, Megan Smith*

**SUMMARY:**

Healthcare delivery and education often assume the best case scenario: a patient willing and able to receive care. Unfortunately, care and training is rarely tailored to serve individuals who do not fit this mold. Homeless individuals represent one such group, a particularly concerning issue, as they struggle with high rates of physical, mental health, and substance use conditions. Many, if not most, have traumatic personal histories and too often the care they do receive re-traumatizes them. The psychiatric field, in particular, in its focus on professional boundaries and stance of neutrality, can produce providers not well-armed to manage those with complex needs. Professional barriers and distance can constrain and hinder the development of rapport, erode authenticity, stifle creativity and engender negative attitudes toward homeless clients. Mainstream services do not often provide clinicians the logistical or clinical flexibility needed to serve such patients, adding to provider disillusionment and burnout. To be effective, psychiatrists must re-imagine their role as a member of a team that necessarily interfaces with law enforcement, disability, social services, local government and policy makers, community groups and others. Interdisciplinary street outreach incorporating psychiatrists, peers, nurse practitioners, students, and social workers has proven successful in engaging and maintaining people experiencing homelessness and psychiatric issues in care. Engaging with individuals during street rounds provides their care teams with critical context about patients' daily lives, resiliencies, barriers to care, and symptomatology in ways that cannot be readily captured during an office- or clinic-based encounter. By engaging with health care professionals as outreach workers first, individuals who have had negative prior experiences with treatment are able to feel out for themselves

whether those professionals are trustworthy, authentic, and useful to their needs. This street-based rapport building creates an on-ramp to office-based services. In collaboration with the presenters, students who had been exposed to homelessness issues through outreach created the Rhode Island Medical Navigator Partnership (RIMNP), which pairs individuals experiencing homelessness and complex health care needs with an interdisciplinary team of students. These students support the partnered patient in accessing care while learning from him or her as the expert in his/her own life experiences. An evaluation of the RIMNP conducted its pilot year found that partnered participants liked their student navigators (using positive descriptors including “nice” and “good”) and wanted more contact with them. Student navigators reported favorable experiences with participation (76%), improvement in attitudes toward the homeless community (76%), and impact on professional development (88%).

No. 35

**Perception of the Quality of Service and Level of Satisfaction Among Outpatients in a Psychiatric Hospital Setting**

Poster Presenter: *Gbonjubola Babalola, M.B.B.S.*  
Co-Authors: *Oyewale Alfred Ogunlowo, M.B.B.S., M.Sc., Adunola Anthonia Pedro, M.B.B.S., Olufemi Oyeleke Oyekunle, M.B.B.S., Ayodeji Abass Bioku, M.B.B.S., Suraju Adeyemo, M.B.B.S., Abosede Adegbohun, M.B.B.S., M.Sc., Ade Jejeloye, M.B.B.S.*

**SUMMARY:**

**BACKGROUND:** There is an increasing awareness and focus on the research on patient quality and satisfaction of health care services as indicators of effective healthcare systems. These research works are known to identify gaps and provide information on development of programs targeted at continuous development. Reliable data on this subject matter has however not been available in many health care facilities including the Federal Neuropsychiatric hospital, Yaba, Lagos. **OBJECTIVE:** This study assessed the quality of care received and the level of satisfaction of patients attending the outpatient department of a public mental health institution in Nigeria. **METHODOLOGY:** A non-probability, convenience sampling method was used to conduct a cross-sectional study. A socio-demographic

questionnaire as well as a modified survey questionnaire to evaluate the quality of service and the level of satisfaction was administered. **RESULTS:** A total of 100 outpatients responded to the questionnaire with equal distribution of males and females (50% each). The mean age of respondents was  $40.02 \pm S.D 10.93$  years. The highest mean score for satisfaction was on the overall quality of care  $8.40 \pm 1.63$ . The study found that the overall satisfaction of patients to the quality of service was good (73%). About 80% of the respondents admitted that they will recommend the service to a family or friend should the need arise. **Keywords:** Quality of Service, Level of Satisfaction, Outpatients, Hospital setting

No. 36

**Effective Use of the Interstate Compact: A Case of a 69-Year-Old Male With Mental Illness Who Wandered Off**

Poster Presenter: *Lionel E. Znaty, M.D.*

Co-Author: *Raj V. Addepalli, M.D.*

**SUMMARY:**

Many patients with mental illness wander off at times when they decompensate. This may hinder ongoing treatment and also prevent effective treatment due to the absence of collateral information regarding previous treatment. Our case highlights the importance of a collaborative approach required when patients wander off to a different state. Mr. W was a 69 year old Caucasian male brought to the psychiatric emergency services from the local men’s shelter in handcuffs, hurling racial slurs to everyone, threatening and menacing. Pt was subsequently admitted to the inpatient unit wherein he initially denied any past psychiatric history. Pt was found to be grandiose stating that he had created the cure for herpes, AIDS, malaria and sleeping sickness. He was evaluated and started on risperidone, which was titrated to 2 milligrams twice daily and sodium valproate 250 milligrams twice daily, which was titrated to 500 milligrams twice daily. Sodium valproate was subsequently discontinued as patient complained of severe sedation and his ammonia levels were found to be increased to 65mg/dL. Patient was found to have a high TSH and reported being non complaint with treatment for hypothyroidism for many years.



Patient constantly refused Levothyroxine during the admission. His case manager who was eventually located in Pennsylvania indicated that patient was a Vietnam War veteran with a thirty year history of schizophrenia and PTSD including inpatient state hospital admissions on Haloperidol decanoate for years. Patient continued to be delusional and refused a switch to other antipsychotics including clozapine. Patient refused brain imaging and blood work. He also insisted that he would not return back to his supportive housing in PA but would move into a nonexistent house which he owned in NYC. In view of minimal improvement in his delusions and absent social support or access to housing in NYC it was felt that he would be best served by transfer to his home state of PA where he had an entire network of treatment providers who were both familiar and willing to treat the patient . The local state hospital in Pennsylvania familiar with the patient agreed for an interstate transfer via the Interstate compact transfer process. This case highlights the importance of the interstate compact on mental health, which was initiated in 1956 to ensure transfer of patients with mental conditions and mental disabilities back to their home state between states which are signatories .The interstate compact also recognizes civil commitment laws on a reciprocal basis and this facilitates a smooth transfer of patients between signatory states. This poster also highlights the difficulty in connecting patients back to the community when patients of mental illness tend to wander off and travel to other states when they decompensate and limited information is available about prior treatment.

No. 37

### **Ethical Implications of Diagnosing and Treating Psychosis High-Risk Syndromes**

Poster Presenter: *Ike B. Iloka, M.D.*

Co-Author: *Faisal Akram, M.D.*

#### **SUMMARY:**

Evidence indicates that longer durations of untreated psychosis lead to early functional decline and poorer overall health outcomes. In response to this, several diagnostic criteria have been proposed to prospectively identify individuals at high risk of psychosis. The Clinical High Risk (CHR) Criteria offer a viable approach to early intervention and prevention

in these populations. But along with such preventive interventions, a thorough ethical workup involving the principles of beneficence, non-maleficence, autonomy and confidentiality is necessary as well. To this end, the ethical implications of diagnosing and treating Psychosis Risk Syndromes have been discussed in the context of emerging evidence from prodromal psychosis research. Specifically, we highlight that the limited capability of CHR criteria in predicting future psychosis exposes individuals to unwarranted labeling and thereby harm from preconceived discrimination and prejudice surrounding Mental health disorders. We argue that a stigmatizing label during adolescence may disrupt or engulf identity formation and interfere with the achievement of personal competencies. Since prodromal psychosis research has also identified individuals who never develop psychosis but continue to demonstrate attenuated positive symptoms with functional decline, questions arise whether it is ethical “neuroenablement” or unethical “neuroenhancement” to treat such individuals. We also touch upon the debate whether diagnosing sub-threshold symptoms in the form of psychosis high risk syndromes raises the possibility of “overmedicalizing” perceptual variations and thinking patterns. Strategic efforts need to be employed to reduce stigma and how to ethically disclose the diagnosis. As such, it will be important to communicate the difference between susceptibility and disease. We conclude that there is a need for interdisciplinary engagement of neuroscientists, psychiatrists, ethicists, legal scholars and policy makers along with continued empirical research efforts to ensure “primum non nocere” and virtuous practice of indicated prevention in psychiatry.

### **Poster Session 3**

No. 1

### **Financial Management Support for SSA Beneficiaries: Looking Beyond the Payee**

Poster Presenter: *Annie Harper*

#### **SUMMARY:**

People receiving benefits from the Social Security Administration (SSA) who struggle to manage their money may be assigned a representative payee

(payee henceforth), who receives the beneficiary's income and ensures that their basic needs are met. While having a payee can have a positive effect on beneficiary health and well-being, there is a shortage of people willing to be payees, and many who would benefit from the support are resistant to entirely relinquish control of their finances. There is no support available for SSA beneficiaries who face financial difficulties but are not considered incapable. This research explored the potential for providing more flexible financial management support to SSA beneficiaries with mental illness, and so reduce the burden on the payee mechanism and offer support to a larger group of people. The research included a qualitative study, including focus groups and individual interviews with people with a payee now or in the past, or who have been advised to get a payee. The same methods were used to learn from people who have served/serve as a payee. It also included a review of the financial services environment exploring potential products and services which could support more flexible support for SSA beneficiaries, including interviews with multiple professionals and experts in the legal and financial services fields. The principal findings of the research include: The payee mechanism provides valuable support to some people with mental illness, but it can also create tension in relationships, cause frustration for those with a payee, and burden those serving as payee; in some cases the financial difficulties that people face which have caused them to be recommended or assigned a payee stem from their poverty and lack of access to appropriate financial services and products rather than their mental illness per se; there are a number of innovative financial services and products available which could enable some people currently assigned a payee to take more control over their finances, although some of these services and product would require adaptation to ensure their suitability for this specific population. There is potential to provide support supplementary to the payee mechanism to enable people with mental illness receiving SSA benefits who face financial difficulties to improve their financial situation and take greater control of their finances. Providers of mental health services should be made aware of financial management support mechanisms, including available financial services and products, which may help some clients

to retain control of their own finances and improve their financial situations. The financial services industry should accommodate the specific needs of people with mental illness, in developing products that minimize negative effects and maximize the potential for people to safely retain control of their own finances.

No. 2

### **Addressing Psychiatric Health Equity in Rural Areas Through Recruitment and Retention Into the Field of Psychiatry**

Poster Presenter: *Shambhavi Chandraiah, M.D.*

#### **SUMMARY:**

Although the need for more psychiatrists is global the inequity of psychiatric resources in rural settings is stark especially with respect to access to psychiatrists for evaluation and treatment. Attracting and retaining physicians for rural areas starts with recruitment into medical school by selecting students from rural areas with a desire to return home to practice, having specific rural track positions, as well as scholarships for students who commit to some period of future rural practice. Recruitment into psychiatry in particular requires screening for applicants who are from rural areas and wish to remain in the area for family or other reasons, regular scheduled contact with the program director and psychiatry faculty advisors who illustrate the value of their choice and remaining in a smaller area, as well as positive psychiatry clerkship experiences including rural elective options to encourage an interest in psychiatric practice. Resident interest to practice in rural sites is fueled by regular or elective rural clinical rotations, moonlighting opportunities in rural settings, experiencing the positive attractions of rural living, and occupational or educational opportunities for spouses/partners in the area. Retaining psychiatrists in rural areas may require sufficient compensation, academic contact, and telehealth opportunities. Specifics of our institution's recruitment and retention strategies and success for medical students, residents, and practicing psychiatrists will be highlighted as a possible model for improving rural psychiatric health equity. A review of other models of recruitment utilized in other parts of the nation to address this issue will also be discussed.

No. 3

**Enhancing Cultural Competency in a General Adult Psychiatry Residency Training Program**

Poster Presenter: *Jennifer Rahman*

**SUMMARY:**

Background: Cultural competency is becoming acknowledged as central to patient care; 75% of residents view it to be a core physician competence. Residency training programs have developed specific curricula, though requirements were found to be broad and varied, making it difficult to assess impact (if offered at all). Various teaching models have increased the capacity of residents to approach social vulnerability of newly-arrived refugees with mental distress, obtain new perspectives, and empathize with patients. The DSM-5 Cultural Formulation Interview (CFI) standardizes assessments via extensive clinical questions and explains the intended goal of specific queries within each domain; while this is currently underutilized in clinical practice, it has the potential to be disseminated on a broader scale. Studies show discussing spirituality/religion with schizophrenic patients may enhance the recovery process. This proposal seeks to enhance knowledge base not already addressed in our training program. National Best Practices: Curricula from NYU, Oregon, McGill, UCSF, and UC Davis embrace exploring patient values versus viewing culture as a homogeneous construct. NYU incorporates Cross-Cultural Interviewing Skills, trauma sensitivity workshops, religion/spirituality, global mental health, social determinants of health/policy engagement, and community mental health. McGill's intensive case study approaches systemic/ethical issues in addition to monthly cultural psychiatry seminars alongside a Cultural Consultation/Transcultural Child Psychiatry Service. Oregon's Cross Cultural Community Psychiatry rotation and Intercultural Psychiatric Program treats refugees/immigrants, as well as re-integrating patients in an Intercultural Socialization Center. UCSF includes Women's Mental Health, LGBT Mental Health, Cultural Psychiatry, Public and Community Psychiatry, and Trauma Psychiatry, community mental health clinics for the underserved, and assertive community treatment programs. UC Davis's 4-year Cultural Psychiatry

didactics focus on Religion & Spirituality, mental health disparities, resident attitude/skills development, and cultural formulation presentations, all areas of this proposed didactic series. Local Context: Our residency training program provides an introductory cultural competency curriculum including one's own cultural background formulation, case-based discussions, articles of cultural historical perspectives, and recently has added perinatal, ethno-psychopharmacology, and implicit bias training. CFI in patient encounters were previously integrated into a biopsychosocial formulation. Proposed Intervention: Lectures: religion/spirituality, refugees, and disparities via various learning styles (readings, video clips, small groups). The proposed curricula seeks to engage while avoiding perpetuating stereotypes/culture-bound syndromes. Evaluation: Resident feedback on current didactics and proposed lectures via surveys, spring 2018

No. 4

**Bridging Gaps Through a Health Education Program**

Poster Presenter: *Marissa Emadi*

Co-Author: *Brigitte Y. Bailey, M.D.*

**SUMMARY:**

Depression is a pervasive major public health concern in the United States with Latinos being less likely to seek treatment. Culture is a likely factor contributing to this disparity. Stigma associated with mental illness and poor mental health literacy affect early termination to treatment and act as a barrier to seeking treatment behaviors. Thus, we propose a series of focus groups to guide the development of workshops to decrease the stigma surrounding mental health and increasing mental health literacy. The focus groups would take place at Clarity Child Guidance Center Outpatient Clinic, a nonprofit treatment center in San Antonio specializing in children ages 3-17 who suffer from serious mental health problems. The information gathered would guide the development of an empowerment curriculum to teach and support positive coping strategies to decrease stress, improve self-image, expand social support, develop healthy habits, and engage an adolescent/child patient population in a dialogue about mental health.

No. 5

**Implicit Racial Biases in Psychiatric Decision-Making in the Emergency Department**

Poster Presenter: *Katrina Hui, M.D., M.S.*

Co-Author: *Elaine Bradley*

**SUMMARY:**

Implicit biases, unconscious associations, based on characteristics such as race and gender, may drive discriminatory behavior without explicit awareness, particularly in instances with increased cognitive stressors based on theories of ego depletion. Such biases have been studied in limited contexts in the field of medicine and appear to impact diagnosis and decision-making in clinicians. For example, in a study conducted with family practitioners and internists, implicit anti-Black biases were as correlated with lower rates of referrals to specialists. However, increased patient contact with diverse populations may reduce implicit biases toward race and mental illnesses. Implicit biases have not been thoroughly examined in psychiatry specifically and may play a role in differences in clinical care across race. There is preliminary evidence indicating a correlation between patient race and both diagnosis and disposition in the psychiatric emergency setting. We designed a retrospective case-control study in a psychiatric emergency department in Toronto to assess whether patients' racial and ethnic backgrounds were correlated with higher rates of restraint use including chemical restraints, mechanical restraints, and seclusion during resident physician shifts. We will present our findings on whether such differences in restraint use may be influenced by factors that increase cognitive stress, such as patient volume and time in shift. Furthermore, we will assess whether level of training, which serves as a proxy for experience and amount of patient contact, may also influence rates of restraint. These results will help inform future curricular developments, shift restructuring, and research in this area.

No. 6

**Raíces: A Pilot Parental Support Group Aimed at Improving Mental Health Outcomes Among Latina Adolescents**

Poster Presenter: *Paloma Lucia Reinoso*

Co-Authors: *Jenny Giang, Mireya P. Taboada, Ritika Batajoo, Melissa Waldo, Michelle Buelow*

**SUMMARY:**

Background: Latinos are the fastest-growing and largest ethnic minority group in the U.S. By 2050, it is projected that close to one fourth of the U.S. population will be Latino. While rates of the mental illness among Latinos are similar to those of the general U.S. population, it is well documented that they face several barriers to accessing mental health care, including language, immigration and insurance status, and cultural stigmas toward mental illness. Specifically, Latina adolescents have the highest rates of suicidal ideation and attempts compared to other adolescents, with a higher prevalence seen in those born in the U.S. The Self-Esteem, Empathy, Empowerment, Discovery of Self (SEEDS) is a well-established mental health therapy program for Latina teenage girls at the Sixteenth Street Community Health Center (SSCHC) in Milwaukee, WI, aiming to reduce these mental health disparities among Latina youth. Prior program evaluation suggests that participants of SEEDS demonstrated decreased social anxiety, improved self-esteem and reduced depression upon completion of the program. However, the long-term benefits among participants were impacted by familial stress and discrimination, as well as parental perception of mental health. A new pilot program called Raíces (Roots) is being offered to parents of children enrolled in SEEDS. The objective of Raíces is to engage parents in a parallel program using peer support, psychoeducation, and normalization of mental health disorders. Methods: SEEDS is facilitated by a licensed psychotherapist and participant are referred to the program by their primary care provider. SEEDS participants are Latina females ages 13-16 who meet Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria for adjustment disorder, anxiety, bipolar disorder, and/or depression. The parents of SEEDS participants are invited to enroll in Raíces, joining a pilot group in a weekly 16-week program concurrent with SEEDS. This pilot program is co-facilitated by bilingual medical students and includes rotating mental health topics covered simultaneously in SEEDS. Anonymous, ten-question, pre- and post-Likert scale surveys exploring cultural

stigma and attitudes towards mental health were administered to participating parents. Anticipated Results and Conclusions: We anticipate that among program participants Raíces will decrease the stigma associated with mental health disorders and help normalize the access of psychotherapy and mental health care. Challenges identified during the recruitment process include participant recruitment and retention in Raíces or their child's withdrawal from the SEEDS program. Future work could focus on improvements in the curriculum, development of a facilitator manual, improved recruitment and participant retention, sustainability and possible expansion to non-SEEDS parents of children with behavioral health issues in the Latino community.

No. 7

**Promoting Mental Health Equity Within the South Asian Community: A Survey Assessing Current Practices Among PCPs**

Poster Presenter: *Simran Brar, M.D.*

Co-Authors: *Glenda L. Wrenn, M.D., Farzana M. Bharmal, M.D.*

**SUMMARY:**

The effect of cultural stigma on mental health services utilization among various racial/ethnic populations is well documented. Stigma prevents individuals from seeking mental health help for themselves and/or their family members. Individuals of Asian descent are one of the fastest growing racial/ethnic groups in the United States, yet understudied with regard to mental health utilization. One study in 2011 showed that this population is the least likely ethnic group to seek out mental health treatment even when severe symptoms are present. Culturally-based stigma has been identified as a primary reason for not seeking treatment. Addressing this health disparity requires a culturally-informed understanding of stigma. We conducted a focused needs assessment among culturally congruent providers during the Indian American Psychiatric Association (IAPA) Atlanta Chapter monthly meeting in order to investigate the observed barriers and mental health needs of a local South Asian community in Atlanta, Georgia from the perspective of psychiatrists who live and work in the community of interest. These providers identified lack of knowledge of mental health symptoms and

treatments as the primary strategy to combat stigma in the community. In addition, it was proposed that the South Asian community be approached at a primary care level where it may be better received. We are now conducting a survey among South Asian primary care providers to investigate current practices related to identification and education of mental health symptoms in the South Asian community. The survey will be distributed to members of the Georgia Association of Physicians of Indian Origin who are identified to be primary care physicians. Surveys will be developed in RedCap and distributed electronically. We will be using close comparative analysis to analyze the survey results. This poster will review our findings and summarize our survey results with descriptive statistics. This represents a step in formulating culturally appropriate education and interventions at a primary care level to mitigate stigma and promote mental health equity within the South Asian community.

No. 8

**WITHDRAWN**

No. 9

**AOT: Are Providers Less Sensitive When Prescribing a Mandated Treatment, Which Risks Making Patient Wonder "Am I Being Punished?"**

Poster Presenter: *Harjasleen Bhullar Yadav, M.B.B.S.*

Co-Author: *Jacob Elliott Sperber, M.D.*

**SUMMARY:**

Patients who are undergoing assisted outpatient treatment or who are mandated by mental health courts into treatment are at risk for having medication side effects less well-monitored during the course of treatment, and are thus more likely to become non-adherent in future, once the court order expires. (Mandatory treatment often goes forward without engagement of the patient with the psychiatrist.) It is noted that the clients receiving assisted outpatient treatment may not be listened to as receptively when they complain of side effects because of their histories of non-adherence in the past. Patients on AOT often feel coerced into treatment, and questions have been raised about the justice of AOT procedures. We present the case of Ms. JD, a 37 year old female, who suffered from

Bipolar Disorder, with psychotic features. She was mandated to treatment by the court because of her history of repeated non-compliance leading to decompensation in the past. She presented to our clinic in distress, seeking a second opinion because of amenorrhea lasting for a year. She was on court-mandated Risperdal Consta 25 mg, the injection scheduled every 2 weeks. She had been discharged to follow up with a provider in the community, who assigned her to a nurse practitioner under her supervision. She had sought consultation from a gynecologist, and an endocrinologist, who had recommended work up, which revealed Prolactin level of 97.1 (normal reference range for lab: 3-30) on 9/02/2017. MRI of the brain on 9/22/2017 did not show any signs of pituitary microadenoma, and pelvic sonogram completed on 9/22 was normal. She did report missing periods occasionally once in a while prior to starting treatment, but this time it was different. The patient reported great distress, which she attributed not only to amenorrhea of one year, but also to mood changes secondary to hormonal changes. We as clinicians should take a number of factors into account, especially when we are mandating our clients to treatment. For example, frequent, and adequate monitoring of side effects, and lab work should be done on a regular basis, including prolactin levels, especially in the case of young females in the reproductive age group. Advocacy for clients becomes even more important in such situations to overcome the already existing stigmas about patients who require mandated treatments, as well as concerns about coercion of clients. This subset of patients can benefit from standards of care which emphasize client-centered approaches, with time and resources to address issues articulated by patients, such as medication side effects.

No. 10

**Pre-Visit Engagement as a Way of Decreasing No-Show Rate to Integrated Psychiatry Appointments in Large Primary Care Settings: A Proposal**

Poster Presenter: *Stephen Paul Ferber, M.D.*

Co-Authors: *Ludwing Alexis Florez Salamanca, M.D., Stephanie Le Melle, M.D., M.S.*

SUMMARY:

Background: Depression and anxiety are disabling conditions that affect one in four individuals in their lifetime. The response to treatment of those conditions is comparable with medical conditions, yet most individuals go untreated. The Collaborative Care Model is a cost-effective, systematic, evidence, population and team-based approach efficient in the management of depression in primary care settings. Columbia University Medical Center/New York Presbyterian Hospital have been implementing the Collaborative Care Model in the largest primary care clinic within the hospital system, the Associates in Internal Medicine (AIM) Practice, where approximately 15,600 patients were served in 2016. Given the size and volume of the clinic, a warm handoff, as recommended in the Collaborative Care Model, has not been feasible. One of the challenges we have encountered while implementing this model is a no-show rate to mental health appointments of 56%. Anxiety, ambivalence and poor understanding of mental health assessment have been identified as contributing factors to the high no-show rate in our integrated psychiatry model. Interventions aiming to improve attendance like phone call reminders, SMS reminders or letters sent by administrative staff have been implemented successfully in other settings, phone calls being the most effective. Those interventions however do not address ambivalence, anxiety and low motivation to attend. Hypothesis: Phone calls made by mental health clinicians with the specific aim to engage patients before the visit will decrease no-show rates. Study design: In a pre-post intervention study, we will measure no-show rates during 6 months before and after the beginning the intervention. Intervention: Mental health clinicians will call patients to remind them of their appointment and assess for barriers to adherence to care. This interaction will allow clinicians to start engaging and developing therapeutic alliances with patients prior to the initial assessment. By addressing stigma, motivation, anxiety, ambivalence, and explaining the assessment process over the phone prior to the visit, we believe that patients will be more motivated to attend. Following a standardized model, clinicians will contact patients one week prior to their scheduled visit. Statistical analysis: We will conduct a univariate comparison between the 2 study groups using a Chi square method, with corresponding 95%

CI and p-value. Implications: If proven effective, pre-visit engagement by mental health providers may improve overall effectiveness of integrated psychiatry in a large primary care settings.

Preliminary results: During the first month of the intervention, the absolute risk reduction (ARR) was 16%, suggesting promising results.

No. 11

### **Federal Agencies Partnering to Address Mental Health Disparities**

Poster Presenter: *Andrea Horvath Marques, M.D., Ph.D., M.P.H.*

Co-Authors: *Anna Ratzliff, M.D., Ph.D., Beverly Pringle, Ph.D., Sara Azimi-Bolourian, Ph.D., M.B.A., Kasey Farrell, M.S., Anne Shields, M.H.A., R.N., Denise Juliano-Bult, M.S.W., Michael C. Freed, Ph.D.*

#### **SUMMARY:**

**Background and Purpose:** For over 2 decades, the National Institute of Mental Health (NIMH) and other federal agencies and foundations, have invested heavily in collaborative care model (CoCM) research. Evidence from over 100 randomized controlled trials is robust, and suggests that when implemented correctly, CoCM is effective for depression, anxiety, suicide prevention, and other behavioral health and medical conditions. In 2017, the Health Service Administration (HRSA) and NIMH partnered to award a contract supporting eleven (11) sites to ensure implementation of CoCM with fidelity. **Implementation:** NIMH and HRSA are partnering to assist a 2-years implementation of a CoCM in nurse-led safety net clinics supported by HRSA through the Nurse Education, Practice, Quality and Retention-Interprofessional Collaborative Practice: Behavioral Health Integration (IPCP:BHI) Program (NEPQR-IPCP: BHI). The goals of this partnership is to address mental health disparities in the treatment of depression and other common mental health disorders in primary care. NIMH is supporting this initiative via a contract with AIMS Center, University of Washington, to provide training to the clinics. All health center are safety-net clinics providing care to underserved populations with a prevalent uninsured patient population. These programs are located in rural, suburban, and urban areas across 6 HRSA regions and serve over 250,000 patients annually. The target population includes

low-income, homeless, and LGBT adults facing significant financial, geographic, cultural-linguistics barriers, and/or with chronic disease conditions (e.g. diabetes, hypertension) and untreated/undertreated mental health conditions or substance abuse.

**Impact:** The NIMH- HRSA collaboration will support Strategic Objective Four (4) of the NIMH Strategic Plan, which is to strengthen the public health impact of NIMH-supported research by providing training and health information dissemination. The HRSA BHI model goal is to increase access to mental health and substance abuse prevention care while improving health outcomes and decreasing hospital costs. The goal of this initiative is to evaluate the impact of training clinics to implement CoCM on patient outcome and on reducing mental health disparities **Conclusion:** Interagency cooperation is vital to leverage federal resources across agencies to maximize use of the evidence-based interventions to reduce mental health disparities. This initiative holds promise for improving health equity as it targets three documented contributors to mental health disparities: access to care, quality of care, and engagement and retention in care.

No. 12

### **Smoking Cessation and Serious Mental Illness: A Shared Priority for Primary Care and Psychiatry With the Greatest Potential to Reduce Mortality**

Poster Presenter: *Sarah A. MacLaurin*

Co-Authors: *Lauren Donahue, Caitlin Mulligan, Benjamin Gorman, Kelly Irwin, A. Eden Evins, Travis Baggett, Oliver Freudenreich, M.D.*

#### **SUMMARY:**

**Background:** More people with serious mental illness (SMI) smoke cigarettes than those without, and individuals with SMI often smoke more cigarettes and are more dependent than general population smokers. In addition to lung disease, smoking is a major contributor to cardiovascular disease, which is the number one cause of death in those with SMI. This year, we assess our efforts to reduce health disparities in the SMI population, and prioritize smoking cessation strategies. **Methods:** 197 patients prescribed clozapine at our urban community mental health center completed a comprehensive tobacco assessment between September 2016 and March 2017. The Fagerstrom Test for Cigarette

Dependence (FTCD) assessed dependence in the smokers in this cohort. Data from our clozapine cohort was assessed in relationship to CDC data of state and national smoking rates. Further, we re-examined our 2015 survey of 100 primary care providers (PCP) to identify priorities for mutual patients. Results: 37% of the clozapine cohort were current smokers, while the remaining were 32% never-smokers and 32% ex-smokers. These rates are more than double the Massachusetts population rate of 14% smokers in 2016. In our cohort, the 56 smokers who completed the FTCD produced a bimodal distribution; 44% scored in the very low or low cigarette dependence and 41% scored high or very high dependence. The 2015 survey of PCPs had a 20% response rate, 100% affirmed psychiatric providers should manage smoking cessation. Conclusions: Quitting smoking can significantly decrease the calculated risk of cardiovascular disease (myocardial infarction, stroke), thereby reducing disparity in life expectancy, currently 28 years lost for those with SMI. Psychiatric providers often have more contact with their patients than other health care professionals and have experience in the evidenced based pharmacologic and behavioral treatments for smoking cessation. Cessation efforts need to be intensive, repetitive, and consistent. Strategies to implement include: screening of all patients, education of all staff (including therapists and group home staff), documented trials of pharmacologic interventions, group education and support, and individual problem solving. Without a deliberate effort, we will not move towards more equitable care for this patient group.

No. 13

**How to Help Psychiatric Patients Get the Care They Need: A Review of NYS Medicaid Programs That Reduce Costs and Increase Access to Care**

Poster Presenter: *Manisha Vijayaraghavan*  
Co-Author: *Neil Pessin, Ph.D.*

**SUMMARY:**

New York's behavioral health system, which provides specialty care and treatment for mental health and substance use, is large and fragmented. The publicly funded mental health system alone serves over 600,000 people and accounts for about \$7 billion in

annual expenditures, with approximately 50% of this spending going to inpatient care. The Affordable Care Act (ACA) offered New York State the opportunity to uniquely transform our Medicaid system, impacting the quality of care delivered to a fragile population of adults and children. The Medicaid Redesign Team (MRT) in New York State approved multiple community based initiatives designed to improve the health of all Medicaid users. The goal of MRT is to reduce hospital utilization and costs but more importantly improve patient health outcomes through coordinated care provided by an interdisciplinary team linking primary, behavioral health, and long term services and supports. We will discuss two initiatives: a) Health Home Care Coordination program that integrates care through improved treatment protocols, a shared plan of care between all providers and health information technology. The Visiting Nurse Service of New York (VNSNY), the largest certified home health agency in the US, Health Home Care Coordination program has served 2600+ Adult Health Home members since 2012. Our patients primarily have psychiatric diagnoses in addition to multiple chronic medical conditions and unmet health-related social needs e.g. homelessness, lack of social support, etc. b) Delivery System Reform Incentive Payments program (DSRIP), started in NYS in April 2014 and challenged traditional models of service delivery, and focuses on system transformation and population health improvement. Through a DSRIP partnership with Bronx Partners for Healthy Communities, VNSNY piloted a Critical Time Intervention (CTI) program in 2017 assisting 30+ homeless members with an SMI dx (schizophrenia and/or bipolar disorder), who have had multiple inpatient stays and are high risk for re-hospitalizations due to their no adherence to treatment, lack of housing and untreated medical conditions. Critical Time Intervention (CTI) is a time-limited evidence-based practice that facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical transition periods. These new initiatives have allowed VNSNY to transform existing services and design new services. This presentation will examine how service delivery innovations can utilize community based care models to reduce cost,



improve access to care and improve patient health outcomes. We will also discuss our implementation challenges, program outcomes and lessons learned through this process.

No. 14

**How to Start an ECHO Psychiatry Training Clinic for Primary Care Providers: The Oregon Story**

Poster Presenter: *Jonathan P. Betlinski, M.D.*

Co-Author: *Keith Cheng, M.D.*

**SUMMARY:**

**BACKGROUND** •There is an ongoing and increasing shortage of practicing psychiatrists in the U.S. Most practicing psychiatrists are over the age of 55. Not all residency and fellowship spots fill annually. •A clear majority of those with mental health disorders seek and receive treatment from primary care providers, and symptom severity does not significantly vary between primary care and psychiatry. •Both providing direct mental health care and providing training for clinicians in rural areas present additional challenges. **METHODS** •Our lead psychiatrists and staff project managers attended Project ECHO training at the University of New Mexico. •Two teams working with different funding sources and using different recruiting strategies developed analogous ECHO clinics for Adult and Pediatric Psychiatry. Participants included Physician Assistants, Nurse Practitioners, and Physicians in Internal Medicine, Family Medicine and Pediatrics. •Child and Adult psychiatry curriculums were developed based on reported needs and deficits perceived by participating primary care providers. **RESULTS** •The majority of participants reported their participation in ECHO led to a high or very high degree of learning across multiple topics in both adult and child psychiatry. •At the end of the Project ECHO clinics, participants reported greater confidence using psychotropic medications, especially when treating anxiety and depression. •Participants in the Project ECHO clinic reported actual behavior change in the medical home. •In post surveys, the clear majority of participants agreed or strongly agreed that “participating and learning about a complex chronic disease through ECHO is an effective way for our clinic to enhance its expertise.” **CONCLUSIONS** •Project ECHO clinics are feasible, enjoyable, well-received, and can be

adapted to meet specific regional needs. •Psychiatry knowledge and confidence in treatment of both adults and children with mental health issues are increased for primary care clinicians who participate in the Project ECHO model. •Project ECHO training also leads to a change in behavior of primary care clinicians. **DISCUSSION** •Project ECHO is a relatively new model for providing consultation and training for clinicians in many clinical areas. Oregon’s experience led to Adult Psychiatry launching the first ECHO program in the state, and subsequently to the first-ever Child Psychiatry ECHO program. •There is a growing body of evidence showing that ECHO clinics can increase work flow capacity to provide evidence-based and best practices specialty care with the result of reducing health care disparities in physician shortage areas. •The main weakness of these studies is a small number of participants. More research is needed to verify that the ECHO model is an effective way of training primary care clinicians to provide mental health treatments, especially to children.

No. 15

**The Impact of Medicaid Health Homes on the Service Use of Beneficiaries With Serious Mental Illness**

Poster Presenter: *Michael Flores*

**SUMMARY:**

**Objective:** To determine the impact of Rhode Island’s (RI) Medicaid Health Home (MHH), a behavioral-based integration strategy, on the health service use of beneficiaries with Serious Mental Illness (SMI). **Study Design:** We used Medicaid claims (2009-2013) and a quasi-experimental difference-in-differences approach with propensity score weighting to compare a treatment group (N=5,272), Medicaid beneficiaries ages 18 to 64 with a diagnosis of SMI that participated in MHH, to a comparison group (N=4,128) that possessed similar characteristics as the treatment group but did not participate in MHH. Between pre- and post-intervention periods, we assessed MHH impact on any service use (dichotomous variables) and number of service visits (count variables). Primary outcomes consisted of 1) outpatient service use, overall and for commonly occurring physical health conditions (chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), diabetes,

hypertension, and obesity); 2) hospitalizations (psychiatric or medical); and 3) emergency department (ED) use (psychiatric or medical). Principal Findings: At baseline, MHH and comparison groups were similar on pre-intervention factors. Among MHH participants, the proportion having any overall outpatient visits increased, between pre- and post- periods, relative to the comparison group, 2.7 percentage-points (95%CI=0.3 to 5.2). Similarly, MHH was associated with an increase in the proportion having any outpatient visits for diabetes and hypertension as well as any psychiatric hospitalization (all significant at  $p<0.05$ ). There were no differences between groups in having any ED use (psychiatric or medical) or outpatient visits associated with COPD, CVD, or obesity ( $p>0.05$ ). Looking at number of visits, relative to the comparison group, between pre- and post-periods, the number of overall outpatient visits increased 62.7/100 person-years (95%CI=24.0 to 101.4) for MHH participants. There was also an increase in the number of medical ED visits ( $p<0.05$ ) but no differences between groups in the number of hospitalizations (psychiatric or medical) or outpatient visits for commonly occurring physical health conditions ( $p>0.05$ ). Conclusions: Investment in a behavioral-based integration strategy can improve access to and utilization of outpatient services. Limited resources and competing demands can lead to an increase in hospitalization and ED use. Our evaluation of RI's MHH provides relevant information that can guide policy development and treatment decisions for health care systems and providers working with a heavily disenfranchised patient population.

No. 16

**WITHDRAWN**

No. 17

**Preventing Psychiatrist Burnout: Balancing Altruism and Self-Care**

Poster Presenter: *Robert E. Garza, M.D.*

Co-Authors: *Chloe Hoang, Sheila M. Loboprabhu, M.D.*

**SUMMARY:**

Professionalism includes demonstrating excellence, respect, integrity, compassion, altruism and

accountability in all endeavors. Altruism involves behavior designed to increase another individual's welfare, even without reciprocity or reward.

Altruism is particularly costly in dangerous situations or when helping involves long-term commitment such as providing mental health care for military veterans. Altruism can provide meaning, fulfillment and deep satisfaction which is the motivating drive for physician behavior. Altruism when not balanced by self-care can result in compassion fatigue and burnout. Self-care includes healthy eating, hydration, sleep, exercise, family time, leisure, hobbies and spiritual practices. The ten American Medical Association Principles of Medical Ethics clearly list the essential physician values of professionalism, honesty, compassion, respect and primary responsibility to the patient. They are however vague when discussing the physician's responsibility for self-care. Professionalism requires physician adherence to high standards of competence and moral responsibility. Society cannot believe in psychiatrist professionalism while burned out psychiatrists exhibit classic symptoms of emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Excessive emphasis on evidence-based medicine dehumanizes illness and suffering, which diminishes the potential for an altruistic and compassionate response by physicians. This gradual erosion of core values negatively impacts professionalism while devaluing the medical profession. In this poster, we describe an initiative to enhance professionalism at a major Department of Veterans Affairs (V.A.) medical center and to restore joy and meaning to the practice of psychiatry. Administrators, senior psychiatrists and suicide prevention coordinators collaborated in an effort to encourage a triad of self-care, boundaries and altruistic behaviors in psychiatrists by 1) addressing psychiatrists' needs such as space, self-care, need for affirmation, mindfulness and meditation training, and providing emotional support in traumatic situations, 2) distributing workload more equitably to prevent overwork and to respect boundaries, and 3) fostering a stronger sense of community among psychiatrists. Psychiatrists reported feeling more supported, and gradual improvement was noted in parameters such as lower burnout, higher retention, and higher productivity.

No. 18

**Community and Global Psychiatry Case Conference:  
An Innovative Psychiatry Residency Initiative to  
Address the Social Determinants of Mental Health**

Poster Presenter: *Gregory Gabrellas, M.D., M.A.*

Co-Authors: *Isabella Morton, M.D., M.P.H., Roya Ijadi-Maghsoodi, M.D., Ippolytos Andreas Kalofonos, M.D., Ph.D., M.P.H., Sonya Gabrielian, M.D.*

**SUMMARY:**

Background: Though psychiatrists are trained in the biopsychosocial model of mental illness, there are few accepted paradigms to teach psychiatry trainees about social determinants of mental health.

Nevertheless, social determinants (e.g. homelessness, social isolation, and access to healthcare) are closely intertwined with biological and psychological factors and loom large in many patients' histories and prognoses. These issues shape how residents perceive mental illness and are relevant in selecting psychosocial interventions, such as supportive housing and employment, that can significantly impact lives. Methods: Within the UCLA psychiatry residency curriculum, we piloted an innovative, resident-driven teaching model that explored the social context of mental illness, health inequalities, and racism encountered in everyday clinical practice. The Community & Global Psychiatry (CGP) case conference brings together residents and faculty to highlight clinical cases that illuminate the social determinants of mental illness and the structural changes needed for health. The CGP case conference aims to strengthen residents' abilities to recognize and address social determinants of mental health in their clinical practice. Residents present cases from their training experiences, including encounters in psychotherapy, inpatient treatments, the emergency room, and medical-surgical wards. Faculty members share perspectives on the case, drawing from varied disciplines across the university, including the social sciences. At the case conference, after the resident's case presentation, faculty give a short lecture on social determinants of mental health that are illustrated by the case, leading to integration of social and psychiatric perspectives. Surveys employing brief open-ended questions are used to assess resident satisfaction and to facilitate iterative quality improvement. Results: One

conference was held to date; three more are planned for this academic year. The first conference included vignettes of patients seen at a community mental health clinic; faculty presenters included a psychiatrist health services researcher and a psychiatrist-anthropologist, who lectured respectively on housing as a social determinant of mental health and social theories relevant to the doctor-patient relationship. Surveys of residents revealed high levels of satisfaction with the conference, highlighting existing gaps in the residency curriculum around social determinants of mental health and the value of social science faculty involvement in the case conference series.

Conclusion: Despite growing awareness of the importance of the social determinants of mental health across communities and health systems, many psychiatry residency curricula have under-prioritized teaching in this area. We present a case study of a resident-driven, innovative case conference model to address this training gap, and share our findings of what residents found to be most valuable.

No. 19

**Empathy Across Difference: Discussing Our  
Identities as Psychiatrists**

Poster Presenter: *Rita Ouseph, M.D.*

Co-Authors: *Nadia A. Oryema, M.D., Xinlin Chen, M.D., Nadejda Bespalova, M.D., Asha D. Martin, M.D., Jose P. Vito, M.D.*

**SUMMARY:**

Background: When psychiatrists and patients meet, each brings aspects of their multifaceted identities to the treatment dyad. Research shows clear disparities in mental health outcomes along lines of relative privilege across multiple categories of patients' social identity, including ethnicity, gender/sexuality, and income. Cultural competency curricula aim to fill in these gaps by addressing patient factors, but leave unaddressed clinicians' identities. In related fields of medicine, measures of clinician implicit bias have been found to correlate with ethnic disparities in treatment decisions. For example, emergency and internal medicine residents with higher measures of implicit bias for white individuals over black individuals were less likely to recommend thrombolysis for black patients when

presented with clinical vignettes concerning for acute coronary syndrome. We hypothesize that greater awareness of our own attitudes, as influenced by our own multifaceted identities, will improve patient care by revealing implicit biases that may cloud clinical decision-making. Recent research in social psychology shows that experiences of power hinder individuals' abilities to take the perspectives of others through unconscious mechanisms. This is hugely important in our work as psychiatrists, which hinges on our ability to make empathic connections within an inherently unequal power relationship. The workshop aims to bring these unconscious forces into conscious awareness for clinicians in order to reduce bias. Methods: Our project is a peer-led workshop that utilizes a multidimensional model of identity and emphasizes structural power imbalances. The workshop is an experiential group process promoting reflection on our multi-faceted identities. The workshop was developed following a literature review of similar trainings and has been modified based on past iterations with psychiatry residents. The workshop starts with participants agreeing to a group frame that allows for confidentiality and mutual respect. The discussion then proceeds through a series of questions in small groups that invite personal reflection on identity and power imbalances. This workshop ends with a debriefing session in the large group. Conclusion: Diversity is increasingly recognized as an asset in the workforce and the NYU psychiatry residency program demonstrates this trend. How do we best utilize our differing perspectives as psychiatry trainees in order to decrease disparities in patient care? This workshop is a starting point towards potentially challenging cross-cultural conversations. Future directions will involve measures of implicit bias pre and post workshop of participants as well as qualitative analysis of themes arising during discussion, which will refine subsequent workshops and provide direction for residency programs developing similar programs.

No. 20

**NCAA Division I Coaches' Experiences With Mental Health Issues in Student Athletes?**

Poster Presenter: *Pratik Ashok Mehta, M.D.*

Co-Author: *Claudia Reardon*

**SUMMARY:**

Background: There is a perception of "mental toughness" associated with athletic participation that may interfere with the identification and treatment of mental illness in intercollegiate student-athletes. With an increasing focus on athlete mental health in recent years, the National Collegiate Athletic Association issued a statement on "Mental Health Best Practices" in 2016 to provide guidelines in supporting mental wellness. The aim of the current study is to survey Division I coaches to better understand the types of mental health diagnoses encountered, screening tools utilized, and resources and treatment available to student-athletes. Methods: IRB approval was obtained for the study. A questionnaire designed to ascertain data on mental health screening and care available to intercollegiate student-athletes was developed using the online research-secure REDCap database. In total, 3188 Division I coaches with current email addresses were invited to participate. The survey was e-mailed to participants. Results: Data collection is underway. To date, survey responses represent coaches of both male and female teams from 15 different sports. Survey responses found that 74.1% of respondents indicated that they do not screen for history of mental health diagnoses during recruitment and 16.9% of respondents indicated that they utilize annual screening of mental illness in their current student-athletes. In addition, 59.5% of respondents encountered an average of 1-3 athletes per season with mental illness, while 40.5% of coaches encountered an average >3 athletes per season with mental illness; 92.8% of coaches encountered an average of 1-3 athletes per season with substance use disorder. During their career, 70.6% of respondents have experienced a mental health emergency in at least one of their student-athletes. In cases where student-athletes may benefit from mental health care, 89.4% of respondents have a protocol in place to refer athletes to mental health services. The most common diagnoses encountered (not including substance use disorder) include anxiety, depression, and attention-deficit disorder. Of substance use disorders, the most common substance encountered is alcohol. Conclusion: There is currently no consensus among athletic programs on universal

screening of student-athletes for mental illness. Given the prevalence of mental illness in intercollegiate athletes, the impact mental illness may have on both athlete wellbeing and performance, and the risk for missed diagnoses in this population, athletic programs may benefit from instituting formal screening and protocols for treatment.

No. 21

### **Intimate Partner Violence in America**

Poster Presenter: *Rahn K. Bailey, M.D.*

#### **SUMMARY:**

Intimate Partner Violence (IPV) remains highly prevalent in American society. It impacts individuals from every class, gender, race, culture, and sexual orientation. Over time, the presentation of IPV has evolved into unfamiliar territory. In today's world, the Norman Rockwell-ian picture of the husband abusing the wife really has morphed into a more nuanced form of IPV that presents atypically from the familiar historical scenarios. In 2017, we must examine IPV with a broader perspective in an order to tackle an increasingly underreported and under-recognized problem. Providers today should expect the unexpected when faced with IPV, as the nature of the beast is dynamic. As with a myriad of psychosocial issues, IPV in the community will not change until we start changing our mindset. It is imperative that we broaden our horizons, allowing an oft-disenfranchised group to move away from the periphery towards the center of focus. Only with acceptance will issues such as IPV be tackled in the future.

No. 22

### **Firearm Violence in America: A National Plague**

Poster Presenter: *Rahn K. Bailey, M.D.*

#### **SUMMARY:**

Firearm violence is a public health epidemic today. This issue straddles all races, socioeconomic classes, and genders. A public health can be defined as a complex state of health affairs that has a significant impact on community health, mortality, and economy, resulting from disease, industrial processes, or poor policy. (1) This article attempts to de-politicize the narrative on firearm violence in

America, exploring the issue as a public health epidemic instead of a partisan political issue. We discuss notion that more stringent firearm control will decrease communal firearm violence across the United States. We emphasize that firearm violence is a universal issue rather than one confined to minorities, mentally ill, or lower socioeconomic classes. Those individuals victimized by firearm violence are disenfranchised. Their voices are seldom heard. High-ranking NRA officials and lawmakers in Washington are only peripherally affected by these issues, yet they hold the largest stake in how the rest of the community will be exposed to this menace. Those ravaged by firearm violence in America are not just primary victims of guns, but also secondary and tertiary victims such as family, friends, and neighbors. Firearm violence is a problem that permeates the very fabric of our society, disseminating across gender, class, race, and creed. The issue warrants a change in cultural attitudes followed by legislative reform before we progress as a nation towards a firearm violence- free future.

No. 23

### **Studying Mental Health Through Multimodal Analysis of Social Media Data**

Poster Presenter: *Amir Yazdavar*

#### **SUMMARY:**

With ubiquity of social media platforms, millions of people are routinely sharing their moods, feelings and even their daily struggles with mental health issues by expressing it verbally or indirectly through images they post. In this study, we examine exploitation of big multi-modal social media data for studying depressive behavior and its population trend across the U.S. to better understand a region's influence on the prevailing environment and available care. In particular, employing statistical techniques along with the fusion of heterogeneous features gleaned from different modalities (shared images and textual content), we build models to detect depressed individuals and their demographics. In particular, previous research glean psychological status of online users via psycholinguistic analysis, supervised and unsupervised language modeling, or studying individual's interests. However, except for a few

attempts, the state of the art investigations are seldom concerned with visual attributes of mental health reflected in the content shared on various social media platforms. According to eMarketer, photos accounted for 75% of the content posted on Facebook. An old saying of "a picture is worth a thousand words" recently changed to "photos are worth a million likes". Similar to Facebook, photos are also very engaging for Twitter users. The tweets with image links get twice the rate of engagement than those without. We recall that getting social support from peers is primary motivation for sharing depressive indicative content. The easiness of expressing emotion through images where they often gaining more attention compared to the verbal form, is plausible motivation for sharing depressive images. Besides, as the psychologist Carl Rogers highlights that we often pursue attitudes which bring us closer to our Ideal-Self. In this regard, the choice of profile image can either represent our online persona or persona we choose to paint for others to see. We believe this can have roots in the mental health status of a person, and the visual attributes of it can provide emotional expression that can yield insight into mental illness. Inspired by that, we aim to study the profile pictures of likely depressed individuals while capturing signals from colors, aesthetic and facial attributes to better understand the psychology of choosing personal profile image. Furthermore, the recent advancements in deep-convolutional neural networks, specifically for image analysis task, has lead to a significant improvement in age and gender classification. Our system leverages these advancements for capturing demographic features to better recognize likely depressed individuals from their shared images. Our approach calls for gleaning and integrating semantics from different modality to enhance our understanding of depressive behavior.

No. 24

**Prediction of Adolescent Suicidal Behavior Using Machine Learning With Electronic Health Records**

Poster Presenter: *Nicholas Carson, M.D.*

Co-Authors: *Brian Mullin, B.A., Maria Jose Sanchez, M.D., Frederick Lu, B.S., Michelle Menezes, A.B., Kelly Yang, B.S., Benjamin Cook, Ph.D., M.P.H.*

SUMMARY:

Background: Attempted suicide is estimated to be as high as 40% among adolescents hospitalized for psychiatric reasons, though adolescents may be reluctant to disclose this to clinicians. We describe an algorithm that predicts suicidal behavior among hospitalized adolescents using natural language processing (NLP) and machine learning (ML) of electronic health records (EHR) preceding admission. NLP is a computerized process that analyzes and codes text (1), while ML develops algorithms used for analysis of coded text (2,3). Methods: Adolescents hospitalized on a psychiatric unit were surveyed for number of suicide attempts in the year before admission. EHR notes for this period were available for 73 respondents (9415 notes). After randomly splitting the sample into training and evaluation datasets, NLP was applied to the training notes, yielding a list of "concept unique identifiers" (CUIs) per the Unified Medical Language System. The random forest machine learning classifier identified CUIs most associated with suicide attempt. A note was considered positive if a majority of the decision trees "voted" to classify the note as being predictive of suicide attempt based on the CUIs it contained. To generate a risk for each patient, we varied the percentage of positive notes at which an individual was considered to be at positive risk for suicide attempt. The validity of these models was evaluated using positive and negative predictive values (PPV and NPV), sensitivity, and specificity. Accuracy was measured with an area under the receiver operating curve statistic (AUC). Results: In the sample of 73 adolescents, 27 (37%) of respondents reported at least one suicide attempt. The mean number of notes was 129 across outpatient, inpatient, and emergency settings (psychiatric and primary care). Several of the CUIs negatively associated with suicide attempt were related to family (i.e., "fathers," "brothers," "parents," "mothers"). In the validation step using evaluation data, the most accurate model was achieved at a cutoff of 50% of notes predicting suicide attempt: PP=0.45, NPV=0.64, sensitivity=0.28, specificity=0.77. The AUC for this model was 0.56. Conclusion: This project is an early proof of concept of a model predicting adolescent suicidal behavior using NLP of clinical notes. The machine learning step yielded an algorithm with strengths in the area of NPV and sensitivity, which could help validate a patient's

denial of prior attempt and aid in risk assessment and discharge planning. Further validation of this algorithm on larger samples from other health systems will strengthen its accuracy. Ultimately, models such as these could be included as alerts in the EHR to guide clinician recommendations. This study was supported by the Harvard Clinical and Translational Science Center (NIH UL1 TR001102).

No. 25

### **"Body and Mind" Integrating Physical Activity Into Outpatient Mental Health Services**

Poster Presenter: *Jayanta Chowdhury, M.D.*

#### **SUMMARY:**

It has been well established in the literature that exercise has a positive impact on mental health. Regular exercise not only improves overall health and reduces the risk for many chronic diseases but also improves mood and decreases anxiety. Studies also show that engagement in regular exercise can help promote abstinence from substance use and may even help with smoking cessation. While the exact mechanism whereby exercise impacts mental health is not clear, there is evidence to suggest that combining exercise with another treatment is better than exercise or treatment alone. Furthermore, psychiatric patients have a high incidence of medical comorbidities a lot of which might be reduced by engaging patients in regular exercise. In 2013, the United States spent approximately \$201 billion on mental health issues such as anxiety and depression; Heart conditions were the second costliest condition at \$147 billion. Here we present the findings of our pilot project, "The Inshape Program" a program that engages mental health patients in physical fitness with a personal trainer. Our hypothesis is, the patients who engage in regular physical exercise remain compliant with medications, routinely follow up with appointments, adhere with their treatment plan and have less depressive, anxious or psychotic symptoms as evidenced by psychometric testing when compared to controls. We aim to add to the growing body of literature that combining exercise with mental health treatment will not only have a positive impact on symptoms but will also lead to less utilization of inpatient services.

No. 26

### **Treatment Considerations in Managing Unplanned Pregnancies in Bipolar Patients**

Poster Presenter: *Avanti Puri*

#### **SUMMARY:**

This is the case of Ms. P, a 34 year old Hispanic woman with a past psychiatric history of bipolar disorder, domiciled in a shelter with multiple prior psychiatric hospitalizations, who was found to have an unplanned pregnancy with antipsychotic and lithium exposure in early pregnancy. She was discharged prior from the inpatient psychiatry unit on Lithium 600 mg twice daily and Olanzapine 15 mg daily. After discharge she reported two sexual encounters. She had 3 visits to psychiatric emergency services before she was readmitted on the third visit. In her first visit after discharge, she claimed to have been raped and was found to have negative urine pregnancy test. Her second visit a few hours later also had negative urine and blood pregnancy tests. On her third visit, she was brought in by her shelter for aggressive behavior and refused pregnancy testing. At this time she was readmitted for uncontrolled mania and restarted on her previous discharge medications: Olanzapine 15 mg daily, Lithium 600 mg twice daily, Clonazepam 1mg daily. She refused several doses of her medications believing she was pregnant. Urine pregnancy test on day 5 of admission was positive. After discussing the potential teratogenicity of Lithium and Olanzapine with the patient, her regimen was modified to Haldol 5 mg twice daily in view of a better safety profile in pregnancy. Significant challenges in the management of this patient included: initial refusal of confirmative serum human chorionic gonadotropin testing, confessing much later to making up allegations about being raped to "get attention", refusal of medication in the early part of her inpatient psychiatric stay, experiencing akathisia and exhibiting severe mood lability, asking for her pregnancy to be terminated and then changing her mind. Other issues included hypersexual behavior and fighting with other female patients over the attention of males on the unit. Review of literature suggests female bipolar patients experiencing manic episodes are more likely to become pregnant than the general population. This is compounded by increased risk of teratogenicity to the fetus if on mood stabilizers. Risk is mitigated when pregnancy is

planned and under supervision of the treating psychiatrist. In this poster we explore some practical recommendations in the treatment of bipolar patients who exhibit high risk behavior such as hypersexuality, and who are at higher risk for unplanned pregnancy. Recommendations include providing routine pregnancy testing at every encounter with the most sensitive assay, systematically documenting sexual health history and contraceptive counseling in initial psychiatric evaluations, calculating duration of medication exposure based on the time of conception found by the assay, and discussing the risks and benefits of continuing psychotropic medication with the patient if the patient becomes pregnant and assessing the need for continuing with medications.

No. 27

**Facebook Ads to Recruit Military Veterans: Reaching Those At-Risk for Psychiatric Disorders and Suicidal Ideation**

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

**SUMMARY:**

Background: Younger military veterans are at high risk for psychiatric disorders and suicide. Reaching and engaging veterans in mental health care and research is challenging. Social media platforms may be an effective channel to connect with veterans. This study tested the effectiveness of Facebook advertisements in reaching and recruiting Iraq and Afghanistan-era military veterans in a research study focused on mental health. Methods: Facebook ads requesting participation in an online health survey ran for six weeks in 2017. Ads varied imagery and headlines. Validated instruments were used to screen for psychiatric disorders and suicidality. Outcomes included impressions, click-through rate, survey completion, and cost per survey completed. Results: Advertisements produced 827,918 impressions, 9,527 clicks, and 587 survey completions. Lack of enrollment in Veterans Affairs health care (193/587, 33%) and positive screens for current mental health problems were common, including posttraumatic stress disorder (266/585, 45%), problematic drinking (243/584, 42%), major depression (164/586, 28%), and suicidality (132/585, 23%). Half of survey participants (n=285) were recruited with just 2 of the 15 ads, which showed

soldiers marching tied to an “incentive” or “sharing” headline. These two ads were also the most cost effective, at \$4.88 and \$5.90 per participant, respectively. Among veterans with current suicidal ideation, the survey-taking image resulted in higher survey completion than the soldiers marching image (p=0.007). Conclusion: Facebook ads are effective in rapidly and inexpensively reaching military veterans, including those at-risk for mental health problems and suicidality, and those not receiving VA healthcare. Ad image and headlines may help optimize effectiveness of ads for specific subgroups.

No. 28

**Patient Perceptions of Care: Telepsychiatry Compared to Face to Face Care in PHP in a Rural Setting**

Poster Presenter: *Simha Esther Ravven, M.D.*

Co-Authors: *Frank Gallo, Mark R. J. McGee, M.D., Alan K. Hagstrom, M.D.*

**SUMMARY:**

Timely access to high quality psychiatric, including substance use care is a public health crisis in many rural areas. When quality mental health care is unavailable, people with psychiatric illness often go without treatment or get inadequate treatment. This is costly to individuals, families, and communities. Mental health professionals, including psychiatrists are geographically focused in major metropolitan areas. Recruiting and retaining psychiatrists to live and practice in rural areas is a challenge. When outpatient and preventive care is unavailable, the burden of care for untreated psychiatric illness is often displaced to emergency departments and acute psychiatric services. Telepsychiatry greatly expands access to psychiatry in underserved areas, including rural areas and small cities. This modality has been studied widely in outpatient contexts, but not at higher levels of care. It has been shown to be comparable or equivalent to in person psychiatric care in regards to accuracy of psychiatric assessment, quality of treatment planning, quality of perceived therapeutic alliance, and treatment outcomes. Evidence suggests that telepsychiatry may be superior to in-person care for patients who may suffer from paranoid delusions or have been the victim of interpersonal violence. This study assessed patient perceptions of treatment in a face



to face (FTF) treatment in a general adult partial hospital program (PHP) to a telepsychiatry model where the treating psychiatrist was available remotely and clinicians of other disciplines were present at the treatment site. Patients were treated in the same PHP program and the program transitioned from having face to face psychiatric care to a psychiatrist who saw patients remotely via secure telehealth technology. Patients' perceptions of care were measured during a period of time with a FTF psychiatrist and compared to a time period with similar program census when psychiatric care was provided via telehealth modality. At discharge, patients completed a 26-item questionnaire to measure their perception of care received in a partial-hospital setting. Five domains of direct care are embedded in the survey: perception of outcomes, dignity, rights, participation, and empowerment. Overall, patients who received telepsychiatry (M = 4.58, SD = 0.35) did not report greater or lesser care satisfaction than did patients who received in-person (M = 4.36, SD = 0.48) delivery of psychiatric services,  $t(38) = -1.66, p > .05$ . An early implication of this study is that using computer technology to provide partial-hospital psychiatric services from a distance shows no adverse effects on patient experience of care. Further study and more evidence will inform the usefulness of telepsychiatry as a comparable adjunct to conventional in-person treatment.

No. 29

**Providing Computerized Cognitive Behavior Therapy Directly to Employees: Uptake and Outcomes From a Multi-Company Rollout**

Poster Presenter: *Kristin S. Budde, M.D., M.P.H.*

Co-Author: *Seth Feuerstein*

**SUMMARY:**

Neuropsychiatric disorders are the leading cause of disability and lost work days in the United States. Some employers are beginning to offer wellness and exercise programs, and studies have found that these programs can save money and improve health. Few programs, however, focus on mental health specifically. Here we present data from a project that included small, midsize and large employers, all of which participated in the dissemination and implementation of computerized cognitive

behavioral therapy (cCBT). The project offered screening and access to condition-specific cCBT applications for depression and anxiety to employees. Ultimately over 9,000 people enrolled and accessed at least one cCBT app. 2823 completed PHQ-9 screening for depression; of these three in four screened in the moderate to severe anxiety or depression range. Even when we compared these numbers to the total enrolled population, we found that still one in five suffered from moderate to severe anxiety or depression. Overall, people who used cCBT and experienced symptom relief and reduced depression. The number of participants experiencing moderate-severe depression decreased from half to a third. And a third of participants who completed cCBT for depression modules moved from moderate-severe depression to the mild-minimal range. In this study, a large-scale mental health initiative identified a large cohort at risk of depression and were immediately referred for computerized care. Those who participated experienced a decrease in depressive symptoms. Given the prevalence of these disorders, the relative ease of cCBT use, and the evidence of positive clinical outcomes, employers should consider making these resources available to their employees.

No. 30

**FDA Approval for Digital Diagnostics and Therapeutics**

Poster Presenter: *Kristin S. Budde, M.D., M.P.H.*

Co-Authors: *David Klein, Brian Keenaghan, Seth Feuerstein*

**SUMMARY:**

Over fifty thousand apps related to mental health and wellness are currently available. Although many of these offer only information or journaling capabilities, many purport to offer treatments, and most are unregulated by the FDA. The FDA's approach to regulating such software is complicated; "healthy lifestyle" apps tend not to be regulated, but much software (particularly programs marketed as a medical device or intervention) does fall under the FDA's purview. The FDA's approach to such regulation continues to evolve; even now the FDA is working to respond to new legislation from the 21st Century Cures Act, which adjusted regulatory guidelines. This workshop will offer a broad overview

of the relationship between new therapeutics and FDA approval and discuss how new legislation is changing how new software is regulated. Panelists will outline the importance of FDA approval for these treatment devices when it comes to reimbursement, safety, and efficacy. All of this information will be contextualized in terms of its practical implications for patient care and outcomes.

No. 31

**Text4MMH (Text for Mother's Mental Health):  
Evaluating the Use of Text Messaging to Screen and  
Inform New Mothers About Mental Health Issues**

Poster Presenter: *Ariel K. Dalfen, M.D.*

Co-Authors: *William Lancee, Kellie Murphy, Andrea  
Lawson*

**SUMMARY:**

Objective: Postpartum depression (PPD) is the most common postpartum mental health issue, affecting 15-20% of new mothers [1,2]. Although screening is the most effective means of identifying women at risk [3], PPD is under-screened and under-diagnosed as tools are too lengthy and not easy to integrate into routine care [4,5]. Furthermore, many mothers do not get timely help. Barriers include lack of time, child care, knowledge of mental health services, and symptom burden [6,7,8,9]. Early screening with well-validated tools that are brief, confidential and easy to administer is essential. The objective of the current research is to evaluate the feasibility and effectiveness of a text message intervention to enhance PPD screening and education in the immediate postpartum period. Methods: Participants gave birth at Mount Sinai Hospital in Toronto, Canada, July 2015-January 2017. Participants received the Patient Health Questionnaire-2 [10] via text message every two weeks and 3 information text messages per week about postpartum mental health for the first 12 weeks postpartum. The Edinburgh Postnatal Depression Scale (EPDS)[11] was administered to all who screened positive, as well as a matched subsample who screened negative. Participant satisfaction was assessed via online survey at 12-13 weeks postpartum. Results: Using a criterion of >1 on either PHQ-2 question, 126 (13.5%) of a total 937 participants screened positive to at least 1 of the texted screens; 102 were matched with members of

the negative screen subsample. Agreement with the referent standard was fair ( $k=0.37$ ) with poor sensitivity (0.49, 0.38-0.61 CI). Adopting a lower cutoff for the texted screen resulted in an improved kappa ( $k=0.45$ , moderate) and sensitivity and specificity, 0.90 (0.81-0.96 CI) and 0.82 (0.79-0.85 CI) respectively. 78% of participants recommended all women in the postpartum be screened for PPD via text message; 87% preferred screening via text message in contrast to other approaches (e.g., in person, telephone); 91% recommended that all women in the postpartum should be sent information texts about PPD. Conclusions: Using text messaging to screen women for PPD and provide information on postpartum mental health appears to be highly sensitive, feasible, and well-accepted. This low-cost technology has excellent potential to be used in mental health care for universal screening and education purposes, and as a first step in the pathway to treatment.

No. 32

**Ketamine and Mindfulness Therapy in PTSD  
Treatment**

Poster Presenter: *Esther Bilenkis, D.O.*

**SUMMARY:**

Introduction: PTSD is a debilitating disease which has been found very difficult to treat and has a high relapse rate after treatment. TIMBER, or Trauma Interventions using Mindfulness Based Extinction and Reconsolidation for trauma memory has been shown to be an effective, personalized treatment for eliminating PTSD and when combined with ketamine, results are evident within four hours. Ketamine is the only pharmacological agent whose mechanism of action allows results within hours. This property lends to its great benefit in treatment of serious psychiatric disorders such as PTSD. Case Report: We present the case of a Biracial female who has been discharged from our care. Her PTSD has been cured and she is maintaining well at 7 months after discharge and returned to work. She suffered from SLE, PTSD from physical and sexual trauma, throughout no medication. Her treatment included just one infusion of ketamine and 12 face-to-face sessions of TIMBER and home practice sessions daily twice and as needed. Conclusions: Ketamine and TIMBER leads to rapid treatment of PTSD. The rapid-

acting Ketamine and the reinforcement with TIMBER leads to long-lasting results and allows the patient to return to life before the illness.

No. 33

**Health Advocacy, Communication, and Teamwork (ACT): Toward More Seamless Integration of Behavioral Health Into Primary Care**

Poster Presenter: *Abigail S. Greene*

Co-Author: *Michelle Silva, Psy.D.*

**SUMMARY:**

Primary care providers are often patients' only points of contact with the health care system, and patients can benefit from the discussion of behavioral health (BH) concerns during these visits. However, there are few resources available to equip patients and providers to have these conversations, and opportunities for intervention are often missed; these trends are amplified in immigrant and refugee communities. The HAVEN Free Clinic (hereafter, HAVEN) is Yale's student-run primary care clinic for uninsured patients. HAVEN has demonstrated its commitment to the integration of primary and BH care through the creation and growth of a BH department. To further promote integration of care and target health disparities in underserved communities, the BH Department at HAVEN has recently partnered with community agencies to develop relevant BH knowledge, and to promote dialogue among community members and providers. The program, entitled Health Advocacy, Communication, and Teamwork (Health ACT) and supported by the American Psychiatric Association Foundation Helping Hands grant, offers 2 series of workshops focused on patient empowerment through psychoeducation and communication. One workshop series is designed for community members (here, members of refugee and immigrant communities in New Haven), and is presented at the relevant community agencies. The second workshop series is designed for primary care providers (here, Yale health professions students). Each workshop series has analogous themes, with materials tailored to the audience. In the first session of both series, participants are challenged to broaden their definitions of health by exploring the connections between BH and physical health, trained to recognize and address signs of common BH

concerns, and asked to share their perspectives on these issues to identify common values and barriers to care. In the second session of both series, participants learn best practices for participating in care integration, including practical communication skills and core competencies for providers, and gain familiarity with local BH resources. In the closing session, providers and community members come together to learn from each other, and collectively identify opportunities for practicing communication skills learned in previous sessions to discuss BH concerns and barriers to care. Each session includes pre- and post-tests, as well as acceptability questionnaires, to assess curriculum effectiveness and participant satisfaction. Quantitative and narrative feedback were used to adapt and refine the curriculum, which was then presented again at the partner agencies; lessons learned regarding the design and implementation of the program will be offered. Preliminary results suggest that Health ACT successfully promotes effective patient-provider communication about BH issues in underserved communities and increases preparedness among future providers to meet the BH needs of diverse patient populations.

No. 34

**Assessing Barriers to Mental Health Care and the Necessity of Mental Health Screening in Mobile, Alabama**

Poster Presenter: *Peter Y. Lee*

Co-Author: *Lauren Marie Chastain*

**SUMMARY:**

Mental health disorders have long carried the heavy burden of being misunderstood and dismissed, and access to mental health has long been neglected and restricted. Over recent years, there has been increasing amount of awareness towards mental health, allowing more people to get the medical attention they need. However, there is still room for improvement. Data from the National Institute Mental Health suggested that in 2016 approximately 56.9% of U.S. adults with any mental illness that did not receive appropriate medical treatment. Furthermore, 35.2% of U.S. adults with serious mental illness, defined as a "mental, behavioral, or emotional disorder resulting in serious functional impairment," did not receive medical treatment

("Mental Illness," 2017 ). Our project focuses on necessity of mental health screening and assess barriers to receiving mental health care in Mobile, AL. Mobile is a city with a population of over 190,000 people in which 23.1% are living in poverty, and 15.8% of those under the age of 65 live without health insurance ("QuickFacts, Mobile city, AL," 2017). We designed a questionnaire aimed at exploring two primary outcomes: a cross-sectional insight into the need for further mental health evaluation based on results from the DSM-5 Self Rated Level 1 Cross-Cutting Symptom measure and personal reasoning for not seeking mental health care. Our project aimed at exploring the differences between a population with stable housing versus without. Using the data collected by the DSM-5 symptom measure, we hope to discern the necessity of further mental health screening and if different subsets of screening tools are needed based on the population. By analyzing personal response data, we aim to determine the most prevalent barriers to seeking mental health care in Mobile, AL. We hope the data can be used to promote the importance of mental health screening in all populations and provide further understanding towards eliminating the obstacles preventing needed mental health care.

No. 35

**The Behavioral Health Outreach Program at the USD Coyote Clinic**

Poster Presenter: *Erik Burnison*

Co-Author: *Brittany Vanness*

**SUMMARY:**

Background: The Avera Downtown Clinic is a main provider for uninsured and low-income patients in Sioux Falls, South Dakota. The clinic has one psychiatrist who sees patients one morning per week. This creates a 3-4 month wait for new patients seeking psychiatric care. Other options for low-cost psychiatric care include Sioux Falls Community Health and Southeastern Behavioral Health Care. The former was discontinued due to a shortage of staff and the latter requires a fee and work with case management. The Coyote Clinic is a student-run free clinic that operates at the Avera Downtown Clinic every 2nd and 4th Tuesday of the month from 5pm-9pm. The clinic provides acute care services, basic laboratory testing, flu shots, and prescription

assistance to uninsured patients over the age of 18.

Objective: The purpose of the Behavioral Health Outreach Program at the University of South Dakota Coyote Clinic is to expand the services of the Coyote Clinic to include free psychiatric care for uninsured adults over the age of 18 in Sioux Falls and increase medical student exposure to mental health care.

Methods: To accomplish this, the clinic began working with psychiatry residents from Avera Behavioral Health who serve as volunteers every 2nd Tuesday of the month. On these clinic nights, medical students perform the initial workup and documentation for the psychiatric appointment.

Following the patient interview, the medical students debrief with the volunteer, psychiatry resident. The students and resident then meet with the patient to discuss any medication changes, the overall plan of care, and conclude the appointment. Residents debrief all patient encounters with the primary care physician on staff for final approval.

Results: The psychiatry residents worked with attending physicians and medical students to facilitate 1-2 new psychiatric evaluations every month. Patients were scheduled for follow-up appointments at the clinic on the 4th Tuesday of a succeeding month as appropriate. Conclusions: The Behavioral Health Outreach Program at the University of South Dakota Coyote Clinic established a new avenue for access to low-cost mental health care in the Sioux Falls community and provided USD medical students with additional experience in the field of mental health.

No. 36

**FIT Clinic Peer Support Group, Year Two: Easing the Burden of Reentry in Louisiana**

Poster Presenter: *Zachary Lenane, M.D., M.P.H.*

**SUMMARY:**

The U. S. imprisons more people than any other country in the world. Within the U.S., Louisiana has the highest incarceration rate, with twice the average state per capita rate. Formerly incarcerated persons (FIPs) are sicker and have significantly higher rates of mental illness than the general population. They are more likely to have experienced trauma as children and adults, and incarceration itself is a traumatic stress capable of causing posttraumatic stress reactions following release. Regular

counseling in particular has been largely unavailable to this population due to a lack of available, affordable services for uninsured and Medicaid patients in the New Orleans area. The FIT clinic was started in 2015 by Tulane professor Anjali Niyogi, MD, MPH, and medical student William Vail to provide free transitional healthcare and case management services for individuals recently released from prison in Louisiana. Funding from the 2016-2017 and 2017-2018 Helping Hands Grants enabled the FIT Clinic to start a bi-monthly peer support group, facilitated by FIPs, focused on the emotional and practical aspects of reentry. Thirty-seven sessions have been held since September 2016 with a median attendance of 15 participants per session. As a component of program evaluation for the first year, 16 formerly incarcerated participants completed anonymous demographic and satisfaction (CSQ8) surveys in September, 2017. Participants were 87.5% male, 100.0% black, and 56.3% age 55 or older. They were incarcerated for an average of 21.6 years and released an average of 6.6 years ago. Two-thirds were referred via word of mouth. Median CSQ8 scores among survey participants was 30.5, indicating high satisfaction. Participant engagement during the second year is currently being evaluated, including return rates. The program began receiving direct referrals in March, 2018 from Louisiana State Penitentiary to provide peer support and counseling services to individuals involved in their re-entry court, which provides rehabilitative mentorship, education, vocational training, and substance abuse treatment to nonviolent offenders to increase the chance of successful reentry. The program is also sponsoring Peer Support Specialist training and certification through the Louisiana Department of Health for two formerly incarcerated participants. Funding from the 2018-2019 Helping Hands Grants will be used to sponsor certification and training for additional group participants. This will provide participants with more ownership of the group, allow them to work full or part-time as certified peer support specialists, and enable the program to hold sessions more frequently.

Saturday, October 06, 2018

**Poster Session 4**

No. 1

**Features Increasing Suspicion for Prodromal Psychosis: A Case Study**

Poster Presenter: *Zane He*

Lead Author: *Jumah Ahmad*

Co-Author: *Ravi Shankar*

**SUMMARY:**

Prodromal psychosis differs from frank psychosis in intensity, frequency and/or duration. The threshold, albeit relatively subjective and arbitrary, is based on symptom severity and the presence of frank psychotic symptoms, which would warrant immediate antipsychotic medication treatment, signifying the end point of the prodromal period. Identification of patients in the early stages of psychosis has proven to be very challenging with many obstacles including the inability to make a prospective diagnosis and concern for harm from inappropriate treatment. Balancing the risks with the benefits of early intervention on function is very difficult, especially considering the age distribution of psychosis onset which is mostly adolescents and young adults as well as the rate of conversion to psychosis which ranges from approximately 20% to as high as 40%. Early recognition and identification of those at heightened risk for conversion to a psychotic disorder would aid in the prevention and early intervention which is vital to ameliorating eventual functional deficits. Since the diagnosis of prodromal psychosis can only be made in retrospect, this article briefly reviews a case of what is likely prodromal psychosis and emphasizes the importance of case formulation in identifying these patients. This case report is on an adolescent with a known diagnosis of major depressive disorder and suicidality who, in addition, has many odd, non-specific disturbances in cognition, emotion, language, communication, perception, motivation, will, initiative, sleep, and stress tolerance. Mood and social manifestations in this adolescent include depression, self-harm, suicide attempts, isolation, and academic failure. Based on these features, she is at increased risk for conversion to a psychotic disorder, which underscores the importance of long-term monitoring, a biopsychosocial approach, and case formulation for the initiation of early intervention. With many different methods and

upcoming algorithms for prediction of conversion to psychosis, it is clear that a case formulation and biopsychosocial perspective is necessary in order to accurately identify these patients. The below case is a real-life report intended to paint a picture for the reader to better visualize, understand, and grasp the image of prodromal psychosis in order to better identify it and decrease rates of conversion.

No. 2

**Pathways to Care for Young Adults With First-Episode Psychosis in a Coordinated Specialty Care Program**

Poster Presenter: *Leslie Marino, M.D., M.P.H.*

**SUMMARY:**

**Purpose:** Substantial research has demonstrated that a longer duration of untreated psychosis (DUP) is associated with poorer outcomes among young adults with early non-affective psychosis. As federal funding has expanded access to evidence-based coordinated specialty care (CSC) in the US, little is known about factors influencing the pathway to care and DUP in non-research treatment settings. This study explores the pathway to care and predictors of time to OnTrackNY, New York state's CSC program. **Methods:** The sample includes 779 individuals ages 16-30 within two years of onset of non-affective psychosis enrolled in OnTrackNY at 19 sites as of September 2017. Multivariate analyses tested the association between the primary outcome of time from onset of psychosis to intervention (OnTrackNY) and a comprehensive list of predictors within the admission assessment domains of demographic and clinical characteristics; social and occupational functioning; suicidality/violence/legal problems; service utilization; family characteristics; and prior mental health contacts. **Results:** The mean time to treatment was 231.18 days (SD=187.66) with a median of 169 days (5.63 months). In multivariate analyses, current school participation ( $p=.011$ ), at least one psychiatric hospitalization ( $p<.001$ ), or 2 or more ER visits ( $p\leq 0.022$ ) were associated with shorter time to intervention. Longer time to first service contact was associated with longer time to intervention ( $p<.001$ ). **Conclusions:** Engagement in school and the early mental health service contacts can predict the pathway to care and time to early intervention services in a cohort of young adults

with early psychosis. This has implications for efforts to reduce DUP.

No. 3

**Olanzapine and Lorazepam Used in the Symptomatic Treatment of Excited Catatonia Secondary to Anti-NMDA Receptor Encephalitis**

Poster Presenter: *Michael Bliss, D.O.*

Co-Author: *Liubov Leontieva, M.D., Ph.D.*

**SUMMARY:**

The following case describes excited type catatonia in an 18-year-old female subsequently found to be secondary to anti-NMDAR encephalitis. She had been brought to the Emergency Department by her parents in an acutely psychotic state characterized by profound disorganization and vivid visual hallucinations. She was admitted to psychiatry and her hospital course was significant for both retarded and excited type catatonia, signs of autonomic instability, and sensitivity to most neuroleptics. Given the atypicality of her symptoms and a family history of autoimmune disease, work-up for autoimmune encephalitis was performed. MRI showed an indeterminate ovarian mass and serum studies were generally unremarkable. The catatonic symptoms resolved over the course of three weeks with lorazepam and olanzapine. Following discharge, a CSF panel resulted with positive titers for anti-NMDAR antibodies. This case illustrates the need to consider autoimmune encephalitis in cases of catatonia. It also presents a case in which symptoms of anti-NMDAR encephalitis potentially remitted without immunotherapy or mass resection.

No. 4

**Treatment Outcomes of Patients With Severe Schizophrenia in a Comprehensive, Case Managed Program: A Seven-Year Follow-Up**

Poster Presenter: *Sylvia Díaz*

Co-Author: *Juan J. Fernandez-Miranda*

**SUMMARY:**

**Background** To increase treatment compliance is important to reach clinical and rehabilitation goals in people with severe schizophrenia **Objectives** To know treatment (clinical and functional) outcomes and variables related of people with severe schizophrenia enrolled in a comprehensive case

managed programme. Methods: 7-year prospective, observational study of patients with severe schizophrenia undergoing case managed comprehensive programme in Spain (N=200). Assessment included the Clinical Global Impression severity scale, the Camberwell Assessment of Needs (CAN), the WHO Disability Assessment Schedule (WHO-DAS), reasons for discharge and medications prescribed at the beginning and after 3, 6, 12, 24, 36 and 84 months. Hospital admissions in the previous seven years and during the follow-up were measured. Results: CGI at baseline was 5.7(0.7). After seven years 46% of patients continued treatment (CGI= 4.1(0.8);  $p<0.01$ ); 33% were medical discharged (CGI=3.4(1.6);  $p<0.001$ ) and continued non intensive treatment in mental health units; the WHO-DAS decreased in the four areas ( $p<0.01$ ) and also the CAN ( $p<0.01$ ) in both groups; 8% were voluntary discharges. Eight patients died during the follow up; three of them committed suicide (1.5%). Hospital admissions decreased significantly ( $p<0.001$ ). All patients had their own case manager, mainly a nurse. 45% of all of them were treated with atypical long-acting antipsychotics, with good tolerability and less voluntary discharges. Conclusions: Retention of patients with schizophrenia with severe symptoms and impairment in a case managed comprehensive programme was really high and helped to get remarkable clinical and functional improvement. Long-acting medication seemed to be useful in improving treatment adherence.

No. 5

**Outcomes of a Case Managed Community Based Treatment in the Prevention of Suicide Among People With Severe Schizophrenia**

Poster Presenter: *Sylvia Díaz*

Co-Author: *Juan J. Fernandez-Miranda*

**SUMMARY:**

Background Case management approach for people with severe schizophrenia improves treatment compliance and helps to reach clinical and rehabilitation goals and to prevent suicidal behaviour. The purpose of this study was to know the retention in treatment of people with severe schizophrenia and the suicide rates among them in a comprehensive, case managed, community based

program. Method 8-year prospective, observational, open-label study of patients with severe schizophrenia (GCI-S $\geq$ 5) undergoing community based, comprehensive, case managed treatment in Gijon (Spain) (N=200). Assessment included at the beginning and after 3, 12, 24, 36 and 96 months: the Clinical Global Impression severity scale (CGI-S), the Camberwell Assessment of Needs (CAN) and the WHO Disability Assessment Schedule (WHO-DAS). Time in treatment and reasons of discharge were measured, including deaths by suicide. Also medications prescribed and hospital admissions were recorded. Results CGI-S at baseline was 5.9(0.7). After eight years 42% of patients continued under treatment (CGI-S= 4.1 (0.9);  $p<0.01$ ); 37% were medical discharged (CGI=3.4 (1.5);  $p<0.001$ ) and continued standard treatment in mental health units; DAS decreased in the four areas (self-care and employment  $p<0.01$ ; family and social  $p<0.005$ ) in both groups, and also CAN ( $p<0.01$ ); 7% had moved to other places, continuing treatment there; 10% were voluntary discharges. Twelve patients died during the follow up, four of them by suicide (2%), while suicide rates among people with schizophrenia in standard treatment in Spain are between 5-10%. All patients had their own case manager, mainly a nurse (89%). 65% of all patients were treated with second-generation long-acting-injectable antipsychotics, with higher retention ( $p<0.01$ ) and less suicides than patients with oral antipsychotics (1 vs 3 patients). Conclusions Retention of patients with schizophrenia with severe symptoms and impairment in a specific and comprehensive, community based, case managed programme, was really high and seemed to be useful to decrease the high rates of suicide among them. Treatment with second generation long-acting antipsychotics also seemed to be helpful. This kind of intensive treatment showed better rates of treatment compliance and suicide behaviour than standard one.

No. 6

**Decoding Psychotic Images Through Art Psychotherapy and Exploration of Potential Application of Virtual Reality**

Poster Presenter: *Mani Yavi, M.D.*

**SUMMARY:**

The application of art psychotherapy allows exploration of psychotic mental states and can assist in recreation of disconnected mental images. Through the empathetic guidance of the therapist and artistic self-expression, where the logical expression and the pressure of time are minimized, patients are able to express deep affective and idiosyncratic material. Pictures created in art therapy can be valuable windows to the intrinsic mental states of the schizophrenic patient. In this report we present and detail the application of art therapy on the inpatient setting, in particular focusing on cases with schizophrenia, to transform anxious, psychotic mental imagery to forms that are psychologically more adaptive and reality-oriented. Lastly we will review the literature on advances in the field of Virtual Reality and discuss the potential of this emerging technology to augment treatment modalities.

No. 7

**Use of Second-Generation Long-Acting-Injectable Antipsychotics and People With Severe Schizophrenia Suicide Behavior Prevention**

Poster Presenter: *Juan J. Fernandez-Miranda*

Co-Author: *Sylvia Díaz*

**SUMMARY:**

Background Adherence to treatment of people with severe schizophrenia is important to reach clinical and rehabilitation goals and to prevent suicidal behaviour. The purpose of this study was to know the retention in treatment of people with severe schizophrenia, suicide rates among them and treatment characteristics (case managed vs standard; oral vs long-acting injectable medication) related. Methods 8-year prospective, observational, open-label study of patients with severe schizophrenia ( $GCI-S \geq 5$ ) undergoing community based, case managed treatment in Gijon (Spain) ( $N=200$ ). Assessment included the Clinical Global Impression severity scale (CGI-S) and the WHO Disability Assessment Schedule (WHO-DAS) at the beginning and after three, 12, 24, 36 and 96 months. And also medications prescribed, laboratory tests, weight, adverse effects reported, hospital admissions and reasons for treatment discharge., including deaths by suicide, were recorded. Results CGI-S at baseline was 5.9(0.7). After eight years 42%

of patients continued under treatment ( $CGI-S= 4.1$  (0.9);  $p<0.01$ ); 37% were medical discharged ( $CGI=3.4$  (1.5);  $p<0.001$ ) and continued standard treatment in mental health units; WHO-DAS decreased in the four areas (self-care and employment  $p<0.01$ ; family and social  $p<0.005$ ) in both groups; 7% had moved to other places, continuing treatment there; 10% were voluntary discharges. Twelve patients died during the follow up, four of them by suicide (2%; suicide rates among people with schizophrenia in standard treatment in Spain between 5-10%). 65% of all patients were treated with second-generation long-acting-injectable antipsychotics (risperidone, paliperidone and aripiprazol), with high tolerability. Among them, there was higher retention (4 vs 16 patients voluntary discharges;  $p<0.01$ ) and less suicides than patients with oral antipsychotics (1 vs 3 patients). Conclusions Retention in treatment of patients with severe schizophrenia in a case managed programme and treated with second generation long-acting antipsychotics was really high and seemed to be useful to decrease the high rates of suicide among them. Both treatment characteristics (case management and common 2G-LAI antipsychotic use) helped to improve treatment compliance and suicide rates than standard treatment and oral medications.

No. 8

**One-Year Follow-Up Paliperidone Palmitate Every 3 Months Versus PP1M. Effectiveness, Tolerability and Satisfaction in People With Severe Schizophrenia**

Poster Presenter: *Juan J. Fernandez-Miranda*

Co-Author: *Sylvia Díaz*

**SUMMARY:**

Background Paliperidone palmitate every three months (PP3M) is expected to facilitate patient's treatment compliance and satisfaction. This study compares PP3M treatment compliance and satisfaction with PP1M in patients with severe schizophrenia previously stabilized with PP1M for at least 2 years. The effectiveness and tolerability were also measured. Methods 12-month prospective, observational, open-label study of patients with severe schizophrenia ( $GCI-S \geq 5$  at the beginning of PP1M treatment) treated with PP3M after at least 2 years of stabilization with PP1M ( $N=63$ ). Treatment



satisfaction with PP3M vs PP1M was assessed with the Treatment Satisfaction Questionnaire for Medication (TSQM) and with a visual analogue scale (VAS, 0-10). Effectiveness was measured with number of hospitalization admissions due to psychiatric decompensation and CGI-S. Tolerability assessments included extrapyramidal symptoms, laboratory tests (haematology, biochemistry and prolactin levels), weight, adverse effects reported and injection-site pain or reaction every three months. Other psychiatric medications and also reasons for treatment discontinuation were recorded. Results CGI-S at baseline was 3.8 (0.5), with no significant changes after 12 months. Only one patient preferred change back to PP1M due to EPS. Nobody discontinued PP3M treatment or were referred to hospital psychiatric ward due to decompensation. There were neither significant changes in weight or prolactin levels nor biological parameters alterations, and lower incidence of sedation and orthostatic hypotension was reported. There was an increase in TSQM (from 'satisfied' to 'very satisfied';  $p < 0.05$ ) and VAS (from 7.5(0.8) to 8.4 (0.7);  $p < 0.01$ ) between 1M and 3M PP treatment. Reasons reported for higher satisfaction were less injections/year, less sedation and lower feeling of being medicated/ill. No differences were found related to doses (Range: 350-1050 mg/3M). Conclusion Apart from similar effectiveness and somewhat better tolerability, patients with severe schizophrenia lengthy treated with PP1M showed more satisfaction with PP3M. This formulation allows patients not only to improve treatment adherence but also to feel more satisfied with it.

No. 9

### **Coprophagia—a Rare Psychiatric Symptom and Possible Treatment Options: A Case Report**

Poster Presenter: *Nilesh Dialani*

#### **SUMMARY:**

Patient is a 63 year old Hispanic male with a past psychiatric history of schizophrenia and depressive episodes and extensive past medical history including anemia, hypothyroidism, hypertension, Diabetes Mellitus, hyperlipidemia, asthma, benign prostatic hypertrophy, and gastroesophageal reflux disease, admitted to acute psychiatric unit for agitation and disorganized behavior (scratching his

arms and legs violently) along with auditory and visual hallucinations. On the unit, patient was started on Aripiprazole 15mg and was titrated to 30mg slowly. Patient became more disorganized, ran in the hallways naked, had an episode of coprophagia, and persistently scratched his upper and lower extremities which caused multiple large and severe lesions on arms and legs. Dermatology was consulted but their treatment suggestions proved ineffective. Patient had another incident of coprophagia and was placed on a 1:1 observation. Quetiapine 100mg was started and cross titrated with Aripiprazole, which was eventually discontinued. Quetiapine was titrated up to 400mg BID. Patient displayed decreased self-mutilating behavior, but his auditory and visual hallucinations persisted. Patient started reporting depressive symptoms at this time, and was also noted to be responding to internal stimuli. Treatment with Risperidone 0.5mg daily was started and titrated up to 2mg BID. Sertraline 50mg was also initiated and was increased to 100mg for depressive symptoms. Patient improved over the next few weeks; his auditory and visual hallucinations subsided and no episodes of self-mutilation or coprophagia were noted. He became more visible in the unit and was eventually discharged. Coprophagia is a rare symptom in schizophrenic patients with only a handful of reported cases. Distinguishing this symptom as an underlying comorbidity or simply a feature of the patient's psychosis is important for determining the best treatment options. This poster discusses our strategies behind the management and successful treatment of schizophrenia with these unusual symptoms.

No. 10

### **Orphan Patients: A Case Series of Patients With Treatment-Resistant Psychosis Requiring Alternatives to Clozapine**

Poster Presenter: *Simon M. Bow, M.D.*

Co-Authors: *Ashley DeGraaf, Jacky Tang, William G. Honer, M.D., Randall Francis White, M.D.*

#### **SUMMARY:**

Background: Clozapine is the gold-standard for managing treatment-resistant psychosis (TRP). Despite superior efficacy, some patients do not tolerate or stop it; research on this population is

scarce. Here we describe inpatients with schizophrenia or schizoaffective disorder treated at the British Columbia Psychosis Program (BCPP) from 2012 to 2017 who required alternative interventions for TRP. Methods: In a retrospective analysis of 275 patient records, 78 with TRP or were not receiving clozapine at discharge. Data collected included demographics; standardized ratings (PANSS, SOFAS, GAPS, CGI); comorbidities; reasons for clozapine discontinuation; and alternative treatments. Results: 85% of patients had previously taken clozapine; the remainder were not offered or refused it. Reasons patients could not have a clozapine trial at BCPP included a history of myocarditis (13%), agranulocytosis (5%) or neutropenia (8%); refusal (18%), poor compliance (12%), poor response (6%), or other severe side effects. Antipsychotics at discharge included oral monotherapy (40%), injectable monotherapy (15%), oral polypharmacy (19%), oral-injectable combination (23%). Polypharmacy was reduced from 1.4 to 1.2, and daily dose equivalent increased 6%. Additional medications included mood stabilizers (45%), antidepressants (26%) and/or sedative hypnotics (26%). Electroconvulsive therapy (ECT) was used in 13%. Psychotherapy showed benefit in 17%. Mean PANSS total score reduction was 18% and mean CGI-S score reduction was 1.3, with 32% and 5% of patients achieving response and remission, respectively. Conclusion: Clozapine may not be feasible for many reasons, but we have documented several alternatives for managing TRP. We are continuing subgroup analyses based on consensus diagnosis, comorbidities, type of approach, and use of ECT, along with a comparator group successfully started on clozapine during admission. These results may inform clinical decision-making in this difficult-to-treat population.

No. 11

**“You Are Not My Sister”: The Challenges of Managing and Safely Discharging a Patient With Dementia and Capgras Syndrome**

Poster Presenter: *Teresa E. Mathew, M.D.*

Co-Authors: *Zachary McCabe, Raj V. Addepalli, M.D., Marieliz V. Alonso, M.D.*

SUMMARY:

Capgras Syndrome is a delusional misidentification syndrome characterized by a delusional belief that a person has been replaced by an imposter. It has a high incidence in patients with Schizophrenia, epilepsy, cerebrovascular disease, Alzheimer’s disease and Lewy body dementia. Mr. A, a 64-year-old Latino man from Dominican Republic, with mild intellectual disabilities and dementia with psychotic features, who was living in the U.S. with his sister and brother-in-law for 7 years, was brought to the emergency room for aggressive and threatening behavior towards family members. Upon initial evaluation, Mr.A reported that his real sister and brother-in-law were kidnapped, and the people living with him were substitutes who were pretending to be his family. He was reported to be verbally and physically aggressive towards his brother-in-law and even threatened to kill him. Mr. A’s family did not feel safe with him at home. It was determined that he was at an elevated risk of danger to his family members and therefore was admitted to the inpatient psychiatric unit for stabilization of his symptoms. During his hospitalization, Mr.A’s thought process was illogical and tangential at times, with a fixed delusion that his family members had been replaced. Labs including B12, Folate and TSH levels were within normal limits. Brain CT was unremarkable. HIV and Syphilis screenings were negative. EEG from 2013 was consistent with mild encephalopathy. Montreal Cognitive Assessment Test showed a score of 16/30. Patient was oriented to self but only partially oriented to time and place. He had good registration and object recognition, fair language and visuospatial skills, and poor recall and attention skills. Patient did not show improvement with initial treatment of Quetiapine 100 mg/day and was subsequently switched to Haloperidol 2.5mg PO at bedtime which was titrated up to 4mg a day with plans to eventually switch to Haloperidol Decanoate to ensure compliance. Donepezil 5 mg/day was added and titrated to 10 mg/day. After two weeks on the inpatient unit, Mr.A was alert and oriented to person, place and year, he was more organized, and there was a decrease in the intensity of his delusions. During the family meeting to discuss discharge planning, patient reported that if he were to go back home to live with the imposters, he would try to hurt them if he got access to a weapon. Mr.A’s brother-in-law was also unwilling to accept

the patient back into the house due to safety concerns, and there were no other family members who were willing or able to provide care for the patient. Mr.A was eventually discharged to a nursing home. Health care providers must take into consideration caregiver burnout, and the risks and benefits of treating a patient with dementia with antipsychotics. This poster highlights the challenges in managing a patient with delusional misidentification.

No. 12

### **Clinical Issues in Management of a Pregnant Psychotic Patient**

Poster Presenter: *Teresa E. Mathew, M.D.*

Co-Author: *Raj V. Addepalli, M.D.*

#### **SUMMARY:**

Management of psychotic patients during pregnancy requires a multidisciplinary approach which involves close liaison between healthcare professionals. Psychotic disorders increase the risk of obstetric complications, stillbirth and infant mortality, and can also affect a woman's ability to care for herself and her child. These risks must be weighed against the effects of antipsychotic medications on the fetus. Ethical concerns regarding autonomy versus beneficence come into play, and the decisional capacity of the patient may come into question when a pregnant psychotic patient refuses to take psychotropic medications. Ms. N, a 30-year-old Hispanic woman with history of Schizophrenia, initially presented to the psychiatric service when she was 32 weeks pregnant, and was admitted into the hospital for decompensation secondary to noncompliance with medications during pregnancy. She refused medications throughout her entire hospital stay due to her concern over the safety of her unborn baby. Ms. N was internally preoccupied, with nonsensical speech and disorganized behavior, but she did not appear to be a danger to herself or others, and was discharged with a plan to follow up with her outpatient psychiatrist. Six days later, when patient was about 34 weeks pregnant, she again presented to the psychiatric ER after wielding a kitchen knife at her shelter. Ms. N was disorganized and delusional, and was re-admitted to psychiatry. On readmission, she was non-compliant with psychiatric medication and prenatal care.

Multidisciplinary meetings were held between mental health professionals, obstetricians and legal professionals in order to determine the most appropriate treatment approach. It was determined that Ms. N lacked the decisional capacity to refuse treatment. She was seen by a mental hygiene judge who allowed for court-ordered psychotropic medications, as well as performance of physical exams, fetal monitoring, routine workup required to monitor the status of the pregnancy, medically necessary C section, and medically necessary procedures for vaginal delivery over her objection. After the court order was received, Ms. N was more compliant with oral antipsychotic medications and with pre-natal care. At about 40 weeks gestation, Ms. N gave birth to a healthy baby girl. Two days later, Ms. N was transferred back to the inpatient psychiatric unit and her baby was placed in foster care by ACS. Ms. N improved to the point of discharge on a regimen of Haldol 10mg/day and Benadryl 50mg/day, and she began receiving long acting haloperidol decanoate. Although Ms. N's providers wanted to give her the autonomy to make her own decisions regarding her mental health and her pregnancy, it was clear she did not have the capacity to make those decisions. This poster highlights how pregnancy becomes high risk when psychosis is left untreated. It is essential that all healthcare professionals work together to achieve a good outcome.

No. 13

### **Treatment of Risperidone-Induced Neutropenia With Haloperidol and Lithium: A Case Report**

Poster Presenter: *Michael Esang, MB.Ch.B., M.P.H.*

Co-Author: *Saeed Ahmed, M.D.*

#### **SUMMARY:**

In clinical practice, blood dyscrasias have resulted from the use of atypical antipsychotics in the treatment of patients with psychiatric disorders, clozapine being a well-known example. Risperidone has been reported as a cause of hematologic abnormalities including neutropenia, lymphopenia, and thrombocytopenia (1, 2). We present the case of risperidone-induced neutropenia in a young Afro-Caribbean man being treated for substance-induced psychotic disorder. Mr. P was a 21-year-old Jamaican male who was hospitalized for aggression, auditory

hallucinations, and paranoid delusions in the setting of daily cannabis use. At baseline, Mr. P's absolute neutrophil count (ANC) was 1740/mm<sup>3</sup> (1800/mm<sup>3</sup> - 7000/mm<sup>3</sup>). He was started on risperidone on the inpatient psychiatric unit to address psychosis. Started at 1 mg twice a day, it was titrated to 3 mg twice a day leading to improvement in psychosis and insight. He was subsequently discharged to follow up with psychiatric care as an outpatient. About 10 weeks after initiation of risperidone, while undergoing routine evaluation by his primary care physician as an outpatient, it was noted that his ANC had dropped to 780/mm<sup>3</sup>. The dose of risperidone was then reduced by half which was followed by an increase in the ANC up to 1180/mm<sup>3</sup>. About 5 months later, his ANC had once again dropped to 540/mm<sup>3</sup>. At this point risperidone was discontinued and replaced with haloperidol 2 mg and lithium 300 mg, both at bedtime. After 4 weeks of treatment with the new combination, his ANC had increased to 1080/mm<sup>3</sup> and he had remained psychiatrically stable. During this period as an outpatient, he had also denied any prior or concurrent symptoms suggestive of an infectious illness. Mr. P's case highlights the need for increased vigilance when treating patients taking atypical antipsychotics, who may have benign ethnic neutropenia (BEN). BEN is a hereditary condition estimated to be present in 10% - 30% of healthy individuals of African or Middle Eastern descent (3). Baseline ANC levels and subsequent regular monitoring for these patients are invaluable in the prevention of any adverse outcomes.

No. 14

### **New-Onset Depression Following the "Flu": A Case Report**

Poster Presenter: *Michael Esang, MB.Ch.B., M.P.H.*

Co-Author: *Saeed Ahmed, M.D.*

#### **SUMMARY:**

Onset of a depressive disorder following a viral, bacterial or parasitic infectious disease episode has been reported in literature. We present the case of an episode of major depressive disorder occurring for the first time in a middle-aged female following upper respiratory tract infection (URI). She presented against the backdrop of an unusually widespread influenza epidemic. Ms. G. was a 47-

year-old single White mother of 3 children all under age 14, who worked as a school teacher, and whose chronic stress had been exacerbated with two severe URIs causing work absence, leading to new onset of depressive symptoms. She had no past psychiatric history and was brought to the ED by her family after medications prescribed by outpatient physicians failed to provide any response. She presented with complaints of insomnia, hopelessness, indecisiveness, anxiety, and inability to care for her children. Except for suicidal ideation, she endorsed 9 symptoms of major depression including loss of focus, anhedonia, anorexia, and weight loss. At baseline she slept 7 hours per night on average, but was now sleeping 2-3 hours per night with delayed sleep-onset and early morning awakening. Her friends described her pre-morbid personality as decisive, uplifting, motivated, supportive, and optimistic. Mental status exam revealed a thin, disheveled, indecisive and anxious middle-aged female who was awake and oriented to time, person, and place. She had psychomotor retardation, soft, perseverative speech, a flat affect, and appeared mildly confused, and internally preoccupied. Her thoughts were linear but narrowly focused on pessimistic ruminations, self-reproach, and negative themes. She denied suicidal or homicidal ideation, any hallucinations or perceptual disturbances, and did not appear grossly delusional. Her cognition, insight, and judgment however were limited. She was admitted to inpatient Psychiatry where mirtazapine was titrated to 45 mg, quetiapine was added at 50 mg, and zolpidem was increased to 10 mg, all at bedtime. Total sleep duration subsequently increased to 4-5 hours per night on average within one week, but with intermittent awakening. She subsequently expressed a desire to return to work and was discharged home on the aforementioned regimen with an outpatient psychiatric follow-up appointment. The sleep disorder experienced by this patient could theoretically be linked to immune activation following 2 consecutive episodes of URIs. The inflammasome, a cellular protein complex implicated in immune activation, has been theorized to be causally related to major depressive disorder (1). Other cytokines, including tumor necrosis factor alpha, have also been implicated in the pathogenesis of sleep disorders and disorders of circadian rhythm

(2). More studies on the role of these inflammatory markers in depressive and sleep disorders are warranted, as they may offer potential targets for intervention in the future.

No. 15

**Vilazodone: A Promising Alternative for Patient With Depression in Chronic Kidney Disease (CKD)**

Poster Presenter: *Hiren Patel, M.D.*

**SUMMARY:**

Background: Depressive disorders are common and significant among the general population and in individuals with chronic kidney diseases (CKD). Major Depressive Disorder (MDD) affects one in five patients with Chronic Kidney Disease (CKD) and is an independent risk factor for hospitalization and death before and after dialysis initiation. Depression occurs in 35% of patients with CKD (2-7). There is no clear-cut guideline available regarding treatment of Depression in patient with chronic kidney disease (CKD). Recently, we got an interesting case of Depression in Chronic Kidney disease (CKD); currently on dialysis and has a history of Kidney Transplant Failure. Case: Patient is a 61-year-old divorced single Hispanic female, living with her son, currently on disability, with a hx of GAD, MDD, kidney transplant failure- currently on dialysis, came for medication management for Depression and anxiety. Patient was referred by her nephrologist for medication management because she was taking Zoloft 200 mg PO daily but still feeling depressed (feeling sad, poor sleep and concentration, low energy levels, anhedonia, unable to maintain her hygiene, feeling worthlessness, helplessness, fleeting thought of suicide) and anxious as well. We discontinued Zoloft after tapering and started Vilazodone 10 mg PO daily and titrated to 20 mg PO daily. The patient reported she is doing much better with the vilazodone, feeling energetic, started doing make-up, reading books, no longer feeling hopeless, or helpless, worthlessness, denies any SI/HI and "panic attacks". She denies having any side effects of medications. Initial PHQ-9 score was 18 and after 4 weeks PHQ-9 was 9; Vilazodone helped patient very well in order to control depressive symptoms and anxiety symptoms as well. Discussion: We comprehensively reviewed the available data that exist about the use of antidepressant medications in

CKD and End stage renal disease (ESRD), and unfortunately it is with small sample size, lack of placebo control, and other limitations. Here, in this case we used Vilazodone in this patient with Chronic kidney disease (CKD) for depression and patient showed impressive outcomes in terms of depression and anxiety as well. Clinicians and psychiatrists should consider Vilazodone as a promising alternative for this patient population after appropriate research.

No. 16

**Effectiveness of Ketamine in Acute Suicidality in Psychiatric Patients**

Poster Presenter: *Safiullah Abro*

**SUMMARY:**

Aim: The primary objective is to examine the efficacy and the risks and benefits of using ketamine to manage acute suicidality in Psychiatric population. Method: The PubMed, Embase, Cochrane databases were searched up to December 2017 for clinical trials, case series and case reports describing therapeutic ketamine administration to patients presenting with Suicidal ideations or suicidality. Searches were also conducted for relevant background material regarding the pharmacological function of ketamine. Results: Ten publications met the search criteria for assessing Suicidal ideations after administration of ketamine. Also, common themes identified included establishing the safety of intravenous ketamine administration in sub-anesthetic doses in controlled settings with ongoing monitoring, and efficacy of multiple infusions. Each study demonstrated a rapid and clinically significant reduction in Suicidal ideations, with results similar to recently published meta-analysis on ketamine and treatment-resistant depression (Yu Han 2016). A total of 97 patients with SI have been reported in the literature as receiving therapeutic ketamine. Five studies delivered ketamine as 40min IV infusion of 0.5mg/kg, while seven studies gave multiple infusions and only 3 delivered a single infusion of ketamine. Most of the studies found the rapid reduction in suicidal ideation, most quickest responses was reported by Aan Het Rot et al., 2010, in which 9/10 participants showed a response within 24 hours of the first infusion and maintained it as long as they received additional infusions, for at

least 6 days after the last one. Conclusion: These results indicated that ketamine has a robust effect and good efficacy in the rapid reduction of suicidal ideations or suicidality. However, large-scale clinical studies are required to examine the long-term sustained effectiveness of ketamine in treating suicidality and MDD.

No. 17

**Clinical Efficacy and Safety of Esketamine Nasal Spray in a U.S. Population of Geriatric Patients With Treatment-Resistant Depression**

Poster Presenter: *H. Lynn Starr, M.D.*

Co-Authors: *Rachel Ochs-Ross, Yun Zhang, Rosanne Lane, Pilar Lim, Jaskaran Singh, Allitia DiBernardo, M.D., May Shawi, Ph.D., M.S., David Hough, Larry D. Alphs, M.D., Ph.D.*

**SUMMARY:**

Objective: To evaluate the safety and efficacy of flexibly dosed esketamine nasal spray plus a new oral antidepressant (AD) compared to placebo nasal spray plus a new oral AD (active comparator) to improve symptoms of depression among geriatric patients with treatment-resistant depression (TRD) living in the United States. Methods: In this double-blind (DB), flexibly dosed, multinational, multicenter study (NCT02133005), 70 U.S. geriatric patients with TRD were randomized 1:1 to flexibly dosed esketamine nasal spray 28/56/84 mg plus a new oral AD or to placebo nasal spray plus a new oral AD twice weekly for 4 weeks. The primary efficacy endpoint was the difference between treatment groups on Montgomery-Åsberg Depression Rating Scale (MADRS) scores on change from baseline to week 4. Secondary efficacy measures included changes on the Clinical Global Impression of Severity (CGI-S) scale, the Sheehan Disability Scale (SDS), and the Patient Health Questionnaire-9 (PHQ-9), which measure changes in general clinical condition and function. Results: In this subpopulation of 70 U.S. geriatric patients, statistically significant improvement in MADRS total score was observed with esketamine nasal spray plus a new oral AD vs placebo nasal spray plus oral AD (active comparator) at DB endpoint utilizing the mixed-effects model using repeated measures analysis (least squares [LS] mean difference [SE]: -5.4 [2.48]; 1-sided p=0.016). The analysis of covariance based on ranks of change

between the 2 groups in improvement of severity of depressive illness as measured by the CGI-S achieved significance at DB endpoint (1-sided p=0.005). Differences in mean changes in SDS and PHQ-9 were (LS mean difference [SE]) -7.6 [2.68; 1-sided p=0.004] and -4.4 [1.68; 1-sided p=0.006], respectively, at DB endpoint. All results favored esketamine nasal spray. The most common adverse events (AEs) for the esketamine nasal spray plus oral AD group were dysphoria, insomnia, nausea, fatigue, headache, nasal mucosal disorder, abdominal discomfort, vomiting, cough, nasal congestion, dizziness, and urinary tract infection. The incidence of AEs in this geriatric population of U.S. patients was similar to the incidence in the overall study population observed in younger individuals. Conclusion: After 4 weeks of treatment, esketamine nasal spray plus a new oral AD compared with placebo nasal spray plus a new oral AD demonstrated a clinically meaningful, statistically significant reduction of depressive symptoms and an improvement in overall severity of depressive illness and in health-related quality of life and functioning in geriatric U.S. patients with TRD. Safety results of geriatric patients from the U.S. treatment environment were similar to those found in the overall study and to those observed in a younger adult population in esketamine studies. Support: Janssen Scientific Affairs, LLC

No. 18

**Clinical Response, Remission, and Safety of Flexibly Dosed Esketamine Nasal Spray in U.S. Geriatric Patients With Treatment-Resistant Depression**

Poster Presenter: *H. Lynn Starr, M.D.*

Co-Authors: *Rachel Ochs-Ross, Yun Zhang, Jaskaran Singh, Pilar Lim, Rosanne Lane, Allitia DiBernardo, M.D., May Shawi, Ph.D., M.S., David Hough, Larry D. Alphs, M.D., Ph.D.*

**SUMMARY:**

Objective: To evaluate the response, remission, and safety of flexibly dosed esketamine nasal spray plus a new oral antidepressant (AD) compared to placebo nasal spray plus a new oral AD (active comparator) to improve symptoms of depression among geriatric patients with treatment-resistant depression (TRD) living in the United States. Methods: In this double-blind, flexibly dosed, multinational, multicenter

study (NCT02133005), a subset of 70 U.S. geriatric patients with TRD were randomized 1:1 to flexibly dosed esketamine nasal spray 28/56/84 mg plus a new oral AD or to placebo nasal spray plus a new oral AD twice weekly for 4 weeks. Response (defined as a 50% decrease in Montgomery-Åsberg Depression Rating Scale [MADRS] baseline score) and remission (defined as a MADRS score  $\leq 12$ ) were measured at intervals until the 4-week double-blind endpoint. Results: In this subpopulation of 70 U.S. geriatric patients, 8/30 (26.7%) patients treated with esketamine nasal spray plus a new oral AD vs 5/34 (14.7%) patients treated with placebo nasal spray plus a new oral AD (active comparator) had a response to treatment at 4 weeks. Remission rates were 5/30 (16.7%) patients treated with esketamine nasal spray plus a new oral AD vs 1/34 (2.9%) in patients treated with placebo nasal spray plus a new oral AD. All results favored esketamine nasal spray. The most common adverse events (AEs) for esketamine nasal spray plus oral AD were dysphoria, insomnia, nausea, fatigue, headache, nasal mucosal disorder, abdominal discomfort, vomiting, cough, nasal congestion, dizziness, and urinary tract infection. The incidence of AEs in the U.S. patients was similar to that observed in the overall study population and in studies with younger patients. Conclusion: In this subpopulation of U.S. geriatric patients with TRD from a larger, multinational study, almost twice as many patients showed a 50% response when treated with esketamine nasal spray plus a new oral AD compared with those treated with placebo nasal spray plus a new oral AD. In addition, remission rates were approximately 5-fold greater in patients treated with esketamine nasal spray plus oral AD compared with patients treated with placebo nasal spray plus a new oral AD. The safety, response, and remission results of U.S. patients were similar to those found for the total population studied and in younger patients treated with esketamine in phase 2 and 3 studies. Support: Janssen Scientific Affairs, LLC

No. 19

**Clinical Response, Remission, and Safety of Flexibly Dosed Esketamine Nasal Spray in a U.S. Population of Patients With Treatment-Resistant Depression**

Poster Presenter: *May Shawi, Ph.D., M.S.*

Lead Author: *Larry D. Alphas, M.D., Ph.D.*

Co-Authors: *Vanina Popova, Kimberly Cooper, H. Lynn Starr, M.D., Allitia DiBernardo, M.D., Carol Jamieson, David Hough, Jaskaran Singh*

**SUMMARY:**

Objective: To evaluate the response, remission, and safety of flexibly dosed esketamine nasal spray plus a new oral antidepressant (AD) compared to placebo nasal spray plus a new oral AD (active comparator) to improve symptoms of depression among patients with treatment-resistant depression (TRD) living in the United States. Methods: In this double-blind, flexibly dosed, multinational, multicenter study (NCT02133002), 91 U.S. patients with TRD were randomized 1:1 to esketamine nasal spray (56 or 84 mg) plus a new oral AD or to placebo nasal spray plus a new oral AD twice weekly for 4 weeks. Response (defined as 50% decrease in Montgomery-Åsberg Depression Rating Scale [MADRS] baseline score) and remission (a MADRS score  $\leq 12$ ) were assessed at 24 hours; at days 8, 15, and 22; and at the 4-week double-blind endpoint. Results: In this population of 90 U.S. patients (1 patient did not dose), responses with esketamine nasal spray plus a new oral AD vs placebo nasal spray plus a new oral AD observed at  $\sim 24$ -hours postdose were 11/43 (25.6%) vs 9/40 (22.5%), respectively. Responses at 4-weeks postdose were 26/40 (65.0%) for patients treated with esketamine nasal spray plus a new oral AD vs 15/38 (39.5%) in patients treated with placebo nasal spray plus a new oral AD. Remission rates at  $\sim 24$ -hours postdose were 6/43 (14.0%) in patients treated with esketamine nasal spray plus a new oral AD vs 4/40 (10.0%) in patients treated with placebo nasal spray plus a new oral AD. Remission rates at 4-weeks postdose were 18/40 (45.0%) in patients treated with esketamine nasal spray plus a new oral AD vs 9/38 (23.7%) in patients treated with placebo nasal spray plus a new oral AD. The most common adverse events for esketamine nasal spray plus a new oral AD were dizziness, nausea, dissociation, headache, dysgeusia, throat irritation, vertigo, nasal discomfort, hypoesthesia, insomnia, paresthesia, anxiety, feeling drunk, hypoesthesia oral, and vomiting. The incidence of these events was similar between the U.S. patients and the total study population. Conclusion: Esketamine nasal spray plus a new oral AD compared with placebo nasal spray plus a new oral AD demonstrated meaningful

reduction in symptoms of major depressive disorder as evaluated using MADRS response and remission rates among U.S. patients with TRD. Safety and response/remission results of patients from the U.S. treatment environment were similar to those found for the total population studied. Support: Janssen Scientific Affairs, LLC

No. 20

**Clinical Efficacy and Safety of Flexibly Dosed Esketamine Nasal Spray in a U.S. Population of Patients With Treatment-Resistant Depression**

Poster Presenter: *May Shawi, Ph.D., M.S.*

Lead Author: *Larry D. Alphs, M.D., Ph.D.*

Co-Authors: *Kimberly Cooper, Vanina Popova, H. Lynn Starr, M.D., Allitia DiBernardo, M.D., Carol Jamieson, David Hough, Jaskaran Singh*

**SUMMARY:**

**Objective:** To evaluate the safety and efficacy of flexibly dosed esketamine nasal spray plus a new oral antidepressant (AD) with placebo nasal spray plus a new oral AD (active comparator) to improve symptoms of depression among patients with treatment-resistant depression (TRD) living in the United States. **Methods:** In this double-blind (DB), flexibly dosed, multinational, multicenter study (NCT02133002), 91 U.S. patients with TRD were randomized 1:1 to flexibly dosed esketamine nasal spray 56/84 mg plus a new oral AD or to placebo nasal spray plus a new oral AD twice weekly for 4 weeks. The Montgomery-Åsberg Depression Rating Scale (MADRS) was assessed at baseline; 24 hours; days 8, 15, and 22; and 4-weeks post-initial dose. The Clinical Global Impression of Severity (CGI-S) scale was assessed at baseline; days 4, 8, 11, 15, and 22; and 4-weeks post-initial dose. The Sheehan Disability Scale (SDS) and Patient Health Questionnaire-9 (PHQ-9) were assessed at baseline, day 15, and 4-weeks post-initial dose to capture changes in patient-reported symptoms of depression and functioning. **Results:** In 90 U.S. patients analyzed (1 did not dose), improvement in MADRS total score with esketamine nasal spray plus a new oral AD vs placebo nasal spray plus a new oral AD observed at ~24-hours postdose was (least squares [LS] mean difference [SE])  $-1.6$  [2.15;  $p=0.225$ ] and at DB endpoint was (LS mean difference [SE])  $-5.5$  [2.58;  $p=0.017$ ]. The analysis of covariance based on the

ranks of change showed a statistically significant difference between the 2 treatment groups in improvement of severity of depressive illness as measured by the CGI-S at day 4 ( $p=0.015$ ) and approached significance at DB endpoint ( $p=0.070$ ). Differences in mean changes in SDS and PHQ-9 were (LS mean difference [SE])  $-4.7$  [2.14;  $p=0.015$ ] and  $-2.9$  [1.53;  $p=0.033$ ], respectively, at DB endpoint. Results for these analyses favored esketamine nasal spray. Adverse events occurring in  $\geq 10\%$  of patients in the esketamine nasal spray plus a new oral AD group were dizziness, nausea, dissociation, headache, dysgeusia, throat irritation, vertigo, nasal discomfort, hypoesthesia, insomnia, paresthesia, anxiety, feeling drunk, hypoesthesia oral, and vomiting. **Conclusion:** Esketamine nasal spray plus a new oral AD compared with placebo nasal spray plus a new oral AD demonstrated meaningful reduction in depressive symptoms as evaluated using MADRS response and remission rates among U.S. patients with TRD. In addition, esketamine nasal spray plus a new oral AD was safe and well tolerated. Support: Janssen Scientific Affairs, LLC

No. 21

**Limitations of Identifying Persistent Depressive Disorder in a Primary Care Setting**

Poster Presenter: *Carla Paola Avellan Herrera, M.D.*

Co-Authors: *Michelle Salpi Izmirly, D.O., Eduardo J. Rodriguez-Perez, M.D.*

**SUMMARY:**

Depressive disorders are a major cause of morbidity and mortality worldwide. Major depressive disorder (MDD) is projected to be the second leading cause of disability by the year 2020. Identification and initial treatment of depression is common in primary care settings using standardized screening tools. Persistent Depressive Disorder (PDD) is a chronic depressive disorder that commonly presents with somatic complaints and is often comorbid with significant personality pathology. While PDD shares aspects with MDD, it is clinically distinct, and identification is often limited, as common screening tools have principally been validated for MDD. Adding to the challenge of diagnosis and management of PDD is that patients frequently normalize or minimize depression-related complaints to their primary physician. Here we



review current screening methods, their advantages and limitations, and possible approaches to more effective identification of PDD in primary care.

**Methods** We conducted a PubMed search for review articles and original research with titles containing combinations of persistent depressive disorder, dysthymia diagnosis, dysthymic disorders, PHQ9 Dysthymia, PC-SAD, and Cornell Dysthymia Rating Scale. 216 articles were identified. Exclusion criteria (Non-English, >20 years old, articles related to pathophysiology or treatment) resulted in the 21 articles reviewed here.

**Discussion** The gold standard for diagnosis of psychiatric conditions, including PDD, is the Structured Clinical Interview for DSM 5 (SCID-5). However its use in primary care settings is not ideal due to time requirements, complexity, and training required. One of the most commonly used screening tools in primary practice is the Patient Health Questionnaire 9 (PHQ-9). However, the PHQ-9 emphasizes a short time-course and neuro-vegetative symptoms of MDD, which can be absent in PDD. A trend towards the use of the PHQ-2, a two-item screen developed from the PHQ-9, faces the same limitations. Previously developed scales specific to chronic depressive disorders, including the Cornell Dysthymia Rating Scale (CDRS), have not been updated to address changes to the diagnostic criteria for chronic depressive disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The most recent versions of The Primary Care Screener for Affective Disorders (PC-SAD) has several advantages, including specificity for chronic depressive symptoms, computer-based administration, and it does not require completion of all items for scoring.

**Conclusions** Persistent Depressive Disorder is a common clinical presentation in primary care, with a significant disease burden. It is important for primary providers to be aware of PDD, its presentation, and limitations of current screening tools. Newer screening tools may permit quicker identification of PDD, in a more cost-effective manner, with the aim of improving the quality of life for patients with chronic depression.

No. 22

**Association Between Financial Stress and Depression: A Systematic Review**

Poster Presenter: *Kunmi Sobowale, M.D.*

Co-Author: *Kimberly Ona Ayala*

**SUMMARY:**

**Background:** Although financial stress has been identified as a unique aspect of subjective socioeconomic status associated mental health, it is poorly operationalized. Understanding financial stress may help elucidate the mechanisms by which low socioeconomic status worsens mental health. Therefore, this systematic review examines the association between financial stress and depression and depressive symptoms.

**Methods:** This review was based on PRISMA guidelines set for systematic reviews. The following databases were search from inception to November 2016: MEDLINE, EMBASE, EconLit, and CINAHL. Two independent researchers performed study selection and data extraction.

**Results:** Of the 1049 studies identified, 148 that met the inclusion and exclusion criteria were included in the systematic review. Populations from 33 countries were represented. Despite mostly ad-hoc measures of financial stress, almost all studies reported a positive association between financial stress and depression. Most measures of financial stress include material hardship and only 31 studies used affective questions making hard to distinguish the unique contribution of these operationalizations.

**Conclusion:** Financial stress is consistently associated with depression. These findings imply that targeting financial stress may be one mechanism for prevention and treatment of depression.

No. 23

**EEG Gamma Synchronization Predicts Response to Paroxetine Treatment**

Poster Presenter: *Baris Metin*

**SUMMARY:**

Resistance to medication is a significant problem in psychiatric practice, and effective methods for predicting response are needed to optimize treatment efficacy and limit morbidity. Gamma oscillations are considered an index of the brain's general cognitive energy; however, the role of gamma oscillations in disease has not been studied sufficiently. This study aimed to determine if gamma power during rest can be used to predict response to anti-depressant medication treatment. Hamilton Depression Rating Scale (HDRS) score resting state gamma power was measured in 18 medication-free

patients during an episode of major depression. After 6 weeks of paroxetine monotherapy HDRS was administered again. Fronto-central gamma power before treatment significantly predicted post-treatment change in HDRS scores, which indicates that gamma oscillations could be considered a marker of response to paroxetine treatment in patients with major depression.

No. 24

**WITHDRAWN**

No. 25

**The Los Angeles County 911 Response to Mental Health and Substance Abuse Emergencies: Process Maps and Understanding the Pivotal Role of Dispatch**

Poster Presenter: *Isabella Morton, M.D., M.P.H.*

Co-Author: *Erick H. Cheung, M.D.*

**SUMMARY:**

Background: Mental health and substance abuse (MH/SA) problems are increasingly the cause for calls to the 9-1-1 system. While the response for medical emergencies is predictably delivered and uniformly regulated, the response to MH/SA emergencies is significantly varied and unregulated, arising from the expectation that 9-1-1 dispatchers should choose whether to deploy law enforcement (LE) officers and/or emergency medical services. As a result, a citizen cannot predict who will respond, how his/her MH/SA emergency will be evaluated or managed, or where he or she will be transported and by what mechanism. LE officers are frequently performing evaluations for MH/SA issues and attempting to manage them, despite the lack of medical training. The Los Angeles Emergency Medical Services Commission (EMSC) issued a report in 2016 titled "The Pre-hospital Care of Mental Health and Substance Abuse Emergencies", which sought to answer: "What happens when a person in LA County calls 9-1-1- with a MH/SA emergency?" In the report, the EMSC firmly asserted that MH/SA emergencies are medical emergencies, and are best addressed by trained healthcare personnel whenever possible. 9-1-1 dispatchers play the central role in determining who will respond, however there is currently a lack of understanding about their processes and protocols. We provide a

brief review of the EMSC report findings, and a detailed focus on a recommendation to understand and modify the 9-1-1 dispatch criteria for MH/SA emergencies. Methods: The consensus recommendations of the EMSC report were generated through a county-wide stakeholder process over a period of 1 year. We surveyed all LA County dispatch agencies (42) and law enforcement agencies (46) to investigate variations in the following areas: volumes and types of MH/SA emergencies, dispatch procedures and criteria, data coding, field response deployment decisions, prevalence of clinicians or mental health trained LE responders, and outcomes of LE encounters. Results: (Preliminary data; final results pending secondary follow up.) 48% of Dispatch agencies and 52% of LE agencies responded to the survey. In LA county, on average 6% of 9-1-1 calls are for a mental health emergency. Of these calls, 11% are primarily related to a suicide attempt; 32% suicidal ideation but no attempt; 22% homicidal or violent thoughts or behaviors; and 35% without suicidal or dangerous behaviors. 26% of dispatch agencies have a defined protocol for determining if a call is a mental health emergency. 9-1-1 dispatch protocols for MH/SA emergencies lack uniformity and oversight, and are largely guided by local customs. There is no standardized practice for coding or dispatching 9-1-1 mental health calls. Of all LE agencies that responded, 83% have embedded mental health clinicians though with insufficient availability. Funding and time were identified as major barriers to increasing mental health training of LE officers.

No. 26

**Struggling, but Below Criteria: Subthreshold PTSD in 9/11 World Trade Center Responders**

Poster Presenter: *Connie Chen*

**SUMMARY:**

Background: After traumatic events such as the 9/11 World Trade Center (WTC) attacks, a subset of individuals may develop subthreshold PTSD, characterized by symptoms that fall short of criteria for a "full" PTSD diagnosis defined by the DSM, yet are persistent and functionally impairing. The U.S. lifetime prevalence of subthreshold PTSD has been shown to be similar to or greater than full PTSD; in WTC responders, subthreshold PTSD may be over

twice as prevalent as full PTSD. Despite its significant disease burden, subthreshold PTSD is often overlooked as a possible diagnosis in trauma-exposed groups. We conducted a cross-sectional study of prevalence and clinical and risk correlates of subthreshold PTSD in WTC responders over 10 years post-9/11, aiming to understand the clinical context of individuals with subthreshold PTSD and inform assessment and treatment efforts for this and other disaster response populations. Method: We invited 6,642 responders monitored at the WTC Health Program to complete a Web-based survey; 4,001 (60.2%) invitees completed the survey between 6/2012-12/2014. The sample included 48.5% police (n=1,942) and 51.5% non-traditional responders (n=2,059) (e.g. construction workers, cleaners). Survey items included the PTSD Checklist-Specific Version (PCL-S), a validated measure used to determine PTSD prevalence; we also assessed demographics, WTC-related exposures (e.g. number of 9/11 traumas), and clinical variables (e.g. medical co-morbidities). Using multinomial logistic regression, we identified risk correlates and clinical characteristics associated with subthreshold PTSD. Results: Mean time of survey completion was 12.2 years post-9/11. Prevalence of full and subthreshold PTSD in police was 9.3% and 17.5%, respectively, and in non-traditional responders, 21.9% and 24.1%. Risk correlates for subthreshold PTSD in both groups included post-9/11 medical problems (risk ratio [RR] in police 1.1, non-traditional 1.2,  $p < 0.001$ ) and post-9/11 traumatic events (RR 1.1, 1.2,  $p < 0.05$ ). Clinical correlates included elevated rates of comorbid depression (4.7% in trauma controls, 18.4% in subthreshold, 67.0% in full PTSD,  $p < 0.05$ ), and alcohol use problems (4.8% in trauma controls, 8.3% in subthreshold, 14.6% in full PTSD;  $p < 0.05$ ). Risk correlates for subthreshold PTSD in police included female gender (RR 1.6,  $p < 0.05$ ), and in non-traditional responders, non-white race (RR 1.6,  $p < 0.01$ ). Conclusion: In WTC responders over a decade post-9/11, subthreshold PTSD was more prevalent than full PTSD, particularly in police. Those with subthreshold PTSD were likely to have multiple medical problems and additional traumatic exposures after 9/11; they also were more likely to have co-occurring depression and alcohol use problems. These findings underscore the burden of subthreshold PTSD in WTC responders, and may help

clinicians working with first responders to screen and assess individuals at risk for developing subthreshold PTSD.

No. 27

**Surfing the Dissociative Spectrum: Learning to Analyze Self-Cycling While Using Medications to Treat Mood Cycles**

Poster Presenter: *Jacob Elliott Sperber, M.D.*

Co-Authors: *Gregory Haggerty, Harjasleen Bhullar Yadav, M.B.B.S.*

**SUMMARY:**

Patients with Dissociative Identity Disorder can be viewed as suffering from severe borderline personality characterized by recurrent cycles of dissociation to disconnect from memories of childhood trauma. The pattern of recurrent dissociation can be thought of as self-cycling. Some of these self-cycling patients use various kinds of acting out, in particular substance intoxication, to enhance their dissociation by pharmaco-dissociation. At the biogenic level, patients with Bipolar I Disorder, in their different mood states, also express highly contrasting personality traits, secondary to the mood cycling. We consider the case of Mr. M, a 23 year-old bank manager with a history of repeated childhood trauma in the form of being physically, sexually, and psychologically abused by his biological father between the ages of 6 to 9, in addition to being bullied in school for his sexual orientation. He was subsequently diagnosed with Dissociative Identity Disorder with recurrent alters as an adolescent, with strong collateral from the mother who witnessed Mr. M dissociate into "harsher version of self who had hit Mr. M resulting in a nosebleed." Mr. M describes at least four distinct alters, including both males and females, with all male alters being "gay," and one particularly "being most gayish." One of his alters was a boy named John; "John was depressed, and is now long gone." The female alters he describes are "formal, and serious." Growing up, he developed Bipolar Disorder I, and has been in treatment for his mood disorder for years. Mr. M has been working with a private therapist for years. This treatment has helped him to develop skills which allow him co-exist with his multiple selves with the hope of complete integration one day as "Mr. M." He has learned to

live by consulting his alters, whom we call his “self committee.” Recently, Mr. M has been smoking cannabis, which he uses to switch into an alter characterized by “highly verbal, expressive, with certain mannerisms.” This confidence functions as defense against the fear and sadness associated with the trauma memories. Standard-of-care treatment of the trauma-based fragmented personality disorder would reflect frequent psychotherapy based on recalling the traumatic memories in a safe setting with a trusted therapist. Mr. M's pleasurable pot use, which also enhances his dissociative defenses, constitutes a major resistance to this treatment approach.

No. 28

### **Healing Relationships for Diverse Psychiatric Populations**

Poster Presenter: *Selby C. Jacobs, M.D., M.P.H.*

#### **SUMMARY:**

While re-imagining psychiatry's contribution to health equity and social justice, it is essential to keep an eye on a fundamental principle: all help-seekers in the public sphere deserve the benefit of healing relationships with those who care for them. Building on three, disguised, diverse case examples – one, a non-compliant African-American man with chronic schizophrenia and co-occurring substance abuse, two, an undocumented, Dominican mother crippled by severe symptoms of anxiety, and three, a demoralized Greek-American man with intractable paranoid schizophrenia and suicidal symptoms - this poster defines healing relationships, discusses methods for creating them, considers their relation to person-centered care and recovery, and discusses the significant uses of healing relationships in public practice.

No. 29

### **An Evaluation of Patient and Staff Perceptions of Care Quality Related to Therapeutic Programming on Stanford's Inpatient Behavioral Health Units**

Poster Presenter: *Alex Clarke, M.D.*

Co-Author: *Katherine Sibley Sanborn, M.D.*

#### **SUMMARY:**

A report published in 2017 by the Robert Wood Johnson Foundation (RWJF) proposed that the term

“health equity” means “that everyone has a fair and just opportunity to be healthier...[which] requires removing obstacles to health.” One of the key steps that the report outlined is to “change and implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed to be healthier.” Within psychiatry, the Recovery-Oriented Care Model represents one such change that aims to broaden the focus of mental health treatment from traditional symptom-reduction toward development of patient-centered, patient-directed life goals and the support of patients' capacity for fulfilling meaningful life roles. Despite meaningful gains, the tenets of recovery-oriented care have remained primarily relegated to the outpatient setting; yet, institutions are beginning to think critically about how a recovery orientation can and should be implemented in the acute inpatient psychiatric care setting. As a result, growing attention is being directed toward the provision of care in these important environments and to the ways in which therapeutic programming and unit space design can help or hinder patient recovery goals. An institution's theoretical approach to care is manifest in its daily therapeutic programming and in the design of the physical spaces which support this care. Stanford Inpatient Behavioral Health is dedicated to providing precision mental healthcare and to creating safe, welcoming, inclusive, health-promoting spaces for patients. As part of ongoing quality improvement processes within the Department, we undertook an evaluation of our acute inpatient unit programming to better understand patients' and staff's perceptions of care quality. The goal of our project was to: 1) characterize and document the current programming, activities available to patients, and design of the supporting space; 2) evaluate patient and staff perception of “time spent in therapeutic activity”; 3) use a validated recovery-orientation assessment tool to measure our current unit practices; 4) identify opportunities for operational changes to improve patient and staff perceptions of care; and 5) generate recommendations for modifications to both therapeutic programming and the facility space design to enable and support these recommended operational changes. In this poster, we discuss the core tenets of recovery-oriented care,

present our assessment of Stanford's current inpatient practices, generate a menu of therapeutic activities representing state-of-the-art, evidence-based, recovery-oriented inpatient mental health care, and discuss physical facility space design guidelines that would support this ideal type of precision-care ward.

No. 30

**Implementing the Collaborative Recovery Model in an Australian Tertiary Mental Health Service**

Poster Presenter: *Kevin Ong, M.B.B.S.*

Co-Author: *Phoebe Williamson, B.A.*

**SUMMARY:**

Background: The Collaborative Recovery Model (CRM) is being implemented across Eastern Health Mental Health Program (EH) to align the Service with Australia's National Framework for Recovery Oriented Mental Health Services (Department of Health, 2013). It is anticipated that CRM will provide a unifying recovery language and practice, improving equity by a renewed focus on social determinants of mental health, and minimising the power imbalance between clinicians and persons coming into the service. Developed by and licenced through the University of Wollongong (Oades, Deane, Crowe, Lambert, Lloyd & Kavanagh 2005), CRM is a strengths-based coaching model and training package that supports both individual and family recovery-focused interventions, as well as organisational cultural change. It is derived from the evidence base for recovery, wellbeing and positive psychology. To meet licencing requirements, initial CRM training is delivered across 3 days, with "booster" training at 6 months and annually, and is further supported by regular reflective practice ("team coaching"). Uniquely, CRM trainers comprise medical, nursing, allied health and lived experience peer workforce. To our knowledge, implementation of CRM at EH is the largest undertaking of its kind by a tertiary mental health service. EH have also contextualised training to meet the unique needs of specialist areas (Child and Youth, Adult and Aged Persons'), with each area being offered separate training to support culture change. Method: Applying the first 2 levels of Kirkpatrick's Four-Level Training Evaluation Model (Kirkpatrick, 1994), the study evaluates the impact of CRM training on staff

learning. Developed in collaboration with one of the CRM authors (Oades), pre/post training measures evaluate the effectiveness of CRM training in relation to staff knowledge, skills and attitudes towards recovery, and the perceived confidence and importance of implementing the model as part of practice. Participants complete measures at initial and booster training (650 staff in total). Results: Preliminary findings revealed an increase in staff knowledge, skills and attitudes post initial CRM training. Follow-up measures demonstrated the importance of "booster" sessions for transferring CRM training into practice, and that regular CRM "team coaching" is essential to drive change in attitude, practice and culture. Conclusion: Implementing a recovery framework is complex, resource intensive, and requires a whole of service commitment. This study provides preliminary evidence to support CRM training in enhancing staff knowledge, attitudes and skills in delivery of recovery-oriented services. Further evaluation of the psychometric properties of the measurement tool, as well as mechanisms required to support sustainability of CRM at EH is required. Future research will also evaluate the impact of CRM training on staff behavioural change, and outcomes for consumers and their families.

No. 31

**Ithuriel the Angel Prisoner**

Poster Presenter: *Lepri Assunta, M.D.*

**SUMMARY:**

In the state of coma the patient may not be aware of his bodily boundaries, he can not locate the pain he senses in a diffused, global, unacceptable, fearful of open spaces, beyond the boundaries of the bed there is the vacuum from which to retreat with Fear. In GdL, LANGUAGE GLOBALITY, neuropsychology re-education is connected to the body-ear that listen to vibrations from the tactile map. Functional tonic reactions to skin perception of the border. A sensitive face to external stimuli and a sensitive side to internal reactions. Current culture involves a body that is agitated and unheard of. Rediscovering a present and proprioceptically active and communicative body in its almost immobility. We try to present a method of communication in the GdL that respects the possibility even in the coma state.

No. 32

**Adolescent Gun Violence: Preliminary Support for a Developmental Perspective**

Poster Presenter: *Spencer Keil*

**SUMMARY:**

Objective: Gun violence takes many forms, including suicide, accidental gun injuries, and violent gun use. Each form has somewhat unique risk factors and conceptual underpinnings. Violent adolescent gun involvement is a major cause of death for young people that is particularly devastating to communities. Despite the urgency of this public health problem, little is known about specific factors related to the patterns or motivations for gun involvement in young people. Using longitudinal data, we look at how gun involvement among high risk youth fluctuates at different stages of adolescence. Methods: This study draws from data collected as part of Pathways to Desistance, a longitudinal cohort study. 1165 male participants between the ages of 14 and 18 were recruited from 2000-2003 following adjudication for serious criminal offenses in Maricopa County, AZ and Philadelphia, PA. They were interviewed at six-month intervals for three years and then annually for four years. Gun carrying and gun use were measured using self-report responses at each follow-up interview. Results: Overall, gun involvement was high among this sample, with 44% reporting carrying at some point during the seven-year study and 19% reporting using a gun. Gun carrying rates in our sample peak at 21% in 18 year olds and follow a bell-shaped distribution at younger and older ages. Of those who carry, older participants carried for longer periods, with 24 and 25 year olds reporting carrying nearly continuously for the recall period they reported this behavior. The probability of using a gun in those who carried varied from 15-45% across ages, with peaks at early ages (15-17) as well as older ages (23 and 24). Conclusions: Taken together, our findings indicate that fewer adolescents carry as they age, but those who continue tend to carry more consistently. These patterns raise the possibility that very different mechanisms for gun carrying and use operate during different age periods. Younger adolescents may carry for limited stretches of time to protect themselves against a perceived threat,

while those in early adulthood may be carrying for more instrumental reasons or as part of an antisocial identity. Likewise, gun use may increase in early adolescence due to decreased emotional regulation and heightened impulsivity while shooting in older ages may reflect deeper involvement in criminality. Alternatively, it may be that while less people carry in early adolescence and in adulthood, those who are carrying may be doing so with a more specific intent to use guns. These findings support a developmental approach using longitudinal data to frame further research on the precipitants of gun violence and to focus prevention efforts more effectively.

No. 33

**Community-Based Models of Care Which Decrease Criminal Justice System Involvement of Homeless People With Mental Health Disorders: A Review**

Poster Presenter: *Myriam Le Blanc, M.D., M.Sc.*

Co-Authors: *Arash Nakhost, M.D., Ph.D., Michaela Y. Beder, M.D., Vicky Stergiopoulos, M.D., M.H.S., Alexander Simpson, M.D.*

**SUMMARY:**

Homelessness, mental health disorders and criminal justice system involvement frequently co-occur in the same individuals. Suffering from a mental health disorder increases the risk of homelessness, and criminal justice involvement. The criminalization of people with mental health disorders is well established, with increasing numbers of people with mental illness facing criminal charges. The concurrence of homelessness, mental health disorder and criminal justice system involvement is associated with poorer outcomes leading to increased complexity of care. Over the last decades, some efforts have been made to create programs that aim to decrease the criminalization of mentally ill individuals, notably diversion programs, like Mental Health Courts, as well as different types of intensive case management. However, criminal justice system involvement is still common in this patient population. From the healthcare system perspective, our usual models of care are not designed to specifically address the challenges of criminal justice system involvement. We conducted a scoping review of the literature to identify current models of community based care which have shown

to decrease the criminal justice system involvement of homeless people with mental health disorders. Models described in the relevant articles are presented in regard to their key characteristics and to their impact on primary outcomes (criminal justice system involvement) and secondary outcomes (mental health, housing status, use of services). The results will help to inform health care providers, judicial system actors and other key decision makers with regards to the types of services that may be required in their specific jurisdiction.

No. 34

**An Involuntary Medication Review Process in a State Psychiatric Hospital: Patient and Process Characteristics**

Poster Presenter: *Lily Arora, M.D.*

Co-Authors: *H. Steven Jay Schleifer, M.D., Kathleen Mencher, John Luchkiw, Donald Eckel, Evaristo O. Akerele, M.D.*

**SUMMARY:**

Background: Treatment over objection remains a challenge nationwide. The primary goal is to ensure balance between patient rights and optimal care. New Jersey recently switched from a clinical 3-step process to a 3-member panel review (independent psychiatrist, representative of hospital administration, and a nonphysician clinician). We reviewed the clinical experience with the new process at one state psychiatric hospital, examining the clinical course and characteristics of patients referred to the Involuntary Medication Administration Review (IMAR) panel. Methods: Clinical data, IMAR duration and disposition for all patients enrolled in IMAR since 2012 were summarized. Patients with clinical evidence of compromised capacity to consent were included in the process. They were compared to refusing patients considered to have full ability to consent. To explore IMAR referral in relation to violent behavior, annualized violent events (aVEs) for a year (2015) were examined in relation to past and ongoing IMAR. Patterns for the initial IMAR years were examined for evidence that IMAR was more limiting of involuntary medication than the earlier 3-step procedure. Results: 1) There have been 388 IMAR cases since 2012, 290 completed with consent or discharge. Mean patient age was 48 (18-83 yrs.),

46% were female, 56% Caucasian, and 85% diagnosed with a psychotic disorder. 2) For completed IMARs, mean days(+sd) in hospital prior to IMAR referral were 661+1772 and, from IMAR inception to consent/discharge, 115+182. Days from admission to IMAR were significantly lower for refusers (n=240) vs those considered unable (n=38) and those not initially but only later considered unable (n=12) (ANOVA F 11.4, df 2,287, p <0.001). 3) Days from IMAR initiation to consent/discharge were 86+138 for R, 160+131 for U, and 549+407 for RU. Group differences were highly significant (ANOVA F 51.6, df 2,287, p <0.001; post hoc comparisons all <0.025). 4) Among clinical characteristics, only developmental disability and U status were associated (independently) with time to consent (p<0.001). 5) Year of IMAR initiation did not predict duration or other outcomes, suggesting that patients treated under the 3-step clinical procedure were likely to be assessed similarly under the more restrictive IMAR. 6) 99 of 959 inpatients were referred for IMAR in 2015. aVEs in 2015 were 5.2+11.7 for never-IMAR patients, 8.7+10.7 for patients with completed IMARs, and 4.4+5.2 for continuing IMARs (ANOVA p<0.04). Conclusions: a) IMAR appears to be a feasible alternative to a clinical 3-step process, while providing added protection for patient rights. b) IMAR may be less useful for patients considered unable to consent. c) Violence is a common indicator for involuntary medication and previous IMAR assignment may be an indicator of continued risk for violence following conversion to voluntary pharmacotherapy.

No. 35

**Relationship Between Restraint and Seclusion and Treatment Satisfaction in Child and Adolescent Psychiatric Inpatients**

Poster Presenter: *Jessica N. Tasca, B.A.*

Co-Authors: *Elizabeth O'Donoghue, B.A., David Pogge*

**SUMMARY:**

Background: Restraint and seclusion (R+S) are used in the management of aggressive and disruptive behaviors in psychiatric hospitals. A large body of research argues against the use of R+S, reporting several negative short- and long-term outcomes (Bonner, Lowe, Rawcliffe & Wellman, 2002; Legris,

Walters & Brown, 1999; Fisher, 1994). However, the majority of these studies are conducted at public hospitals serving adult patients. Although some research includes data on adolescents, these are often combined with adults and rarely examined separately, and there has been almost no research on the use of R+S with children. The small body of literature concerning R+S with children and adolescents suggests that these may be qualitatively different phenomena (Pogge, Pappalardo, Buccolo, & Harvey, 2011 and 2013; Bath, 2014; Day, 2002; Cotton, 1989). Methods: In an inpatient setting serving children and adolescents two archival databases were examined. The first contained detailed information from all R+S events and the second contained the results of a satisfaction survey routinely conducted by the hospital as part of their quality assurance. One year of data were examined. Adolescents (i.e., 13-17 years) completed the satisfaction survey at the end of their hospital stay and the parents of children (i.e., 5-12 years) completed the same survey around the time their children were discharged from the hospital. Because these represent different sources of information, they were examined separately. Results: The analysis included 976 children (mean age: 9.87) and 1800 adolescents (mean age: 14.92). Of the child group, 54% experienced at least one R+S event while only 28.6% of the adolescent group experienced such an event. Analyses of the 12 items on the satisfaction rating form revealed only one significant difference between parents of children who experienced a R+S event and the parents of those who did not. The parents of children who experienced no R+S were slightly less satisfied with the child's primary therapist than the parents of those who did. There was no significant relationship between the number of R+S events children experienced and their parents' ratings of satisfaction on any of the 12 items. Among the adolescents, 28.6% experienced at least one R+S event. Those who experienced an R+S event were very slightly less satisfied on 11 of the 12 items. Number of R+S events has a very small correlation with ratings on three items. Conclusion: This study provides further support for the belief that the experience of R+S is qualitatively different for children and adolescents, it highlights the value of obtaining information from multiple sources when examining the impact of R+S, and it suggests that the

relationship between adolescents' experience R+S and their satisfaction with their inpatient care is, at most, very small.

#### Special Sessions

Friday, October 05, 2018

#### **Integrating Behavioral Health and Primary Care: Practical Skills for the Consulting Psychiatrist**

Faculty: *Anna Ratzliff, M.D., Ph.D., John Sheldon Kern, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations.

#### SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation



strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project.

### **Primary Care Skills for the Psychiatrist**

Chair: *Jeffrey T. Rado, M.D.*

Presenters: *Aniyizhai Annamalai, M.D., Lydia A. Chwastiak, M.D., M.P.H., Alyson Myers, M.D., Mary Beth Alvarez*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss lifestyle modifications that are useful; 2) Improve current state of the art knowledge in treating diabetes, hypertension and dyslipidemias; 3) Develop skills in understanding the use of treatment algorithms for prevalent chronic illnesses in the SMI population; 4) Increase comfort in using screening guidelines for early identification of common diseases; and 5) Understand key concepts in prevention and treatment related to obesity, tobacco use and vaccinations.

#### **SUMMARY:**

Patients with mental illness, including those with serious mental illness (SMI), experience disproportionately high rates of tobacco use, obesity, hypertension, hyperlipidemia and disturbances in glucose metabolism. This is often partially the result of treatment with psychiatric medications. This population suffers from suboptimal access to quality medical care, lower rates of screening for common medical conditions and suboptimal treatment of known medical disorders such as hypertension, hyperlipidemia and nicotine dependence. Poor exercise habits, sedentary lifestyles and poor dietary choices also contribute to excessive morbidity. As a result,

mortality in those with mental illness is significantly increased relative to the general population, and there is evidence that this gap in mortality is growing over the past decades. Because of their unique background as physicians, psychiatrists have a particularly important role in the clinical care, advocacy and teaching related to improving the medical care of their patients. As part of the broader medical neighborhood of specialist and primary care providers, psychiatrists may have a role in the principal care management and care coordination of some of their clients because of the chronicity and severity of their illnesses, similar to other medical specialists (nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer). The APA's formal Position Statement calls on psychiatrists to embrace physical health management of chronic conditions in certain circumstances. Ensuring adequate access to training is an essential aspect of this new call to action. There is a growing need to provide educational opportunities to psychiatrists regarding the evaluation and management of the leading cardiovascular risk factors for their clients. This course provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors which contribute heavily to the primary cause of death of most persons suffering with SMI, and allows for the profession of psychiatry to begin to manage some of the leading determinants of mortality and morbidity in patient populations frequently encountered in psychiatric settings.

Saturday, October 06, 2018

### **Applying the Integrated Care Approach 201: The Advanced Course in Collaborative Care**

Chair: *John Sheldon Kern, M.D.*

Presenters: *Anna Ratzliff, M.D., Ph.D., Patricia Ellen Ryan, M.D., Kristyn Spangler, Jeffrey T. Rado, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the most important tasks required for successful implementation of a collaborative care program; 2) Describe the use of collaborative care payment codes; and 3) Demonstrate registry data evaluation and use in collaborative care.

#### SUMMARY:

In the last two years, the APA / AIMS Center Support and Alignment Network (SAN) project has trained over 2300 psychiatrists in the Collaborative Care model to provide behavioral health services in the primary care setting. Most of these psychiatrists received their training in in-person presentations at live District Brand or APA meetings. Many of the psychiatrists have gone on to be involved in successful implementations of the Collaborative Care model, and many more are preparing to do so. So far there have been 20 completed SAN learning collaboratives, an advanced online training activity. There continues to be strong interest among participating psychiatrists in ongoing support and training in Collaborative Care, and this workshop will present the opportunity for exposure to advanced topics in Collaborative Care. We will discuss a number of areas crucial to the successful implementation of Collaborative Care programs, including an up to date review of the new CMS payment codes for Collaborative Care, an update of recent Medicaid and private payor rollouts and a thorough introduction to the APA / AIMS Center Financial Modeling Tool, that has been assisting organizations with making credible financial plans for Collaborative Care implementation. Two organizations who have successfully implemented Collaborative Care programs will present their experiences, with a focus on those issues most critical to successful roll-out. Finally, there will be a review of techniques and strategies for efficiently training members of the Collaborative Care team, including care managers and PCP's. There will be opportunity for participants to engage with panel members in order to reflect the diverse real-life experiences of building and implementing a Collaborative Care program.

Symposia

Thursday, October 04, 2018

#### **Addressing the Mental Health Needs of Survivors of Intimate Partner Violence (IPV) in the Community**

Chairs: *Mayumi Okuda, M.D., Rosa Regincos*

Presenters: *Tatyana Pena, Ladan Shaikh, M.D., Elizabeth M. Fitelson, M.D., Obianuju Jennifer Berry, M.D., M.P.H.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the common barriers to mental health care for Intimate Partner Violence (IPV) survivors; 2) Discuss findings from the evaluation of a program that integrates mental health services with community based ones for IPV survivors; 3) Summarize clinical, legal and training recommendations that can improve access to care for marginalized IPV survivors; and 4) Describe the rationale for a multi-specialty collaborative model that effectively treats IPV survivors' multiple needs.

#### SUMMARY:

Despite the affluence of American society, health disparities continue to exist along racial, ethnic and socioeconomic lines and empirical evidence demonstrates that minorities continue to experience enormous disparities in many facets of health. Intimate Partner Violence (IPV) and its mental health consequences are no exception. Low-income ethnic minority populations face an increased risk of both IPV and its resulting mental health problems. Women from ethnic and racial minorities report higher prevalence rates of lifetime IPV compared to non-Hispanic White women. Marginalized populations, such as foreign born women, are also more likely to experience IPV than those who are native born. Additionally, minorities are more likely to report prior discrimination by mental health providers, overall negative beliefs about mental health (including discomfort in discussing personal matters), a greater social stigma related to being identified as having mental health problems, and a general distrust of formalized mental health providers, which can become a barrier to accessing care. Lack of adequate health insurance, long waiting lists and a lack of services in clients' native language are common barriers for care. Particularly for immigrants, seeking help can bring fear of deportation, not to mention to the perception that appropriate, culturally-congruent services in their communities are already severely lacking. In response to these barriers, we piloted a program to integrate psychiatric and psychological care into the

Family Justice Center (FJC). The FJCs are national non-profit organizations that provide legal and other advocacy services for IPV survivors in one location (a “one-stop shop”). FJCs serve survivors of all ages, genders and sexual orientations, regardless of citizenship status or relationship status with their abusers. This presentation will illustrate lessons learned throughout the development and expansion of this program, while focusing on its accomplishments and challenges. The presentation will also describe the findings of our program evaluation as well as our future directions. It will also provide a platform for discussion on methods to increase awareness and training on IPV and non-combat trauma and how to enhance the national capacity to provide mental health services for this underserved population. This symposium will be presented by a team of professionals in the fields of advocacy, social work, psychology and psychiatry who have experience working with IPV survivors and their families. At the conclusion of the symposium, participants will discuss practical strategies that can improve access to care, while learning about a model that provides integrated services to IPV survivors and other non-combat trauma survivors.

#### **Criminal Justice and Mental Illness: Stepping Up**

Chairs: *Daniel H. Gillison, Steve Leifman, J.D.*

Presenters: *Fred Charles Osher, M.D., Stephanie Le Melle, M.D., M.S., Altha J. Stewart, M.D., Thomas Dart*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the extent of the crisis and the impact it is having on patients and the community; 2) Engage in the creation of recommendations for The Stepping Up Initiative to take into consideration as they look to create treatment resource guides for county leaders; 3) Engage in thoughtful discussions with experts in the field about what Psychiatrist can do to help this population; and 4) Produce recommendations on how to get more Psychiatrists involved in The Stepping Up Initiative.

#### **SUMMARY:**

The number of people with mental illnesses in the U.S. jails have been at a crisis level for some time:

two million individuals with a serious mental illness like schizophrenia, bipolar disorder, and major depression are admitted each year. We know that around three-quarters of these individuals also suffer from a co-occurring substance use disorder. The Stepping Up Initiative has been involved in making an effort at the county level to address this issue, with over 440 counties passing a resolution to Step Up to address the over incarceration of the seriously mentally ill. This year there is a push for counties to obtain base line data, through establishing a shared definition of Serious Mentally Ill (SMI), use of a validated mental health screening tool, record clinical assessment results, and report out to key stakeholders. Psychiatrists are going to be crucial in how The Stepping Up Initiative is going to be able to use the data that is collected to help to create treatment resources for county leaders, make suggestions on how to engage psychiatrists in the further advancement of The Stepping Up Initiative, and how to tackle the tough questions of access to care for some of our counties that do not have a psychiatrist. This session will include presentations from Community Psychiatrist Stephanie Le Melle, MD, MS, a person with lived experienced, and leaders in the field. There will be a panel discussion following the presentations that will include Judge Steven Leifman, Fred Osher, MD, our presenters, and leaders from each of the national organizations. Following the panel discussion there will be three break-out sessions for individuals to rotate through that will address: ideas for treatment resources, how to better engage psychiatrist in the initiative, and ideas on how to tackle access in counties. This session will be an interactive experience, where participants will be asked to engage in thoughtful conversations, come up with tangible solutions, and operationalize action steps for The Stepping Up Initiative to take.

#### **Improving Medication Adherence: An Expert Consensus Report of the National Council Medical Director Institute**

Chair: *Joseph John Parks, M.D.*

Presenters: *Melissa Odorzynski, Pharm.D., M.P.H., Patrick S. Runnels, M.D., Paula G. Panzer, M.D., Jeffrey Alan Lieberman, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Participants will be able to describe the prevalence of medication nonadherence, risk factors, and impacts; 2) Participants will be able to understand and implement shared decision-making to improve medication adherence; 3) Participants will be able to assess individual patient adherence risk and jointly strategize with patients to reduce them; 4) Participants will be able to select and pursue improved medication dispensing arrangements to improve adherence; and 5) Participants will be able to design a multidisciplinary approach to improving adherence within their organization.

#### SUMMARY:

As noted by former Surgeon General C Everett Koop “Medications only work in patients who take them” For people with chronic medical illnesses, medication non-adherence substantially adds to the burden and leads to poorer long-term outcomes. Adherence to treatment in persons with mental health disorders is further undermined by the impairments in cognition and insight that often accompany mental illness. Consequently, the frequency and impact of poor adherence to treatment are even more pronounced in persons with mental health disorders than in other medical conditions . The National Council for Behavioral Health Medical Director Institute convened a diverse group of practitioners, administrators, policymakers, researchers, innovators, educators, advocates and payers for an in- depth discussion representing a variety of viewpoints over a two-day meeting. The participants were selected to provide a broad range of perspectives and expertise in working with individuals suffering from mental illness and substance use disorders. Expert panel members provided reports and research from their area of expertise for review, as well as their unique perspectives to the vexing problem of Medication Adherence. The National Council’s goal in producing this paper is to provide information and describe strategies that can be implemented by a wide range of stakeholders in his or her individual sphere of influence across the behavioral health field including: the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA); provider

organizations; professional trade organizations for psychiatrists, nurse practitioners, physician assistants and pharmacists; consumer and family advocacy groups; insurers of behavioral health benefits; pharmaceutical manufacturers; pharmacy benefit managers and policy makers in the behavioral health arenas. This symposium includes an environmental scan, summary problem statement, solutions based on research and experience in the field, and a set of actionable recommendations. Since the consequences of non-adherence for this population are devastating for both physical illness and behavioral health conditions alike, this paper covers factors related to non-adherence for all, not just psychopharmacologic medications. The proposed solutions address the behavioral health field specifically. It is likely, however, that many of these initiatives can be effectively applied in treatment settings delivering care to persons with other chronic conditions. Just as following a sound medication regimen is an essential part of patient care, non-adherence to medications, represents a major vulnerability to improved health outcomes. The symposium and report describes the problem, identifies solutions and proposes concrete steps to increase the portion of patients who get the full potential benefit of the medications they are prescribed.

#### **Opioid Emergencies: Practical and Policy Considerations in the Management of Opioid Use Disorder in the Emergency Setting**

Chair: *John S. Rozel, M.D.*

Presenters: *Abhishek Jain, M.D., David A. Pepper, M.D., David J. Yankura, M.D., Brian Scott Fuehrlein, M.D., Ph.D., Leslie Zun, M.D., M.B.A.*

Discussant: *Jon Scott Berlin, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will understand the scope and impact of opioid use disorders; 2) Attendees will understand the history of heroin and opioid policies in the US; 3) Attendees will recognize three ways to apply MAT in the emergency setting; 4) Attendees will recognize three ways to engage people with opioid use disorders in emergency settings; and 5) Attendees will recognize the challenges of treating pain in the emergency setting.

#### SUMMARY:

Opioid misuse and overdoses have become a critical public health burden and been recognized as a national emergency by the federal government. More people are dying of opioid overdoses than homicides and suicides combined. The causes of this crisis are complex, multifactorial, and still a subject of fierce debate. What is indisputable, however, is that emergency departments are the front line for battling the epidemic of opioid use disorders. While so much public attention has focused on the use of naloxone, this symposium will look at what happens after the revival when professionals try to shift the course of illness to recovery. This symposium will look at the opioid crisis as seen through the lens of emergency providers. Building on an overview of the history of heroin and opioids in America, presenters will explore the rapidly developing field of emergency management of substance use disorders. Presentations will include a comprehensive literature review, explorations of programs with a spectrum of detoxification interventions including medication assisted treatments, and close with a review of the challenges of pain management in the ED setting. Efforts will be made to discuss a broad spectrum of potential interventions that will be relevant for a variety of emergency settings. The discussant has been chosen specifically to help the ensuing discussion focus on recovery and engaging with difficult patients. Presenters will illustrate each topic with a number of clinical examples and lead the audience through practical decision making strategies. Given the fast-paced nature of this evolving public health threat and the clinical and policy tools to intervene, the presenters may adapt their content further as the year progresses to assure the audience receives a timely and up to date overview of this issue.

#### **Psychiatry, Health Equity and the Diseases of Despair and Disparity: The Antidotes of Hope, Inclusion and Resilience**

Chair: *Kenneth Stewart Thompson, M.D.*

Presenters: *Ruth S. Shim, M.D., M.P.H., James Lamont Griffith, M.D., Kenneth Stewart Thompson, M.D.*

Discussants: *Aidaspahic S. Mihajlovic, M.D., M.S., Michael T. Compton, M.D., M.P.H.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the role of psychiatry in addressing health inequities; 2) Understand the multifactorial roots of health inequities and the diseases of despair/dispairity; 3) Comprehend what hope, resilience and inclusion are and how to cultivate them in people and communities; and 4) Develop an agenda for social psychiatry, health equity, inclusion, resilience and hope.

#### SUMMARY:

Psychiatry is late to the struggle for health equity. For some time, it's primary focus on equity has been on improving access to mental health services and seeking parity of payment. Scant attention has been paid to the contributions that public health/population health concepts, such as the social determinants of health, social inclusion and health equity, might make to psychiatric thinking. Similarly, perhaps even less thought has been paid to the contributions psychiatric thinking about trauma, resilience and recovery etc might contribute to public/population health. However, the times and intellectual fashions are changing, prompted by a growing appreciation of the limitations of clinical interventions and the importance of a population health approach to the health of communities, fueled by a growing outrage at the inequities in our society. Of particular note is the fact that, for the first time in recorded history, the health status of a demographic group of Americans has significantly deteriorated, similar to what happened in Russia after the Soviet Union collapsed. Angus Deaton and Anne Case, as well as others, have found that impoverished, middle age poorly educated white Americans, both men and women, are dying earlier than they previously had, with opiate overdoses, suicides and alcohol toxicity being the primary sources of this increase. They have termed these the "diseases of despair", tracing their etiology to the distress caused by the social and economic dislocations occurring across America. Of course, not only poor white Americans carry the burden of the "diseases of despair". Poor people of all races/ethnicities have long suffered from much higher rates of morbidity and mortality than wealthy

people, as have people of color, especially American Indians and African Americans, relative to whites. It is clear that the circumstances people live in- historical, social, economic, geographic, psychological etc- drive their health and well being. It is also clear that our society is changing dramatically, with large social and economic dislocations still to come. Disparities in wealth and power continue to increase. Efforts to achieve health equity are going to have to address these disparities and the diseases and despair they generate- “despairity”. This is precisely the moment when a fusion of psychiatry and public health/population health is most called for. This presentation will outline ideas about this fusion. It will describe the links between health equity and psychiatry. It will underline the circumstances people are living in and the dislocations, past, present and future, they face. It will detail the diseases of despair from a psychiatric perspective and ask what psychiatry can do to help implement the antidotes to despair- hope, inclusion and reliance. The final half hour will focus on creating an agenda for a public health psychiatry committed to achieving health equity.

### **Treatment in Transition: The Rapidly Evolving Landscape of Transgender Care**

Chair: *Matthew Lee Dominguez, M.D., M.P.H.*  
Presenters: *Angela Devi Shrestha, M.D., Amir K. Ahuja, M.D.*  
Discussant: *Kenneth Bryan Ashley, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Explain the complexities of sexual identity and the importance of a psychosexual health survey; 2) Describe minority stress and its role in the health disparities of transgender populations; 3) Review the history and evolution of transgender medicine and mental health care; 4) Understand the current standards of care in the treatment of gender dysphoria; and 5) Discuss challenges to treatment from hormone side effects, to insurance issues, capacity evaluations, medication, and therapy.

#### **SUMMARY:**

Despite the increasing visibility of transgender (TG) and gender non-binary (GNB) populations and the promotion of cultural competence as a core skill for

mental health providers, few clinicians are given opportunities to work with these communities during their training. This deficit in education leaves providers unprepared to deliver culturally appropriate treatment to TG-GNB patients and prevents them from meeting the standards of care for those struggling with gender dysphoria. For decades it has been observed that TG-GNB populations are at increased risk of trauma exposure, substance abuse, and suicidal behaviors, with lack of access to appropriate health care services only increasing these disparities. In addition to experiencing social prejudice in regards to sexual orientation and gender identity, TG-GNB populations face obstacles when attempting to obtain not only gender affirming services but also basic preventive health care. In order to address these issues, we will review the checkered history of transgender medicine and mental health care, with emphasis on the evolution of sexual identity theory. We will then utilize modern tools for exploring these identities with patients during evaluation and treatment. We will review minority stress theory in order to enhance our understanding of the development of mental illness and health risk behaviors, with focus on the risk of diminishing health care utilization when TG-GNB populations are met with microaggressions in the very systems they turn to for help. We will examine how these systems may be improved upon by reviewing the groundbreaking work of gender clinics across the country, as well as, introducing the nation’s first Transgender Psychiatry Fellowship Program. Finally, through case examples, we consider a wide array of challenges faced by both providers and patients when navigating the system of TG-GNB health care.

Friday, October 05, 2018

### **Black Mental Health in the 21st Century**

Chair: *Altha J. Stewart, M.D.*  
Presenters: *Donna Marie Norris, M.D., Billy Emanuel Jones, M.D., Carl Compton Bell, M.D., Helena B. Hansen, M.D., Ph.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in the community; 2) Demonstrate

and apply new skills that will be useful in public psychiatry settings; 3) Examine how the current health care system affects patient care; 4) Describe how to transform systems of care; and 5) Recognize how to bring new innovations into a variety of treatments to improve patient care.

#### SUMMARY:

Over the past decade, commentary in American culture, sparked by the election of Barack Obama to the presidency, has considered the possibility of a postracial American society. Intellectuals of all persuasions have suggested that the old black-white dichotomy is now old news, but is this pervasive sense of progress and contentment widespread among blacks? Racism and racial segregation have left their mark on the mental health care of black patients in the United States, even as the civil rights movement of the 1960s and 1970s produced its own effects on the rights of black patients and on the futures of black mental health care professionals: increased attention to the disparities in outcomes of mental health care between blacks and other groups, the significantly improved climate in which health care research is carried out with black populations, and the enhanced access of black professionals to a broad spectrum of training and practice facilities throughout the country, including the APA, where the first black president took office in May 2018. It is time to reflect on black individuals' needs in mental health care, as well as the efforts of black psychiatrists and other mental health professionals whose training and clinical, research, and teaching activities are relevant to providing care for blacks and other nondominant groups. This symposium takes a comprehensive and candid look at mental health for black Americans relating to patient care, training, and research in the current cultural context. The presenters will provide personal narratives of their past experiences and their expectations of what the future may hold for the care of the black community. The session will explore different aspects of patient care—the unique challenges of delivering mental health care to the black population—and offer creative ways of addressing these challenges. It has taken a long time for a black psychiatrist to become president of the APA. We look now to the future of black

professionals and the mental health care of black Americans.

#### **Immigration and Mental Health**

Chair: *Falisha Marie Gilman, M.D.*

Presenters: *Andres Barkil-Oteo, M.D., M.Sc., Michelle Silva, Psy.D., Marco Ramos, Kashif Ahmed*

Discussant: *Esperanza Diaz, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how the experience of immigration impacts mental health at individual, community, and population levels; 2) Implement interventions directed at the psychosocial, cultural, and political factors that contribute to immigrants' mental health; and 3) Advocate as a mental health provider for the well-being of immigrant communities and know strategies for educating the public about the stress of the immigrant experience in the U.S.

#### SUMMARY:

According to 2016 U.S. Census Bureau data, 13.5% of the US population is foreign born, nearly half of whom are non-U.S. citizens. These numbers have been increasing for decades, but so has the diversity of those who are relocating to the U.S. This has impacts on psychiatric practice and psychiatrists are finding themselves treating immigrant patients, often without any formal training. Furthermore, research is beginning to demonstrate how the current political climate is causing additional emotional and psychological stress on an already vulnerable population. While there is a wide range of rates and presentations of mental illness in this population, the core to providing quality patient care is understanding the social and cultural factors that shape patients' experiences and implementing these into formulations and treatment plans. In this session, clinicians will share their experiences working with immigrant and refugee populations, focusing on individual, community level, and educational interventions. Special focus will be given to systems of care developed within a community mental health center, including integrated care, culturally sensitive and linguistically appropriate care, and collaboration with community organizations to leverage limited resources.

## **People With Mental Illness in the Criminal Justice**

### **System: Answering a Cry for Help**

Chair: *Kenneth Minkoff, M.D.*

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

#### **EDUCATIONAL OBJECTIVES:**

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

#### **SUMMARY:**

Justice involvement of people with mental illness, often with co-occurring substance use disorders, has reached critical levels. Hundreds of thousands of people with serious mental illness are incarcerated, and many more are under community correctional supervision. An APA publication from the group for the advancement of psychiatry (gap) committee on psychiatry and the community serves as the foundation for this symposium. The symposium begins with a brief context of the problem of justice involvement for individuals with mental illness. The focus of the symposium however is not just to describe the problem, but, using the results of the gap publication, to provide specific examples of how participants can take action, in their own practices, programs, and local systems, within available resources. The foundation of the gap report was soliciting letters from Dear Abby's column describing stories of individuals and families with behavioral health conditions who had been incarcerated. The committee received over 3000 letters. These letters not only are used to engage the listener in the experiences of "real people", they were used by the committee as "case examples" for illustrating innovative practice and program approaches for improving services to prevent or reduce incarceration. In line with the report, the symposium

will organize the discussion according to the sequential intercept model, developed by dr. Mark Munetz, one of the committee members. At each intercept point, there are illustrations for how to respond to the scenarios in the letters, with recommendations for action steps that lead to changes in clinical practice, program policy, and local system collaboration, that can be undertaken by psychiatrists, program leaders, and other practitioners, working at any level. After introducing the letters and describing the sequential intercept model, each presenter in the symposium will focus on a particular intercept, using specific examples. The intercepts include: provision of proactive and welcoming crisis response to prevent arrest; partnering with law enforcement and court personnel after arrest; collaborating with judges around sentencing and therapeutic justice; partnership between community systems and jail-based services; and partnership with community corrections to provide integrated interventions to address co-occurring disorders and criminogenic risk. Each of these areas will provide an opportunity to involve participants in thinking and talking about what they might be able to change in their own settings. Finally, our discussant will engage participants in thinking about opportunities to influence systems change on the state and national level through describing the stepping up initiative. Our discussant will raise further questions and set the stage for active audience engagement on this clinically, politically, and ethically challenging topic.

Saturday, October 06, 2018

### **Addressing Social Determinants and Health Disparities Using Technology**

Chair: *John Torous, M.D.*

Presenters: *Dominika A. Winiarski, Ph.D., Liza Hoffman, L.I.C.S.W., M.S.W., Kunmi Sobowale, M.D., David Mohr, Ph.D., Niranjan S. Karnik, M.D., Ph.D., Keris Jän Myrick, M.B.A., M.S.*

Discussant: *Anita Everett, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

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



reduce health disparities through increasing uptake and adherence to mental health technology; 3) Identify the barriers, risk, and benefits to patients in using new technologies for clinical care; 4) Understand global mental health efforts around technology use to bring care to underserved population; and 5) Assess the potential and readiness of your practice for using technology to reduce health disparities.

#### SUMMARY:

The increasing ownership and access to technology, especially in the form of smartphones, offers a new tool for psychiatry to increase access to care and bring services to those unable to access them today. But translating the potential of technology to health disparity populations including those with psychotic disorders, those who are homeless, those not able to access psychiatric care, and those living in low income countries requires looking beyond smartphones or apps and focusing on the needs of health disparity populations. This session will focus on bridging technology with social determinants and health disparities through bringing together a diverse panel of experts with focuses on how understanding people, design, and implementation can unleash to ability of technology to advance psychiatric care of all.

#### **I See You: Dismantling Stigma in Communities of Color**

Chair: *Glenda L. Wrenn, M.D.*

Presenters: *Darin Latimore, M.D., Ruth S. Shim, M.D., M.P.H., Rhonda Matlock Mattox, M.D., Lucy Ogbu-Nwobodo, M.D., M.S.*

#### EDUCATIONAL OBJECTIVES:

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

#### SUMMARY:

Stigma is a social injustice sustained within society. Communities of color face multiple sources of

stigma, including self-stigma perpetuated by internalization of racism and prejudice. Introduce mental health stigma, and it is not surprising that help-seeking for mental health in communities of color can be perceived as dangerous and ill-advised. How can communities of color trust systems and structures that have a history of dignity violations? This session will discuss perspectives on strategies to dismantle stigma among communities of color. We will share evidence-based approaches to fostering resilience and culturally-centered care. Participants will be invited to share their experiences and learn new ways to promote a society where all people feel welcomed and safe when they need mental health treatment. We will challenge participants to move beyond cultural competence to aspire to demonstrate cultural humility to effectively communicates "I see you", despite any real or perceived differences in race or culture.

#### **Toxicology 450 or How I Learned to Stop Worrying and Manage Psychotropic Toxicities**

Chair: *Deepak Alapati, M.B.B.S., M.P.H.*

Presenters: *Joseph J. Rasimas, M.D., Travis D. Olives, M.D., M.Ed., M.P.H.*

Discussant: *Cynthia Di Giandomenico, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the toxicological effects and adverse drug reactions associated with psychotropic medications ; 2) Understand the importance of psychiatric care in the management of the patient with poisoning or adverse drug reactions associated with a psychotropic drug; 3) Identify the pathophysiology of defined toxidromes and differentiate between them; 4) Understand the toxicities, diagnosis, and management of bupropion, benzodiazepines, propranolol, high-dose ketamine and atypical antipsychotics ; and 5) Incorporate knowledge of pharmacokinetics and toxicokinetics into psychiatric prescribing practices.

#### SUMMARY:

Poisoning is a major cause of mortality and morbidity in the US. Unintentional poisoning is the seventh leading cause of nonfatal injuries, while intentional poisoning is the third most common suicide method. Psychotropic medications are not

only commonly implicated in poisonings but are also among the commonest causes of poison-related fatalities. Psychiatrists, in addition to toxicologists, play a major role in the management of patients experiencing psychotropic drug toxicities or adverse drug reactions (ADRs) during hospitalizations. The Minnesota Poison Control System (MPCS), at Hennepin County Medical Center (HCMC), which serves 5.5 million people in Minnesota, North Dakota and South Dakota has a staff of pharmacists well-trained in toxicology, which has enabled them to guide advanced management of patients requiring toxicological treatment. Between 2013 and 2017, MPCS received 7,615 calls regarding atypical antipsychotics (APs); 12,147 cases involved benzodiazepines (BZDs); 4,347 calls were received about beta-adrenergic antagonists; bupropion accounted for 2,754 calls. Moreover, the emergency department at HCMC has contributed to the medical community's understanding of the management of agitated patients with high-dose ketamine, including direct comparisons with more traditional sedatives. Due to the predominance of these medications in the psychiatrist's armamentarium and the expanding indications for their use, this symposium will address the toxicities and ADRs associated with bupropion, propranolol, BZDs, APs and high-dose ketamine. The toxicities of these drugs may manifest as a defined toxidrome, such as the anticholinergic, sympathomimetic, or sedative-hypnotic toxidrome, due to specific receptor-binding properties. More ill-defined consequences associated with these drugs may occur due to life-threatening drug-drug interactions (Eg: BZDs with opiates). These drugs also possess unique molecular mechanisms which may give rise to drug and class-related side effects (seizures with bupropion; dissociation with ketamine; EKG changes with APs). Some overdoses require specific antidotes for optimal treatment (flumazenil and physostigmine), while grave poisonings may require advanced management techniques (high dose insulin or Intralipid therapy for propranolol overdoses). There is often intense debate surrounding the use of these drugs in clinical practice, their toxic potential, and the management of their toxicities. Yet continued research will allay some of this controversy, and provide evidence for the most beneficial ways to utilize them. By highlighting the clinical experience and ongoing

research at HCMC, in the context of these medications, we will strengthen proficiency in the management of their toxic effects and ADRs. Ultimately, these model scenarios and the principles gleaned from them will assist psychiatrists in understanding and contributing to toxicologic care in a variety of clinical settings.

**Trauma-Informed Care of the Transgender Patient:  
A Primer for Community Psychiatrists**

Chairs: *Karl Goodkin, M.D., Ph.D., Ludmila B. De Faria, M.D.*

Presenters: *Karl Goodkin, M.D., Ph.D., Ludmila B. De Faria, M.D., Daena L. Petersen, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Learn about the challenges transgender population faces when seeking mental health care during transition; 2) Develop awareness of the mental health needs of transgender population, including comorbid conditions; 3) Recognize the risk of clinician bias complicating mental health care for the transgender population; and 4) Learn and demonstrate culturally sensitive tools to provide trauma-informed care to transgender patients through role-playing.

**SUMMARY:**

A 2010 study of over 7,000 transgender persons, The National Transgender Discrimination Survey Report on Health and Health Care, reported that greater than 50% of medical providers have inadequate understanding of the health needs of their transgender patients and 28% of transgender patients avoid healthcare due to provider related bias issues. Transgender patients experience multiple cumulative life stressors, including homelessness, unemployment, increased substance and alcohol use, higher risk of homicide, high rates of suicide, and HIV. The lack of provider competence combined with increased physical and mental health stressors within the transgender patient population results in significant health disparities and minority stress. This symposium aims to build clinical skills and competence in providers attending these sessions to facilitate the delivery of culturally sensitive care and to decrease rates of transgender patient care avoidance stemming from overt

traumatic events as well as internalized transphobia. Participants will increase awareness about mental health needs of the transgender population, including comorbid conditions; and will learn to recognize how clinician bias complicates care for this vulnerable population. Participants will also learn and demonstrate culturally sensitive skills and use new tools to provide trauma-informed care to transgender patients through experiential training, including role-playing, vignettes, and case examples. Presentations reviewing the current literature will be conducted in a lecture format, including information on demographic data of transgender population; unique mental and physical health disparities; current challenges, including legislative and policy issues that continue to perpetuate traumatic experiences; and a review of trauma-informed care. Presenters will help participants understand micro and at times macroaggressions that transgender patients face when seeking health care. Presenters will offer feedback, explore resources and provide cultural competency training. The audience attending this session will have an opportunity to develop awareness of mental health needs of the transgender population; reflect on their own attitudes and identify biases toward transgender patients and recognize how that may affect care provided; and practice skills to provide trauma-informed care to transgender patients. In summary, community psychiatrists often encounter transgender patients in their practices and may feel ill-equipped to address their needs. They often have to advocate on behalf of their patients with patients' families, other health care providers (general practitioners, endocrinologists, surgeons), government agencies (Department of Motor Vehicles) and even workplace and schools. As such, they should be familiar with available resources, standards of care and culturally sensitive, effective care. This symposium aims to provide them with tools to achieve that goal.

**Utilizing Collaborative Data-Sharing to Understand How Psychiatric Diagnoses Predict Emergency Department Use, Inpatient Admissions, and Cost of Care**

Chair: *Brian Don*

Presenter: *Jeffrey C. Eisen, M.D., M.B.A.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the value of collaborating with partner agencies in sharing data; 2) Expand upon existing connections to improve understanding of client populations; and 3) Apply data-driven principles to improve quality of care.

**SUMMARY:**

Community mental health organizations face a variety of challenges in ensuring that their clients receive high quality care at low costs. One persistent problem is that individuals with psychiatric challenges utilize the emergency department and are admitted to the hospital at significantly higher rates than the rest of the population, which inflates the cost of care for these individuals, and does little to improve their physical health or quality of life. In this symposium, we describe an effort to reduce ED utilization, inpatient admissions, and the overall cost of care via an innovative data sharing initiative between the largest coordinated care organization and community mental health provider in the Portland, Oregon metropolitan area. First, we will describe how data tends to be isolated across different organizations, such that a community mental health provider or coordinate care organization may not be able to effectively understand the challenges facing the individuals they serve using their own electronic health record or payer data. Next, we will provide an overview of how HealthShare of Oregon and Cascadia Behavioral Healthcare established data-sharing agreements in order to identify the areas of concern within their shared client populations. Finally, we will provide a thorough overview of predictive statistical models used to examine how psychiatric diagnoses contribute to ED utilization, inpatient admissions, and overall cost of care at the population level, as well as how these analyses were used to direct programming to address insights identified therein.

**Why Psychiatry Is Essential to Suicide Prevention in Health Care Systems**

Chair: *Michael Hall Allen, M.D.*

Presenters: *Michael Hogan, Ph.D., Michael Schoenbaum, Richard McKeon, Ph.D., M.P.H., Anna Ratzliff, M.D., Ph.D., Jean Scallon, M.A.*

Discussants: *Jane Pearson, Julie Goldstein Grumet*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe psychiatrists' key roles in the organization and delivery of effective suicide prevention in health systems; 2) Understand how collaborative care can be a foundation for psychiatrists to extend their expertise to integrated, 'suicide safe' care; 3) Identify tools in electronic health records being used to support the "Zero Suicide" framework; and 4) Implement work flows that efficiently support 'suicide safe' care.

#### SUMMARY:

Suicide has many contributors including disparities in health care access and other inequities. Most people who die by suicide never reach the mental health system but the vast majority have other contacts with the health system within a year of their death and over 20% within a month of an ED visit. This has led to calls for expanded risk detection and intervention in health care settings. Psychiatrists should play major roles in the understanding of risk and the organization and delivery of care as more suicidal individuals are identified. Learning healthcare systems link suicidal behavior to care processes and service use patterns, consider improvements that can be tested and measure the impact on suicidal behavior outcomes. Reports from behavioral health systems in the US and the UK indicate that if multiple improvements are implemented, suicide rates among patients accessing those systems are reduced. Evidence based improvements include consistent screening, lethal means counseling, crisis access, continuity of care, outreach and coordination with the justice system. The Zero Suicide (ZS) initiative, led by the National Action Alliance for Suicide Prevention, is a commitment to preventing suicide attempts and deaths among individuals receiving treatment within health care systems. ZS seeks to improve the systems' ability to identify who is at risk and implement effective services for at-risk individuals. While effective interventions that reduce re-attempts have existed for some time, these innovations have had limited uptake in the US. Systems change has been slow. However, as risk algorithms built into EHRs and other innovations diffuse, demand for effective suicide prevention

practices to help elevated risk patients will increase. This symposium will address current national and international ZS implementation efforts. ZS resources, specifically the Zero Suicide Academy and Tool Kit, will be described. ZS is built on assumptions that improvements take place within a learning health care system. Approaches to track quality improvement efforts such as screening tools, clinical work flows, delivery of effective interventions, and measurable outcomes (suicide attempts and deaths) will be presented. Federal efforts to establish the empirical bases for ZS have included grants funded by NIMH and SAMHSA. Brief overviews of these studies and their approaches will be described. States and private health care organizations have also aspired to Zero Suicide goals, and examples of those efforts, and lessons learned will be presented. The collaborative care model can serve as a foundation for building ZS work flows, patient centered care, and provider team training. Discussion will focus on ways in which psychiatrists can lead successful implementation of suicide prevention efforts in systems of care. Audience response will be used to gauge attendees level of engagement in suicide prevention, attitude toward changes and ability to impact systems.

#### **Workforce Inclusion: Roadblocks and Relevance of Black Men in Psychiatry**

Chairs: *Carl Compton Bell, M.D., Rahn K. Bailey, M.D.*  
Presenters: *H. Steven M. Starks, M.D., Phillip Michael Murray, M.D., Francois Williams, Emanuel Demissie, Norman Harris, Kevin Mauclair Simon, M.D., Vabren L. Watts, Ph.D., Altha J. Stewart, M.D., Ranna I. Parekh, M.D., M.P.H.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Highlight the impact of increased workforce diversity on patient care and mental health disparities; 2) Examine barriers for recruiting Black men into psychiatry; 3) Offer strategies for recruiting and sustaining men in the field of psychiatry; and 4) Provide insight of unique experiences for Black men navigating through the psychiatric workforce.

#### SUMMARY:

Research shows that increased diversity within a physician workforce is an effective strategy for addressing health disparities—associated with more minority and underserved patients having access to culturally sensitive health care. According to the Association of American Medical Colleges (AAMC), Black men currently make up 2.6% of the nation’s psychiatric workforce compared with 36% for white men. From 1978 to 2014 the number of Black males matriculating into US medical school decreased 5%, making Black males an at-risk population for not entering the medical profession. This symposium will examine barriers for recruiting Black men into the medical profession, particularly psychiatry. The symposium will address the social and academic support systems needed to recruit and sustain Black men in psychiatry; while highlighting current APA programming designed to address the shortage of Black men in the profession. In unpacking APA’s fourth strategic initiative: “Supporting and increasing diversity within APA,” this session will draw on the experiences and insight of Black men who have and are currently navigating through the psychiatric workforce. The format will encompass role playing, lecture, and other interactive strategies to facilitate the development of practical solutions.

Sunday, October 07, 2018

### **Alternatives to Incarceration for Individuals With Serious Mental Illness: Opportunities and Challenges**

Chair: *Miriam C. Tepper, M.D.*

Presenters: *Sarah Yvonne Vinson, M.D., Carolyn Gaebler, Madelon Baranoski, Ph.D., Christine E. Montross, M.D., Louis James Kraus, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe key historical and policy trends resulting in criminalization of the mentally ill, and the health risks associated with incarceration; 2) Describe the sequential intercept model for diverting offenders with mental illness out of the justice system and into community-based treatment; 3) Identify the ways in which the inequities in the criminal justice system are related to health disparities faced by communities of color; 4) Understand what steps can be taken in the

juvenile justice system to improve outcomes for youth with mental illness; and 5) Understand how jail diversion works and for whom it can be helpful.

#### **SUMMARY:**

People with serious mental illness are at high risk for involvement in the criminal justice system. One analysis of public mental health service recipients found that nearly a third had been arrested over a ten year period, and among transitional aged youth, one half had been arrested (Fisher et al). Estimates of the prevalence of mental illness among prison and jail populations vary, but people with serious mental illness (SMI), trauma, and substance use disorders are consistently found to be overrepresented in jail and prison populations, with rates of SMI estimated to be as high as 14% (Prins et al). Many of these individuals have iterative contact with both the criminal justice and the public mental health systems. Individuals who cycle through these two internally fragmented systems carry not only the disproportionate health risks associated with SMI, but also the health risks associated with incarceration. They also ultimately bear the risks associated with the often fragmented care which occurs at transition points between and within these systems. These compounding layers of health inequity call for action at all possible points of intervention. To this end, a range of approaches have been undertaken to improve outcomes for justice-involved individuals with SMI, such as training of law enforcement officers, offering crisis evaluation services, pre-trial diversion, mental health courts, jail-based treatment, and re-entry supports. However, these approaches are not universally available, and there is a critical role for the mental health community in supporting the development of these services in a more comprehensive manner. People of color are also disproportionately represented in US jails and prisons, and racial/ethnic minority populations are known to face wide ranging health disparities. The potential impact of mass incarceration is felt not only by incarcerated individuals, but also by families and communities left behind by those who are imprisoned. Community mental health professionals are ideally situated to support treatment, professional education/activism, and legislative advocacy around the impact of mass incarceration

on communities of color. In this workshop, we will first review historical and policy trends resulting in criminalization of the mentally ill, as well as highlight the multiple health risks associated with incarceration. We will discuss the impact of mass incarceration on minority populations, and the impact this has had on communities of color. We will then discuss several interventions designed to divert offenders with mental illness out of the justice system and into community-based treatment. We will highlight work being done in the juvenile justice system and in jail diversion. Amidst the numerous improvement opportunities in both the mental health and criminal justice systems, we will highlight areas where mental health professionals might be able to have the greatest impact.

**The Impact of Environmental Toxicants on Neurodevelopment and Behavior: From Awareness Toward Prevention and Greater Health Equity**

Chairs: *James Lee Fleming, M.D., Ludmila B. De Faria, M.D.*

Presenters: *Irva Hertz-Picciotto, Ph.D., Frederica Perera, D.P.H., Ph.D., Mark Mitchell, M.D., M.P.H., Aly Cohen, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the importance of moving from a peripheral to a leadership role for psychiatry in addressing threat to neurodevelopment and behavior from environmental toxicants; 2) Appreciate the pervasiveness of exposure to toxicants, the critical developmental stages of toxic vulnerability as well as the proven cost-benefit impact of prevention vs exposure; 3) Identify factors making minority and poor communities more susceptible to the adverse impact of environmental toxins including proximity to pollution sources and limited resources for intervention; and 4) Identify factors making minority and poor communities more susceptible to the adverse impact of environmental toxicants including proximity to pollution sources and limited resources for intervention.

**SUMMARY:**

This program aims to educate psychiatrists about the growing body of evidence connecting environmental

toxicants with neuro-developmental and other psychiatric problems. While most psychiatrists are aware of the neurotoxic effects of lead and mercury, there is little awareness of the similar effects of numerous other chemicals from a wide range of sources including pesticides, household products, cosmetics and combustion related air pollutants. In contrast to other medical organizations, organized psychiatry (including the APA and AACP) has not issued policy statements or guidelines on either health effects or preventive strategies in relation to toxic chemical exposure. Organizations which have taken these actions include the American Medical Association, the American College of Obstetrics and Gynecology, the National Medical Association, the American Nurses Association and the American Academy of Pediatrics (the latter has also endorsed guidelines on the prevention of prenatal and childhood exposure to known toxins). The APA Assembly passed an Action Paper on this issue in May 2015 with the primary focus being to educate psychiatrists. Unfortunately, a formal education plan has not yet materialized and this symposium would be the first concrete implementation of this action. This program also aims to re-imagine psychiatry in a leadership role in the following key areas in relation to the neuropsychiatric effects of toxicants: clinical recognition of exposure risks, prevention strategies and creation of greater environmental health equity in poor and minority communities. The latter objective will be facilitated by a review of key literature demonstrating a disproportionately high degree of exposure to environmental pollutants in these communities due to factors such as proximity to freeways and siting of industrial plants and waste facilities in these communities. Other factors contributing to health inequity will be reviewed such as socioeconomic stress, insufficient advocacy in government and changing priorities of the current regulatory environment. Specific chemical classes with the greatest evidence for neuro-developmental and behavioral toxicity will be presented including polycyclic aromatic hydrocarbons (PAHs) and organophosphate (OP) pesticides such as chlorpyrifos, which the EPA Administrator recently decided to not ban despite the EPA's own risk assessments indicating well documented neurotoxicity. Other key aspects of toxicant exposure risk will be discussed including genetic and

epigenetic vulnerabilities, critical developmental stages at which greater vulnerability exists as well as the significant, proven cost-benefit impact of prevention efforts. Finally, practical tools and resources will be made available which can allow clinicians to better educate patients and the public about preventive, exposure-reduction measures to protect neurodevelopment of the growing fetus and in the mental health of the general population.

#### Workshops

Thursday, October 04, 2018

#### **Advocacy Skills for Psychiatrists: From Getting Started to Taking It to the Next Level**

Chair: *Michaela Y. Beder, M.D.*

Presenters: *Flavio Casoy, M.D., Marc W. Manseau, M.D., M.P.H., Karen M. Rice, M.D., Carissa Caban-Aleman, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of micro, meso, and macro approaches to addressing social determinants of health; 2) Gain practical skills in a diversity of advocacy approaches; and 3) Discuss challenges in balancing the roles of clinician and advocate.

#### SUMMARY:

We live in challenging times: economic inequality is increasing both locally and globally. Governing systems are increasingly unstable, with the entrenchment of deep divisions within populations and the rise of extremist political parties. The social fabric is frayed, as we witness both decreasing confidence in democratic institutions and as the shadow of thermonuclear war again falls over the world. These international and societal dynamics correlate with health effects, from illnesses related to wars, climate disasters, and refugee crises, to rising drug addiction and suicide rates in economically marginalized areas, to a general decrease in longevity in the United States. There is an urgent need to counter such difficult trends with renewed engagement for social justice, human rights, and health equity. Physicians in general, and psychiatrists, in particular, are uniquely equipped to

meet this critical need for advocacy. As physicians and mental health professionals, we bring a valuable perspective to social justice issues within both individual clinical encounters and society at large. We work with some of the most marginalized people, and see daily the impact that poverty, racism, homelessness, insecure immigration status, and lack of access to healthcare can have on wellbeing. Building on a well-received workshop at the 2017 Institute for Psychiatric Services in New Orleans, we hope to focus this workshop on helping participants new to advocacy learn how to start and to help veterans deepen their impact. After providing a general overview of how to impact the social determinants of health (SDH) at the micro-level and how to best engage politically and in our communities at the meso- and macro-levels, we will showcase different advocacy skills through examples of the work of particular psychiatrists in the response to the disaster in Puerto Rico, in the hope to end gun violence, for refugee justice, and in the labor movement. We will address how to balance work responsibility and day-to-day life with increased participation in advocacy, specific skill sets from lobbying to writing to teaching. We also plan to elicit examples and stories from members of the audience and foster new connections among IPS attendees interested and motivated to engage in advocacy.

#### **Borderline Personality Disorder: Best Practices to Optimize Care in Diverse Treatment Settings**

Chair: *Victor Hong, M.D.*

Presenters: *Brian A. Palmer, M.D., M.P.H., Daniel Price, M.D.*

Discussant: *John Gunder Gunderson, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn innovative methods in managing BPD in the inpatient setting; 2) Gain knowledge in how to avoid common pitfalls when treating BPD patients in the emergency department; 3) Review ways to optimize recognition and treatment of college and university students with BPD; and 4) Understand the challenges and opportunities in assisting primary care colleagues with management of BPD patients.

#### SUMMARY:

Individuals with borderline personality disorder (BPD) are high utilizers of health care resources in all settings, representing a significant public health burden. Due to stigma and lack of adequately trained providers, treatment for these individuals remains inconsistent and can cause iatrogenic harm. The presenters will discuss the myriad challenges and opportunities in distinct treatment settings, focusing on giving BPD patients what they deserve—consistent, evidence based, and informed care, no matter where they are seen. Good Psychiatric Management (GPM) is proposed as an ideal framework and pathway towards this goal. The inpatient unit can be an effective setting in which to engage in crisis management, but mismanagement can lead to high risk situations and disruption of the milieu. GPM principles are well-suited to guide inpatient care, given the emphasis on diagnostic disclosure, communication with outpatient providers, psychoeducation, involvement of families, and measured psychopharmacological management. A particularly challenging setting in which to manage BPD patients is the emergency room, where they present frequently and recurrently. Mismanagement of BPD patients in this setting can lead to inappropriate hospitalizations, inadequate safety assessments, and overuse of medications. GPM's practical and specific guidelines offer the organized, measured approach necessary to avoid pitfalls. Its emphasis on interpersonal hypersensitivity, maintaining an active and authentic approach, and measured process for managing safety issues are of particular benefit in this setting. BPD patients present often in primary care settings and require significant resources due to high rates of medical and psychiatric comorbidity. Polypharmacy is common, as is inappropriate management of suicidality and self-harm. GPM offers primary care providers guidance regarding management of difficult patient-provider interactions, appropriate pharmacological treatment, and prioritization of chief complaints, all important components of a successful treatment. The recognition and treatment of BPD on college campuses remains limited, with very few schools providing specific psychoeducation, training for their mental health providers, or empirically-validated treatments for students with the disorder. A structured approach is needed to

dispel myths, combat stigma, and appropriately treat these students. Because GPM training is designed as an entry-level approach, it may fit particularly well in the campus counseling center milieu, where staff may have a variety of training backgrounds. In addition, GPM's flexibility may fit with students' varying vacation schedules and campus clinicians' part-time availability. Finally, GPM is an inherently useful risk management tool, allowing campus clinicians and administrators more confidence in managing complex clinical situations.

#### **Combining Jail Diversion With Permanent Supportive Housing: Innovations in Los Angeles**

Chair: *Kristen Ochoa, M.D., M.P.H.*

Presenters: *Elizabeth Kim, J.D., L.C.S.W., Sonya Shadravan, M.D., Nichole I. Goodsmith, M.D., Ph.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the mechanisms by which individuals with serious mental illness, substance use disorders, and homelessness interface with the legal system; 2) Understand the concept and role of jail diversion, including existing models with various points of interception, used nationwide; 3) Explain the concept of competency to stand trial and its relationship to legal and mental health outcomes; 4) Discuss an innovative Los Angeles County program combining jail diversion with interim supportive housing, case management, and supportive services; and 5) Explore program outcomes to date, as well as challenges, obstacles, and current quality improvement endeavors.

#### SUMMARY:

The correctional system is well-known to be the largest provider of mental health services in the United States. Los Angeles county jails, in particular, house the largest number of acutely psychiatrically ill individuals in the nation. Over the past decade, various measures have been developed nationally that aim to minimize incarceration for these individuals, in favor of routing them into mental health services. Such programs fall under the umbrella term of "jail diversion" and can occur at various stages, both before and after arrest. In this workshop, we will provide a brief introduction to the burden of mental disorders in the correctional



system and to the concept of jail diversion. We will highlight the experience of the Los Angeles County Office of Diversion and Reentry (ODR), newly formed in 2015. Speakers include the program's Medical Director and Assistant Clinical Director, who will discuss the scale and scope of their office's work, their stakeholders and mechanisms for interdisciplinary collaboration, and unique challenges. We will emphasize the role of permanent supportive housing, intensive case management and specialized probation, as well as share a special focus on felony pre-trial diversion for persons with serious mental disorders and innovative diversion programs, both misdemeanor and felony, for those found incompetent to stand trial who are released from jail and restored in the community. We will also share our innovative funding and contracting mechanisms which allow services and housing to come on-line quickly to meet the demand. As of the writing of this abstract (May, 2018), the LA County Office of Diversion and Reentry has diverted and released 2,200 persons with serious mental disorders and/or severe substance use disorders from the LA County jails. Participants in this workshop will have an opportunity to share their own experiences with justice-involved patients and various forms of diversion programs, and to explore opportunities for further development of such programs in their local cities and states.

**Fostering Resilience and Addressing Social Determinants: A Pilot Model of Post-Disaster Interventions in Puerto Rico**

Chair: *Vanessa Torres Llenza, M.D.*

Presenters: *Carissa Caban-Aleman, M.D., Dimas Javier Tirado-Morales, M.D., Hector Colon-Rivera, M.D., Alan Tomas Rodriguez Penney, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Provide resilience principles and how they can be applied to disaster-relief response efforts; 2) Identify the most common post-disaster effects on the mental health of vulnerable populations; 3) Demonstrate how to utilize psychological first-aid and mindfulness principles to instill hope in communities recovering from disasters; 4) Understand stress and resilience as bio-psycho-social-spiritual processes; and 5) Define the

most significant social determinants of mental health that shaped the implementation of these interventions for the communities that were assisted.

**SUMMARY:**

On September 20, 2017, hurricane Maria passed through Puerto Rico shortly after the island was affected by hurricane Irma. Since then, the island has been put to the test. Many families lost their homes, their jobs, their businesses, their healthcare, and all sense of normalcy in their lives. Puerto Rico faces significant barriers to its recovery, due to the complexity of its current sociopolitical status and an ongoing fiscal crisis that limits the island's access to resources and its power to demand action. Community leaders and non-profit organizations were at the forefront and quickly stepped up to the task of rebuilding Puerto Rico. Many disaster survivors and community leaders have endured significant trauma and were physically and mentally affected. They continue to be at risk of burnout. Fostering the natural ability of individuals to successfully cope with and use climate change-enhanced adversities as transformational catalysts is significantly influenced by their social surroundings and emotional supports. The presenters of this workshop have collaborated with various local organizations as members of CrearConSalud, Inc, a non-profit organization created by Puerto Rican psychiatrists invested in mental health education efforts in the island. In the response efforts coordinated by this group, the main goal has been building a culture of resilience and self-sustainability within communities and their leaders that capacitates them to feel empowered as a means to combat hopelessness and burnout. This workshop will provide an outline of the most prevalent post disaster effects on the mental health of Puerto Ricans and how these have been shaped by significant social determinants before and after the hurricanes. This workshop aims to describe how the principles of psychological first-aid, mindfulness and transformational resilience have been used to design and implement a series of direct educational and supportive interventions to teach self-care skills, instill hope, promote wellness, and empower several Puerto Rican communities that were disproportionately impacted by these climate-

enhanced natural disasters. To conclude, speakers will elaborate on the importance of community engagement and empowerment to promote a resilience-enhancing social system of recovery.

### **Hematologic Side Effects and Benign Ethnic Neutropenia With Clozapine**

Chair: *Deanna Kelly, Pharm.D.*

Presenters: *Gopal Vyas, D.O., Deanna Kelly, Pharm.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the prevalence of neutropenia associated with clozapine and how it might compare to other antipsychotics; 2) Describe the characterization of Benign Ethnic Neutropenia and its role in the treatment and monitoring of clozapine; and 3) Examine other hematologic issues encountered with clozapine treatment and discuss treatment options and controversies.

#### **SUMMARY:**

Clozapine is the most effective antipsychotic for treatment-refractory schizophrenia. Despite overwhelming evidence of its superior efficacy across a multitude of clinical problems affecting individuals with schizophrenia spectrum illnesses, clozapine is underutilized globally and in the US in particular. One of the most significant and limiting barriers to its increased implementation are hematologic risks and the consequent FDA-mandated blood monitoring. The risk of neutropenia and resultant blood monitoring, particularly for severe neutropenia (< 500 cells/mm<sup>3</sup>) is one of the most frequently cited reasons for not prescribing clozapine. This symposium will present recent epidemiologic data and discuss the prevalence and severity of neutropenia and neutropenia-related mortality globally. We will also present data on clozapine's use in Benign Ethnic Neutropenia and the role of race and genetics in understanding modified guidelines for neutropenia monitoring. Lastly, the symposium will cover other hematologic issues associated with clozapine treatment such as eosinophilia and thrombocytopenia. The symposium will conclude with active case presentations on hematologic issues with clozapine treatment and

allow for discussion of treatment options, recommendations and controversies.

### **Leadership Stories From Psychiatric Residency and Clinical Administration: Practical Skills for Training Future Psychiatric Leaders**

Chair: *Luming Li, M.D.*

Presenters: *Michael Henri Langley-Degroot, M.D., Megan Elizabeth Pruette, M.D., Kevin Mauclair Simon, M.D., Lawrence Malak, M.D., Marc W. Manseau, M.D., M.P.H., Anita Everett, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss leadership challenges residents face during training through case examples of resident leader experiences at several large academic training institutions across the U.S; 2) Provide insight into career transitions from residency into clinical administrative roles through leadership stories from successful clinical administrators and early career psychiatrists; 3) Share resources and tools within APA and within academic institutions for helping cultivate future leaders who can positively impact mental health equity and public sector psychiatry leadership; and 4) Foster practical leadership skills and discussion of emotional intelligence, organizational behavior, influence, and communication skills that can be useful for job negotiations, c.

#### **SUMMARY:**

Leadership within public sector psychiatry are imperative to promoting mental health equality and a robust perspective on mental health systems. This group of psychiatrists are poised to spearhead innovative strategies for advocating for equitable mental health services and appropriate implementation of population health, in accordance with shifts in public policy and healthcare reform. Reimagining psychiatry's impact on health equity will require strong leaders with clear vision. Basic knowledge of leadership skills is important to equip psychiatrists and psychiatric residents to serve the role of helping promote health equity. Although residency training offers many informal opportunities to develop leadership skills, there are few organized programs and curricula around basic leadership and management skills. Within the

leadership literature, key features of a strong leader include the capacity to deliver a clear vision, work effectively within teams, navigate organizational and interpersonal dynamics, be effective communicators, be influential and inspirational, and demonstrate emotional intelligence. Throughout the session, the panelists will introduce innovative methods for incorporating leadership skills in residency and clinical administrative roles. Panelists will represent psychiatrists from across the U.S. with various leadership positions, who will share case-based perspectives on how to incorporate leadership skills into clinical advocacy, residency education, and early career administrative roles. Each speaker will share a 7-10 minute short case on a memorable leadership story that has been influential in his or her career, such as the development of a leadership curriculum for junior residents, the promotion of state-level and national mental health access advocacy efforts in collaboration with APA, and the early challenges of career transitions and eventual successes within clinical administrative roles. In addition to sharing practical skills, the speakers will provide insight into several leadership opportunities for career growth, including the APA fellowships as an example of leadership training during residency, and discuss how individual psychiatrists have been empowered to lead the national movement of healthcare equity and promote improved access to psychiatric care. Overall, the session will focus on career transitions within psychiatry, and utilization of leadership skills throughout training and afterward to promote better job negotiations, wellbeing within work environments, and opportunities for further career growth. A discussion will follow at the end to talk about how to incorporate practical leadership skills into individual practice.

**Mental Health Services for Youth Experiencing Homelessness: A Multidisciplinary, Harm-Reduction Approach**

Chair: *Jason Schweitzer*

Presenters: *Priti Ojha, M.D., Steve Hyun Koh, M.D., Diana Rabban, L.C.S.W., Marla Flores*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the complex interplay of social and economic factors impacting

youth experiencing homelessness; 2) Understand range of circumstance of youth homelessness, from “couch surfing”, to shelters, to “the streets”; 3) Understand common causes and risk factors contributing to youth homelessness, including family conflict, economic problems, and transitions out of various systems; 4) Recognize the burden of psychiatric illness resulting from and contributing to youth homelessness; and 5) Identify treatment modalities effective in reducing the cycle of youth homelessness.

**SUMMARY:**

The negative impact of homelessness on children and youth cannot be understated. Due to their transient nature, youth experiencing homelessness can be a hidden population, often falling through cracks of systems, and being historically underrepresented in local, state, and federal intervention efforts. Physical and sexual abuse, chronic medical problems, and psychiatric illness disproportionately impact youth who are at-risk for homelessness or are homeless. Additional factors, such as substance abuse, engagement in illegal activities to meet basic needs, and human trafficking, exacerbate homelessness and its negative sequelae. Interplay between these factors can disrupt critical aspects of development, often delaying cognitive and emotional growth, impacting attachment and social functioning, limiting academic success, and derailing professional skills building. Youth experiencing homelessness often have a significant history of complex trauma and experience ongoing crises throughout treatment. The long-term outcomes can be devastating. Youth experiencing homelessness present with unique needs, and benefit from a creative and comprehensive treatment approach that focuses on harm reduction, resilience, and recovery. During our workshop, we will introduce a multidisciplinary, youth and family focused approach to helping youth decrease these risks, achieve stable housing, and address psychological, social and psychiatric needs. To provide context, we will touch on the myriad risk factors for youth homelessness, and review the common mental health challenges that face this population, such as PTSD, depression, anxiety, and substance abuse. We will provide examples of multi-disciplinary care plans, and discuss factors that can

strengthen service delivery such as optimizing team communication, addressing basic needs, applying trauma-informed care principles, and creating safe and inviting service delivery spaces.

### **Microaggression and Strategies to Overcome Prejudice**

Chairs: *Ranna I. Parekh, M.D., M.P.H., Carl Compton Bell, M.D.*

Presenters: *Vabren L. Watts, Ph.D., Eric Yarbrough, M.D., Kali Denise Cyrus, M.D., M.P.H., Erica Lubliner, M.D., Deepak Penesetti, M.D.*

Discussants: *Ranna I. Parekh, M.D., M.P.H., Carl Compton Bell, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Introduce the concept and historical underpinnings of microaggressions; 2) Define different forms of microaggressions-- microinequity, microassault, microinsult, and microinvalidation; 3) Offer strategies to overcoming prejudice within the medical workforce; and 4) Discuss effective practices to eliminate bias when treating patients.

#### **SUMMARY:**

In 1970, psychiatrist Chester Pierce, MD, coined the term “microaggression” to describe an everyday, subtle form of discrimination experienced by African Americans post Jim Crow. Since then, the term has been extended to all minorities and marginalized groups. Today’s medical literature outlines a variety of microaggressions—microinequity, microassault, microinsult, and microinvalidation—and its impact on the treatment of patients and working with minority medical professionals. This workshop describes the insidious nature of conscious, and often unconscious, bias affecting behaviors of people. The co-chairs will introduce the concept and historical underpinnings of microaggressions and offer strategies to overcoming prejudice. The panel will provide real life examples of microaggression and effective practices to eliminate and combat bias. There will also be questions and vignettes for audience to engage in discussion.

### **The 3AM Phone Call: Advancing Crisis Services into the 21st Century**

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

Discussant: *Kenneth Minkoff, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the underlying principles and goals of a crisis system; 2) Describe core components of a robust crisis continuum and list examples of best practice programs; 3) Discuss strategies for financing and stakeholder engagement to support crisis services; and 4) Apply lessons learned to his/her own community.

#### **SUMMARY:**

A friend calls you in the middle of the night because their loved one is struggling with suicidal ideation, escalating opiate abuse, or new-onset psychosis. What would you recommend they do? Is there an easy way to access the behavioral health system in your community? Are you confident that your friend’s loved one will get their needs met while being treated with compassion and respect? If not, do you want to see improved crisis care in your community? Then this workshop is for you. Easy and immediate access to behavioral health crisis services decreases avoidable emergency department utilization, hospitalization, and incarceration. Not only are these outcomes clinically desirable, but also tend to be a more cost-effective use of taxpayer-funded health and public safety services. However, because crisis services are typically funded at the state or county level, the scope and quality of services dramatically vary between communities. For this reason, the new Interagency Serious Mental Illness Coordinating Committee (ISMICC), which was created by the 21st Century Cures Act, has advised the federal government to develop a national standard for crisis services. This workshop is intended to help participants prepare and advocate for the next generation of crisis services. We will begin with an overview of underlying principles, goals, and components of a robust crisis continuum, followed by examples of several best practices programs. Emerging work on clinical guidelines and outcome measurement will be described. Finally, we will discuss strategies for financing and stakeholder engagement, with an emphasis on how to tailor to participants’ unique community needs and constraints.

Friday, October 05, 2018

### **A Conversation on Diversity**

Chairs: *Vabren L. Watts, Ph.D., Ranna I. Parekh, M.D., M.P.H.*

Presenters: *Eric Yarbrough, M.D., Ruth S. Shim, M.D., M.P.H., Altha J. Stewart, M.D., Saul Levin, M.D., M.P.A.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Give APA members an opportunity to share experiences, history, and perspectives about diversity in organized psychiatry; 2) Discuss how health care and patient demographics are impacted by diversity; 3) Share ideas that will help APA better serve its minority and underrepresented (M/UR) constituents, and patients a part of underserved communities; and 4) Develop strategies to increase diversity and inclusion among all APA members.

#### **SUMMARY:**

Since 2015, APA's Division of Diversity and Health Equity (DDHE) has sponsored "Conversations on Diversity" at APA Annual Meetings and the IPS: The Mental Health Services Conference. These sessions provide a setting in which attendees of all backgrounds can share their experiences and perspectives about diversity, inclusion, and cultural sensitivity. Information from the sessions helps APA set objectives and create programs to increase engagement of minority and underrepresented (M/UR) psychiatrists within our organization and ensure equal access to high-quality psychiatric care—health equity—for all patients regardless of race/ethnicity, age, religion, nationality, sexual orientation, gender identity, socioeconomic status, or geographical background. The event has evolved as a platform for members to increase awareness of inclusion and cultural competence and highlights diversity as a key driver of health care and institutional excellence.

### **Advocating for Physician Well-Being: A Leadership Role for Psychiatrists**

Chairs: *Richard Fredric Summers, M.D., Rashi Aggarwal, M.D.*

Presenters: *Carol Ann Bernstein, M.D., Julie A. Chilton, M.D., Matthew Louis Goldman, M.D., M.S.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Increase awareness of the high rates of burnout, depression and suicide in psychiatrists in particular and physicians in general; 2) Understand the evidence-based approaches to promote physician well-being; 3) Discuss how to use the toolkit created by the APA workgroup to increase awareness in your institution; and 4) Identify best practices for advocacy and specific interventions to promote wellbeing within your organization.

#### **SUMMARY:**

Professional burnout among physicians has become a pervasive problem that deserves immediate attention. At least fifty percent of physicians in the United States report symptoms of burnout. Burnout and lack of satisfaction with work-life balance have been increasing over time. Burnout is associated with increased medical errors and poorer patient care, as well as mental health disorders, including depression, anxiety, substance use, and suicide. These negative outcomes too often result in increased attrition, decreased productivity, and financial risk to healthcare organizations. Addressing burnout is not only important from a moral and ethical perspective but also a worthwhile investment from a financial standpoint. In addition to burnout, physicians are at increased risk of depression and suicide, including psychiatrists in particular, and they are less likely to access mental health services than the general population. It's time to take care of our own and advocate for change in the medical culture so that psychiatrists and other physicians can access mental health care without facing so many obstacles. Decreasing stigma, creating more easily accessible treatment options for busy doctors, and changing questions on medical licensing applications are all important steps that will be addressed in this presentation. The Ad-hoc Workgroup on Psychiatrist Wellbeing and Burnout was convened by the APA's Board of Directors to make recommendations on the development of activities and products to facilitate the APA's focus on wellbeing and burnout. The workgroup recognized that in addition to addressing

our own wellbeing, we as psychiatrists are in an ideal position to provide expertise and knowledge to others in the health care professions, especially with regard to distinguishing between burnout and depression and the best approaches to addressing both conditions. The workgroup has developed a comprehensive PowerPoint presentation and a manual to support APA members to serve as ambassadors in their home institutions with the goal of improving wellbeing and reducing rates of burnout, depression, and suicide among the physician workforce, including psychiatrists and physicians of all specialties. The goal of this workshop is to support and help psychiatrists who wish to take on such leadership roles in their organizations.

### **Are We Racist? Examining Racial and Ethnic Bias in Psychiatric Evaluations in AOT**

Chair: *Myla Harrison, M.D.*

Presenters: *William A. Fisher, M.D., Serena Yuan Volpp, M.D., M.P.H., Scott M. Soloway, M.D., Samantha Aaron, M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe literature on racial/ethnic disparities in AOT; 2) Examine NYC racial inequities in AOT decision making; and 3) Explain next steps to improve outcomes.

#### **SUMMARY:**

The New York City Assisted Outpatient Treatment (AOT) Program, which allows for individuals to be mandated to outpatient psychiatric treatment for up to one year per order, has long been reported to have an overrepresentation of black and Hispanic individuals mandated to treatment when compared with the general population. While studies have been done reviewing that overrepresentation in referrals received by AOT for investigation to pursue an initial order, until now there have been no reviews of how the AOT program continues the inequity in subsequent renewal orders. In 2017, the AOT program in New York City, under the auspices of the New York City Department of Health and Mental Hygiene (NYC DOHMH), conducted an internal racial equity assessment. As part of this assessment, the AOT program analyzed 3,044 AOT cases that were

closed between 2012 and 2016 to conduct an internal systematic review of how people of different racial/ethnic groups have been affected by the AOT program. We focused on decisions to renew, or not renew, the initial AOT order. Our analysis determined that black and Hispanic individuals were overrepresented in the AOT program. In examining renewals we statistically controlled for the usual factors that might influence the renewal decision such as age, gender, order length, substance use, Emergency Department visits, hospitalizations and arrests. We found that Caucasians were less likely to have an AOT order renewed and were more likely to have their AOT case closed for reasons defined by the program as positive. Black and Hispanic individuals were less likely to have what the program defines as a positive closure reason and were significantly more likely to have a case renewed than a Caucasian consumer. These findings implicate not only the mental health system at large but also the individual psychiatrists making the final decisions regarding whether or not additional AOT orders will be pursued. One explanation for the persistent inequity is unconscious bias on the parts of the psychiatrists, AOT clinical staff providing information to those psychiatrists, and the community treatment providers from whom AOT clinical staff receive information. To address these possibilities in psychiatric decision making, the AOT program has undertaken a root cause analysis and trainings for psychiatrists and AOT staff on topics including unconscious bias. The presentation will be used to catalyze an audience discussion of racial and ethnic inequities in the mental health system and the ways in which racial and ethnic biases by mental health professionals can further cement those inequities.

### **Buprenorphine Update and Evolving Standards of Care**

Chair: *John A. Renner, M.D.*

Presenters: *Andrew John Saxon, M.D., Petros Levounis, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Explain changing patterns of opioid use disorder; 2) Describe current efforts to expand medication treatment; 3) Explain changing

models to expedite treatment admission; and 4) Describe evolving evidence-based standards of care for opioid use disorder.

#### SUMMARY:

This workshop will describe recent changes in the epidemiology of opioid use disorder, including the current epidemic of fentanyl abuse, and will review: 1) Regulatory changes in 2016-17 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.

#### **Certified Community Behavioral Health Centers at One-Year: A Panel Discussion of the First Year of Achievements and Challenges**

Chair: *Joseph John Parks, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List the requirements for comprehensive services required of CCHBCs; 2) Describe the perspective payment methodology and how it is able to support more innovative services compared other payment methodologies; 3) Describe changes in access and available staffing as a result of CCBHC implementation; and 4) Describe opportunities for enhanced psychiatrist leadership and involvement in organizational management under the CCBHC model.

#### SUMMARY:

In July 2017 a two-year, 8-state initiative to expand Americans' access to mental health and addiction care in community-based settings began at 67 Certified Community Behavioral Health Centers (CCBHC) in eight participating states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. This workshop will present a panel discussion by CCBHC Medical Directors providing an update on the achievements

and challenges of their first year of operation. The federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs) includes: - integrating both substance abuse and mental health services and behavioral health services with primary care. - Becoming more data-driven - they are required to collect and report data on 27 different performance indicators some of which are costs, some utilization measures, some process measures in some outcome measures. Some are behavioral health and some related chronic medical illness. - Requirement to have a continuous quality improvement plan and process - requirement to have been 24 seven crisis response capability- including emergency crisis intervention, 24-hour mobile crisis teams, and crisis stabilization services - requirement to make evening and weekend hours available - requirement to have a Medical Director - requirement to actually directly provide (or contract with partner organizations to provide) both substance abuse services and mental health services - requirement to provide medication assisted treatment for addictions - requirement that their patients get a general health risk assessment and get monitored for metabolic syndrome - requirement to have a formal system to assess the current competence of any staff providing treatment services Overall a substantially higher level of performance than most CMHCs currently. CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care (Prospective Payment). There is the option of doing a performance bonus payment CMS has defined 11 performance measures that must be met for any quality bonus payment to occur-the state can add additional quality bonus requirements and states have wide discretion in how big a quality bonus payment to make. Ultimately, the demonstration program is expected to infuse more than \$1.1 billion into community-based services, making it the largest investment in mental health and addiction care in generations. The prospective payment system will remove the current financial disincentives that behavioral health organizations have to increase psychiatric staffing. The requirement to have a medical director and the additional service requirements will significantly broaden and enhance the role of psychiatry. The panel discussion will highlight achievements such as increase psychiatric

staffing, increased integration with substance abuse treatment services, and increase access to care.

### **Coming Out of the Closet: LGBTQ Education in Medical School and Residency Training**

Chairs: *Neeral K. Sheth, D.O., Max Alan Lichtenstein, M.D.*

Presenters: *Stephen Mark Goldfinger, M.D., Marshall Forstein, M.D., David R. Beckert, M.D., Pratik Bahekar, M.B.B.S., Nhut Giuc Tran, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand health disparities in LGBTQ populations; 2) Identify challenges facing healthcare delivery for Transgender populations; 3) Recognize gaps in the current curriculum and barriers to implementing LGBTQ topics into medical school and residency education; 4) Identify possible issues that might arise as a result of one's LGBTQ identity during residents' encounters with patients; and 5) Discuss ways in which the relationship between faculty supervisors and residents might be impacted by one's LGBTQ identity.

#### **SUMMARY:**

Background: Health disparities among LGBTQ people include mental health issues, substance abuse, & violence. The implementation of LGBTQ-related health topics in medical school & residency curriculums is essential to reducing health disparities facing LGBTQ populations. The Association of American Medical Colleges (AAMC) recommends that "medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for GLBT patients." The introduction of LGBTQ topics into medical schools has shown to reduce bias against LGBTQ people & improve quality of care. Implementation of LGBTQ curriculums, however, have been limited to the institutions that develop them. Although AAMC's Advisory Committee has developed a set of competencies & a framework for LGBTQ topics for undergraduate medical education, a survey of US & Canadian medical schools reported that only 11 of the 132 medical schools taught all 16 LGBTQ topics identified by the authors, and on average had less than 5 hours of LGBTQ-specific content. The National Center for Transgender

Equality reported (2011) that 50% of respondents reported having to teach medical providers about transgender care. Hence, physician preparedness in addressing LGBTQ-specific health topics remains problematic. The ACGME also emphasizes evaluating residents on LGBTQ healthcare competency, however there is currently insufficient data on whether there have been sufficient changes in residency education. Objective: In this workshop, participants will increase knowledge of LGBTQ health disparities & challenges facing healthcare delivery for transgender populations. Participants will learn of issues that residents might encounter as a result of one's own LGBTQ identity or a patient's LGBTQ identity. Participants will also discuss ways in which the relationship between faculty supervisors and residents might be impacted by one's LGBTQ identity. Methods: Current literature and expert experience will be presented in lecture format, including: LGBT health disparities; current initiatives in transgender health; barriers on diversity hiring; & barriers in implementing LGBT topics in medical education. Presenters will lead an interactive question and answer exercise with the audience to illustrate the knowledge gap, & then facilitate a Q&A between participants and program directors to identify solutions to promoting LGBTQ diversity in medical education. Results: Participants will be able to recognize the gaps in educational curriculums at their home institutions that can lead to health disparities for LGBTQ populations. We will encourage understanding of attitudes & bias that may arise during clinical psychiatric encounters & supervision. Conclusion: Implementation of LGBTQ-topics into medical education is vital in addressing health disparities facing LGBTQ people. Although curriculums exist, they are not uniformly incorporated into didactics. Audience Collaboration will help achieve objectives.

### **Comparing Interventions to Achieve Mental Health Equity at the Local Level: Telepsychiatry Versus Collaborative Care**

Chairs: *Arkaprava Deb, M.D., M.P.A., M.P.H., Stephanie Le Melle, M.D., M.S.*

Presenters: *Sasidhar Gunturu, M.D., Ludwing Alexis Florez Salamanca, M.D., Vijal Parikh, D.O., Rishi Sawhney, M.D.*



#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will demonstrate understanding of the variety of ways to define and measure mental health inequity; 2) Participants will be able to list different determinants of inequity including mental health access; 3) Participants will demonstrate basic knowledge of the strengths and weakness of using telepsychiatry to address inequity at the local level; 4) Participants will demonstrate basic knowledge of the strengths and weakness of using collaborative care to address inequity at the local level; and 5) Participants will be able to discuss why certain interventions will be more impactful in their own locality.

#### SUMMARY:

Total Health Equity is a very worthy aspiration; however, it is important not to underestimate the challenges of exploring and addressing the problem in the most impactful way. We will operate a workshop to rigorously investigate the challenges of exploring the magnitude of inequity at the local level and the process of describing the explanatory framework for mental health inequity. We will then describe different interventions to address the larger access problem, specifically collaborative care and tele-psychiatry. Our program will be heavily audience interactive and incorporate regular participation, a break out session into small groups to consider the merits of the different interventions, and audience electronic voting. Groups will also qualitatively report recommendations back to the larger session. We will utilize the "Problem Solving Paradigm" used in public health (Guyer B, "Epidemiology and Health Services", 1998) to systematically explore the mental health inequity problem and compare the two very promising methods to address the equity gaps in access. The process of defining mental health inequity and measuring the magnitude of it will require us to consider whether inequity is better seen through the perspective of gender, race, nationality, age, culture, vocation, income, geography, or even disability. In order to consider the best interventions, we will subsequently organize the key determinants of mental health inequity. Among the many causative factors, we will emphasize "access to mental health" since it spans across economic, social, and political

determinants. Our discussion of interventions to address access will be limited to local or state level programs and panel members will subsequently describe two prominent interventions. For both collaborative care and telepsychiatry, our presenters will define the interventions, the resources required, the process of delivery, and the existing knowledge on the impact of the interventions. Our presenters will also describe their own practical experiences with implementing these interventions. Next, we will have the audience break into groups of 6 to 10, with separate groups considering the merits in favor of collaborative care or telepsychiatry. Based on audience interest, we will also support a group that suggests a different intervention. We will have the groups describe the merits systematically with an "Intervention Decision Matrix" that parses the recommendations based on 8 distinct criteria (also from the "Problem Solving Paradigm used in Public Health" by B Guyer, "Epidemiology and Health Services", 1998)). This will occur over two breakout sessions. After this feedback, we will have displayed a completed intervention decision matrix and have the entire audience vote electronically on the most impactful local intervention. We will conclude with invitation for comments on what local factors would help decide between interventions.

#### **"I Can't Get No Satisfaction": Creating Meaning in Our Work as Psychiatrists**

Chair: *Peter L. Chien, M.D.*

Presenters: *William Chandler Torrey, M.D., John M. Santopietro, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify elements which make psychiatry meaningful to themselves; 2) Understand themes of what makes this work meaningful for others in the published research and for others in the room; 3) Learn concrete ideas for how to address challenges in our work and reorganize the psychiatric workflow; and 4) Interact with colleagues and experience the relationships, partnerships in recovery, and community that can bring meaning to our work.

#### SUMMARY:

What gives you satisfaction in psychiatry? We all have a thirty second response which we can give to a medical student. But what would presently resonate with you if you had an unhurried chance to reflect, consider, and discuss with colleagues? This workshop will give you a chance to discuss what is meaningful in psychiatry for you as well as to hear what is meaningful to others in the room and in the published research. What themes draw us together in this work? How might we address inefficient psychiatry workflow, the lack of time, and other obstacles to do the meaningful work that we want? We work in a helping profession which is also potentially rewarding for ourselves. Come with the spirit to explore and listen to others. Perhaps part of our satisfaction may be in exploring these questions in a community together.

**Race From Our Past: How the History of Psychiatry Creates a Present Legacy of Racism in Clinical Practice**

Chairs: *Sonya Shadravan, M.D., Sir Norman Melancon*

Presenters: *Sarah Yvonne Vinson, M.D., Kimberly Ashby, Ann Crawford-Roberts, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand vocabulary for discussion regarding race, power, and marginalization from the teachings of Critical Race Theory; 2) Understand the role that medicine and psychiatry have played in creating and reifying current manifestations of systemic racism; 3) Identify current disparities in psychiatric practice of diagnosis and treatment, and introspect on the role of mental health practitioners in perpetuating these disparities; 4) Identify, through interactive clinical cases, ways in which historical racial stereotypes continue to subconsciously facilitate oppression in clinical practice; and 5) Create cultural formulations with a richer understanding of the ‘making of Race’ and its role in facilitating inequity.

**SUMMARY:**

In a national context of political and racial polarization, many physicians feel powerless and ill-equipped to engage in discourse and advocacy regarding race, racism, and the promotion of equity.

Collective understanding is limited by white guilt and conceptions of racism overly focused on individual animus and intent—rather than focus on the role of systemic oppression and implicit individuals in perpetuating disparity. Further, attempts to engage in racial discourse through an ahistoric lens robs individuals of the capacity to comprehend the deep legacy of racism and the ways in which that foundation silently perpetuates the current reality. In the practice of psychiatry, we are not immune from these same limitations in understanding. While the APA has made clear statements regarding the profound impact of racism on the mental health of racial and ethnic minorities, mental health practitioners continue to lack tools for addressing this reality in day-to-day practice. Many of us are devoid of skills in introspecting on the capacity we have to subconsciously perpetuate inequity. We fall short in the assessments we make, in the questions we do and do not ask, and in the treatment plans we recommend or avoid. Without a familiarity with the racialized history of our field, many see our diagnostic tools and processes as objective and free from bias. In this workshop, we seek to provide an overview of the ways in which psychiatry’s history has been implicit in the definition and perpetuation of oppressive racial categories. This ranges from Benjamin Rush’s conception of Negritude to the changing face of schizophrenia during the civil rights movement, and includes the differential regard for the crack/cocaine vs opiate crisis in contemporary discourse. Our goal is to locate this clinical pattern within a broader historical context of slavery and capitalism; thereby, highlighting the role that cognitive dissonance played and continues to play in the creation of this racial stratification. We strive to illuminate how Blackness in particular has been pathologized within a psychiatric framework, and how notions regarding freedom, violence, pain tolerance, protest, and white apathy from our past, continue to parallel current practice and presumption. We plan to arm participants with a vocabulary and toolkit to elevate their conversations around race and power. Through interactive analysis of real clinical vignettes, we hope to empower participants to identify concrete ways in which historical patterns are echoed today. In turn, this will increase their ability to intercept their daily patterns of oppression and further promote health equity.

Finally, we hope to allow this newfound appreciation for the historical context of oppression to enrich the widespread application of the cultural formulation in psychiatric interviews.

**Real World Experiences in an Unreal World:  
Psychiatry and Climate Change**

Chair: *David Alan Pollack, M.D.*

Presenters: *Asim A. Shah, M.D., Ayana Jordan, M.D., Ph.D., Carissa Caban-Aleman, M.D., David Alan Pollack, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize current immediate and urgent mental health and public health impacts of climate change; 2) Understand roles that psychiatrists and other mental health professionals should perform in facilitating recovery from immediate and longer term CC related disasters; 3) Become motivated and have opportunities to determine how to prepare for and work to mitigate, prevent, and reverse mental health consequences of climate change; 4) Become aware of available resources to facilitate such public health and mental health activities; and 5) Recognize how CC is a major social determinant of health and mental health and that building community resilience is a key component in the effort to address the ongoing health risks of CC.

**SUMMARY:**

There is abundant evidence that climate change (CC) poses direct and indirect risks to individual, community, and planetary health. These health risks are derived from increased global temperature, rising sea levels, air pollution, increased environmental CO2 levels, and other factors that reflect rapid and extreme changes in the environment. These environmental changes are clearly manifest in acute and extreme weather and geophysical events, but also in longer term impacts on physical, economic, social, and political conditions at local, regional, national, and international levels. These impacts are already occurring and are clearly expected to increase leading to devastating effects well into the future. The health risks include a wide range of physiological and psychosocial clinical symptoms and conditions,

among which the mental health and public health consequences are estimated to be substantial and long-lasting, requiring immediate and ongoing planning and implementation of efforts to combat the acute and chronic impacts by a wide range of health and public health professionals, including psychiatrists and other mental health professionals. This workshop, one of several interrelated IPS presentations, will review the recent experiences of psychiatrists working in settings in which CC has directly contributed to the mental health risks to which persons have been exposed. These include Hurricane Harvey's acute impact on the Houston area, the longer-term impacts of floods, mudslides, and deforestation in West Africa, and the acute and ongoing impacts of extreme weather and the sociopolitical factors causing delays in recovery in Puerto Rico. We will share efforts of practicing psychiatrists to raise and respond to concerns about climate change with patients, incorporating appropriate responses to anxiety and other symptoms patients may already experience and preventive warnings about future risks. Finally, we will discuss public health efforts to prepare individuals, communities, and larger geopolitical entities to prepare the population for further impacts of CC. Such efforts, to maintain individual and community health while motivating the population to remain active in mitigating, preventing, and reversing many of the hazards of CC have been called "transformational resilience". In all of the examples we share, we focus on the knowledge, skills, and attitudes that individual psychiatrists and other mental health and health professionals must develop to competently contribute to the efforts to maintain and improve the health of the planet and its constituent components, including current and future psychiatric patients. These activities include clinical, public health, and policy functions. In addition to our abilities to understand and treat mental health conditions, our expertise must also be used to inform and correct the denial of the reality, urgency, and immediacy of CC in all of its manifestations.

**Strengthening Mental Health in Appalachia:  
Confronting the Health Care Challenges of Rural  
America**

Chair: *John F. Chaves, M.D.*

Presenters: *James Lamont Griffith, M.D., R. Lawrence Merkel, M.D., Vabren L. Watts, Ph.D., Sejal Patel*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the sociocultural and geographic boundaries of Appalachia and analyze how these affect both the epidemiology of mental illness and care disparity; 2) Learn strategies for addressing barriers to care that are present in rural, economically-depressed Appalachia, in which psychiatric care historically has been a marginal part of healthcare systems; 3) Develop skills for engaging and collaborating with partners in a culture that may be wary of psychiatrists; 4) Discuss ways to improve healthcare in this region with a focus on local action; and 5) Introduce the APA Mental Health Disparities Program to IPS attendees.

**SUMMARY:**

Appalachia refers to a geographical and sociocultural region that covers approximately 200,000 square miles along the Appalachian Mountains, spanning from New York to Mississippi(1). Despite dramatic regional economic changes over the past 60 years, much of the region remains economically distressed(1). The region has been inordinately affected by prescription drug misuse(2) and mental health provider shortages(3), leaving this area lagging behind the rest of the country in psychiatric care(4, 5). In addition to being rural and underserved, other sociocultural factors create unique difficulties, including a culture that bears strong stigma against psychiatric illness and intervention alike. By addressing these challenges, psychiatrists have the opportunity to be a model for health equity in the region. The American Psychiatric Association has formed the APA Mental Health Disparities Program in Central Appalachia with the goal of strengthening mental health care in this region. During this workshop, representatives of this program will guide participants through the epidemiology of mental health in the region and its unique barriers to care. Participants will learn about and practice assessments and interventions to counter stigma, including stigma against the provider him or herself. An additional focus of the workshop will be mental health service utilization including telepsychiatry and other means of force

maximization. Participants will be asked to share their experiences and expertise and to discuss innovative solutions to existing problems. The focus will be on local action including mobilizing community resources. These resources include religious, educational, and law enforcement organizations, and success in many Appalachian communities depends on effective partnership with these institutions. Participants will leave the workshop with a better understanding of the current state of psychiatry and mental health needs in Appalachia and tools for assessment and intervention that can be applied to any disadvantaged population. They will also leave with an increased awareness of how an individual may improve healthcare by means of community-based intervention.

**Women Physicians: Wellness and Burnout in the Time of #MeToo and #Timesup**

Chair: *Kathleen A. Crapanzano, M.D.*

Presenters: *Carine M. Nzodom, M.D., Rumneet K. Kullar, D.O., Eva Marina Mathews, M.D., M.P.H., Lauren A. Mulligan, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Articulate the challenges for individuals and institutions in the identification and remediation of a culture of harassment; 2) Effectively describe the effect of sexual harassment on physician wellness and burnout; 3) Discuss the cultural norms that allow for harassment to continue and that must be addressed; 4) Acknowledge the complexity for all parties in their attempts to; and 5) Create a list of potential actions to support female physicians and promote change on interpersonal, departmental and institutional levels.

**SUMMARY:**

The #MeToo movement has opened the conversation about sexual harassment to a widespread audience with the intended goal of breaking the silence and taking a strong stance on this long-standing problem. Many published articles have identified sexual harassment of future doctors starting in medical school. Student doctors usually remain silent for fear of retaliation, guilt, shame and a possible catastrophic impact on their training.

Those sentiments often continue during residency training and beyond. The sequelae associated with sexual harassment are far reaching. Psychological effects include isolation, depression, guilt, anger, fear, low self-esteem, and helplessness potentially leading to poor work performance, limited career advancement and burnout. Psychiatry is not immune; some studies have shown a higher prevalence of sexual harassment of female psychiatrists than other medical fields from both colleagues and patients. In our workshop, we will directly explore the effects of sexual harassment on physician burnout and well-being by sharing the most recent literature and first-hand stories from female physicians. Participants in the workshop will collaborate to explore cultural norms and other obstacles – interpersonal and institutional – that are of concern when addressing harassment. They will suggest actions to promote positive change. Participants will be provided with the results from a survey of female physicians within the state of Louisiana. We will showcase videos and commentary about the rising effort to change culture through personal reflection, responsibility and action driven by the #IDidThat, #IHave and #IWill movements that have been inspired by #MeToo.

Saturday, October 06, 2018

### **Addressing the Social Determinants of Mental Health: Expanding Recovery From Individuals to Society**

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

Discussants: *Seeba Anam, M.D., Ruth S. Shim, M.D., M.P.H., Marc W. Manseau, M.D., M.P.H., Jeffrey C. Eisen, M.D., M.B.A.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Define the social determinants of mental health (SDMH); 2) Overview of the effects that SDMH have on the recovery of persons with severe mental health challenges (SMHC); 3) Provide examples of screening tools for SDMH and discuss how they can be implemented in clinical practice; 4) Understand structural competency as a framework for training with a particular awareness of SDMH; and 5) Become familiar with evidenced-based

interventions on SDMH and discuss how they can be implemented in clinical practice.

#### **SUMMARY:**

Social determinants of mental health (SDMH) are “the conditions in which people are born, grow, live, work and age” (World Health Organization definition). Although they have a larger impact on mental health outcomes than individual-level interventions, these factors are rarely addressed in training or screened for in practice. This is problematic because unequal access to the social determinants creates inequities in mental health outcomes, especially for people with serious mental illness (SMI), around whom such inequities tend to cluster. In this workshop, we will explore how the social determinants of mental health impact those with SMI and how we may begin screening for them and intervening, with examples of such endeavors presented by our panel before we invite participants to discuss and share how they might proceed in kind.

### **Cycloid Psychosis: The Subjective Experience and Objective Data**

Presenters: *Carolyn S. Furdek, D.P.T., Rif S. El-Mallakh, M.D.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify Cycloid Psychosis; 2) Treat Cycloid Psychosis; and 3) Educate their patients about Cycloid Psychosis.

#### **SUMMARY:**

Cycloid Psychosis is a recurrent psychotic illness that is characterized by recurrent psychotic disorder in which episodes of hallucinations and delusions are associated with minimal thought disturbance and a dearth of mood symptoms but with frequent sleep disturbance and anxiety. Onset of symptoms is usually rapid and response to antipsychotic medications is nearly always complete. Interepisode function is nearly always good and devoid of psychotic symptoms. Clinical and biologic studies find that there is minimal overlap with either mood or schizophrenic disorders. Accurate incidence and prevalence data are not available, but it is probably half as common as schizophrenia and has a female preponderance. Clinical identification of cycloid

psychosis improves patient education and determination of the prognosis. Presentation of subjective experience of cycloid psychosis will highlight all of these clinical characteristics.

### **Helping the Helpers: Understanding Vicarious Traumatization and Burnout**

Chairs: *Mayumi Okuda, M.D., Rosa Regincos*

Presenters: *Elizabeth M. Fitelson, M.D., Tatyana Pena, Ladan Shaikh, M.D., Obianuju Jennifer Berry, M.D., M.P.H.*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe common reactions experienced by mental health providers who work with traumatized populations; 2) Discuss individual and organizational recommendations that can prevent and/or ameliorate the cognitive, emotional and physical effects of working with traumatized populations; and 3) Summarize resources and strategies available for mental health providers working with traumatized populations.

#### **SUMMARY:**

For mental health providers, working with traumatized populations can lead to personal and professional growth. Moreover, it can offer mental health providers the rewarding opportunity to work with a resilient population that capable of making enormous changes in their lives. However, the process of learning about cruelty, vulnerability, pain and the devastating impacts that trauma can have on individuals and societies is not always free of its challenges. In the same way that trauma affects the individuals who have experienced it, working with traumatized populations can deeply transform the lives of mental health providers. Mental health providers may experience a wide range of reactions as a result of their empathic engagement with traumatized patients and patients' descriptions of traumatic experiences. These experiences and reactions may fall into a continuum with different terms being used to describe the cognitive, emotional and physical impact that providers experience when they work directly with traumatized individuals. Historically, some of these experiences and reactions have been described as vicarious trauma, secondary traumatic stress or

compassion fatigue. Burnout—a more general phenomenon that occurs among mental health providers working within a wider range of settings—can also occur when working with traumatized populations. Surprisingly, these cognitive, emotional and physical effects associated with providing direct care to traumatized populations have been largely overlooked by mental health providers and systems of care. This presentation will use clinical scenarios to conceptualize these conditions separately in order to have a comprehensive understanding of these phenomena. The presentation will also describe associated risk factors and symptoms in order to better help mental health providers identify, prevent and/or minimize their effects. Particular attention will be paid to the inclusion of this material in training curricula as well as the practice of self-care at individual and institutional levels. This presentation will illustrate lessons learned throughout the development and expansion of a program that integrates mental health services with community-based ones for intimate partner violence (IPV) survivors, while describing the development of a training and supervision model for mental health providers caring for IPV survivors in such settings. The presentation will also provide a platform for discussion on methods to increase awareness, along with training on trauma reactions experienced by mental health providers; we will also discuss how best to protect mental health providers who provide services for this population. This workshop will be presented by a team of providers from the fields of advocacy, social work, psychology and psychiatry, who have extensive experience working with trauma survivors in a wide variety of settings.

### **Psychiatry Resident Training in the Correctional System: Overcoming Barriers and Increasing Interest Among Trainees**

Chair: *Elizabeth B. Ford*

Presenters: *Sarah Kauffman, Megan Elizabeth Pruette, M.D., Cara Angelotta*

#### **EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the increased need for psychiatrists with a basic exposure to the correctional system; 2) Appreciate the barriers for trainees to gain more exposure to the correctional

system; and 3) Identify ways to overcome these barriers and how to increase resident exposure to the correctional system.

#### SUMMARY:

There is an increasingly dire need for psychiatrists in the local, state, and national correctional system. Up to 25% of the population in jails and prisons have received mental health care in the last 12 months and up to 50% report current symptoms of mental illness. Several societal factors have contributed to this increased need of mental health treatment in jails and prisons. Despite this increased need, few residency programs provide an opportunity for trainees to gain exposure to this population. Additionally, many psychiatrists spend at least part of their career working in the correctional setting. The lack of training in this population during residency means they are ill-equipped for the particular issues that arise with this population. Even if a psychiatrist chooses to not practice in a correctional facility, as public psychiatrists, the majority of our patients will interact with the jail and prison system throughout their lives and treatment courses. Understanding the impact of this exposure is imperative to better contextualize our patients' social history and provide the most informed, effective, and compassionate care possible. We will review the national and cultural trends that have led to an increased need for psychiatric care in correctional facilities. We will then explore the deficits in residency training experiences within correctional settings. Many factors contribute to this lack of training exposure, including several recurrent themes discussed by residency directors nationwide. Panelists will share their training experiences in a range of correctional settings, including the difficulties that have been encountered in creating rotations in the justice system. Last, we will troubleshoot some common barriers to exposure and brainstorm ways to increase this type of education.

#### **Social Justice and Resident Recruitment: Making Equity, Diversity, and Inclusion a Reality in Training Programs**

Chairs: *Nicolas E. Barcelo, M.D., Uchenna Barbara Okoye, M.D., M.P.H.*

Presenters: *Rene Salazar, Lynn Gordon, Nichole I. Goodsmith, M.D., Ph.D., Sonya Shadravan, M.D., Maria Gabriela Aguilera Nunez, M.D.*

#### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what diversity means and explore an evidence base for the positive impact of resident diversity on program outcomes, knowledge generation, and patient care; 2) Identify the complex ways in which implicit bias enters resident recruitment and selection, and cite practices to counter this bias; 3) Review existing literature regarding best practices for recruitment and retention of residents underrepresented in medicine; 4) Discuss case studies of two residency programs' interdisciplinary approaches to furthering justice, equity, diversity, and inclusion; and 5) Examine obstacles and strategies from the audience's experiences in order to generate a collective toolkit for change.

#### SUMMARY:

Racial disparities in health constitute a public health crisis. The cause of these disparities is multifactorial and includes both systemic processes and individual-level phenomena, including physician unconscious bias. In this climate of ongoing inequity, terms like "EDI" (Equity, Diversity, and Inclusion), and "implicit bias" have become buzzwords for change within medical schools and residency training programs. While applauding a general concept of diversity, many advocates and allies lack a deeper understanding of what diversity means, and why it matters in residency training. Furthermore, few can articulate how the promotion of trainee diversity relates to broader improvements in health disparities and outcomes for underserved populations. These gaps in understanding can impede progress in creating more diverse, equitable, and just training environments. In this workshop, we will explore the concepts of diversity and "underrepresented in medicine" (URM), providing evidence for the value of diversity in residency training and health professions. Participants will be introduced to the subtle ways racial biases influence measures commonly used to assess residency applicants, including medical student clinical evaluations, standardized test scores, and AOA

Honor Society induction, as well as the interview and ranking processes. Participants will learn current frameworks and strategies for effectively promoting diversity and justice within residency education and academic medicine departments, with an understanding of relevant legal considerations in recruitment policies. We will share a case study of one institution's resident-led initiative to increase diversity through resident and faculty recruitment; to use residency forums and didactic curricula to promote a nuanced understanding of issues related to equity, diversity, and inclusion; and to frame these efforts within a larger goal of effecting culture change within the residency program and Department of Psychiatry. Finally, we will facilitate an interactive break-out session for participants to share their own obstacles, strategies, tools, and best practices, so as to improve cross-institution dialogue and knowledge sharing. Speakers include leadership and residents from two academic medical centers who will provide first-hand insights into the opportunities and challenges of carrying out this work.

**Women Psychiatrists and Money: Personal Practicalities, Payment, Professional Practice, and Power**

Chair: *Sarah Yvonne Vinson, M.D.*  
Presenters: *Kasey Gartner, Glenda L. Wrenn, M.D., Andrea M. Brownridge, M.D., J.D., M.H.A., Lara Elizabeth Aycock Frye, M.D., Nzinga Ajabu Harrison, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand basic principles regarding personal financial planning needs of women psychiatrists; 2) Explore the potential impacts of gender in negotiations through panel discussion; 3) Discuss practical considerations regarding private practice and the challenges and opportunities it poses; and 4) Identify different approaches to leveraging physician income in the pursuit of advocacy.

**SUMMARY:**

The majority of psychiatric residents are women. Though gains continue to be made in terms of representation in the field of psychiatry, and many

professions within the larger society, gender inequities with regards to earned income and wealth persist. Even highly educated women are susceptible to the impact of traditional gender roles on self-advocacy in the form of negotiation or assertiveness in the workplace. Effective procurement and use of monetary resources is a critical aspect of both personal and professional security and development. There is little in the medical or residency training process that addresses this highly relevant issue, let alone its interplay with gender. In this workshop, the interplay of money with women psychiatrists' personal and professional roles will be explored through a variety of perspectives. The psychiatric physician panelists hail from private practice, corporate, academic and public psychiatry contexts, and they will be joined by a Field Director and Financial Advisor from a major financial planning firm. The workshop topics will include practical considerations for women psychiatrists in personal financial planning, negotiation, private practice management, and different approaches to leveraging physician income in the pursuit of advocacy.

Sunday, October 07, 2018

**Increasing Access to Care for Homeless Clients: Clinical Pearls and Models of Care**

Chair: *Michaela Y. Beder, M.D.*  
Presenters: *Deborah Anne Pink, M.D., Anthony J. Carino, M.D., Joanna Fried, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate enhanced clinical skills in caring for people experiencing homelessness; 2) Understand models of care best suited for a homeless population, including street outreach, shelter-based care, and ACT level support; and 3) Discuss challenges unique to caring for homeless people with complex social, psychiatric, substance use, and medical needs.

**SUMMARY:**

Homelessness impacts over 1 million North Americans every year. In our difficult economic times, there are many paths to homelessness. For some people, job loss leads them to lose their



homes, while for others mental illness and substance use, coupled with insufficient access to care and social supports, leads to years on the streets, in shelters, and in and out of jails. Psychiatric providers often encounter people who are homeless in emergency and forensic settings, but there is an increasing number of clinicians who work in settings directly targeting people during episodes of homelessness. These “Homeless Psychiatrists” have developed a clinical approach, as well as an understanding of larger systems issues, and have a unique perspective on how to best provide treatment and services for consumers who are homeless and who often have little or no access to ongoing psychiatric and medical care. In this interactive workshop, experienced urban psychiatrists working with innovative organizations will provide an overview of evidence based practices in homelessness mental health care, as well as clinical pearls from their clinical experience. Models of care for homeless populations will be reviewed, including street outreach, critical time intervention, housing first, psychiatric treatment and integrated care in shelters and drop-in centers, and ACT teams with a homelessness focus. This workshop will also cover best practices in psychopharmacology for people experiencing homelessness. Access to mental health care remains challenging for many people who are homeless - they are often transient, disconnected from services and supports, struggling with acute psychosis and/or substance use, the long-term effects of trauma, and cognitive challenges. Using interactive case examples, psychiatrists from two large urban settings, New York City and Toronto, will discuss best practices in treating clients who are homeless, including a review of clinical pearls, evidence-based practices, models of care, ways of increasing access, and psychopharmacologic management.

**Tools to Treat Mental Health Needs and Promote Well-Being of African Americans During the Current Political and Social Climate**

Chairs: *Jean-Marie E. Alves-Bradford, M.D., Carine M. Nzodom, M.D.*

Presenters: *Rahn K. Bailey, M.D., Kimberly A. Gordon-Achebe, M.D., Michelle P. Durham, M.D., M.P.H., Latoya Sheree Comer Frolov, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the impact of the current social and political climate on the mental health of African Americans; 2) Identify 3 risk factors of the African-American population for mental health problems; 3) Provide 3 tools to assist in treating and promote wellbeing in African American children and adults; and 4) Identify 3 resources to increase knowledge about the African American population.

**SUMMARY:**

Over the course of American history, African Americans have suffered from physical, sexual, emotional, psychological trauma during enslavement, Jim Crow, and the civil rights movement (Aymer 2016). Alexander (2004) proposes that cultural trauma occurs when there is a collective agreement that members have been mistreated, and it shapes their identity. Both overt and covert acts of racism act to influence the psyche of African Americans. Numerous recent cases of police brutality and the current political climate including the white supremacy movement, violence in Charlottesville and President Trump’s response demonstrate that there continues to be explicit, and implicit biases against African Americans. Acts of covert racism are experienced in the form of microaggressions or slights wherein the recipient has an intuitive sense that an act of prejudice occurred during the interaction. Charkraborty & McKenzie (2002) propose that the experiencing of frequent microaggressions serves as a conduit for chronic stress. APA members have reported an increase in their patients suffering from stress, anxiety, mood symptoms and trauma related to the change in the U.S. political and social environment. This workshop will provide up-to-date information and scientific evidence to help psychiatrists and other health care providers in treating African American children and adults. Participants will learn how the current social and political climate impacts the mental health of African Americans. Panelists will provide tools and resources to assist psychiatrists and other mental health professionals in promoting wellbeing and treating the mental health needs of African American children and adults. Through case presentation and break out groups, participants will

practice matching which tools and treatments are best used in specific cases. Participants will better understand the struggle that African Americans face and its origin.