

THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

FALL 2009

A MESSAGE FROM THE PRESIDENT

The Psychiatric Society of Virginia (PSV) Fall Meeting in Roanoke was another great success and worth every cent! Dr. Vieweg and the rest of the planning committee put forth a program that could easily match any national APA meeting in both quality and depth. The topics and the speakers were excellent. They offered complete and well prepared sessions and the format kept an animated pace and allowed for active participation from all attendees. In addition, many of the presenters are PSV members. The venue was also great. The meeting rooms, audiovisual support and accommodations were of the highest quality. As I review the feed-

back and evaluation sheets, close to 98% of all participants rated the overall quality of the program "very good to excellent." The same percentage rated the venue in the same category. An overwhelming majority of responders also would like to return to the same location.

The residents' poster session was also another success. This year we had 18 posters and all Resident Training Programs



J. Edwin Nieves, MD, DFAPA
President

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Get Off the Couch
INTEGRATION OF MENTAL HEALTH SERVICES IN NON-TRADITIONAL SETTINGS
March 26-27, 2010 • Sheraton Park South • Richmond, VA

PSYCHIATRIC SOCIETY OF VIRGINIA

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Psychiatric Society of Virginia
2209 Dickens Road • Richmond, VA 23230-2005 • (804) 754-1200
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PLAN NOW! PSV SPRING MEETING MARCH 26-27, 2010

Mark your calendars for March 26-27 for a meeting that promises to get everyone "off the couch" and moving in the Spring.

Presenters will be featuring examples of programs in which mental healthcare has been integrated in innovative ways. Tentatively on the schedule are Dr. Robert K. Schneider, Chief of the Mental Health Service Line at McGuire administration medical Center (VAMC), Dr. Bella Sood, Professor of Child and Adolescent Psychiatry, Virginia Treatment Center for Children/Virginia Commonwealth University, Dr. George Cortina, Veterans Integrated Service Network (VISN) Chair

in the Commonwealth were represented.

As many of you recall, we began these poster sessions three years ago as a means to maintain a viable succession plan, and a broad base of support and presence in our state psychiatry residency training programs. I was very proud to walk through the poster session and recognize the names of all faculty co-authors. Since our meeting, many of the residents have called or corresponded to express their comfort among the membership. The residents felt very welcomed.

As we move to the close of the year, I feel we have had a very successful year. Our meetings have been well attended and the Society has maintained a presence in matters that involve our patients and our discipline. It is with a great sense of humility that I can say it has been a pleasure to have been your President for this past year. The health of the organization has been maintained by the commitment of all our members. We have shared our strengths and everyone has turned out when there is work to be done.

of Geriatrics and Extended Care and Geriatric Psychiatrist at the Hampton VAMC.

The afternoon will prove equally as engrossing as we explore integration of mental health into the media. The world is ever-changing and the avenues of dissemination of information are growing. Mental healthcare must not be left behind. As our sons, daughters and grandchildren, Twitter and Facebook, we must recognize that our patients are accessing many modes of communication as well. How can the media be used for advocacy, teaching, and dissemination of information? Let us find out together at the Spring meeting.



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Letters to the editor and editorial contributions are welcome. Submissions may be sent to Jose Edwin Nieves, MD, FAPA, or to Kathleen Stack, MD, FAPA, via email at jose.nieves@med.va.gov or to kathleen.stack@med.va.gov. Paid advertising is accepted on a first-come, first-served basis. To place your advertisement or to request a rate sheet, contact Beverly Bernard at PSV Headquarters via email at beverly@societyhq.com or by phone at (804) 565-6321.

A MESSAGE FROM THE EDITOR

VIRGINIA ENDS STATEWIDE PHARMACY FOR THE MENTALLY ILL

By Kathleen Stack, MD, DFAPA



Kathleen Stack, MD, DFAPA

I was dismayed to read in the APA News Briefs about the closing of the state pharmacy which had been providing medications for those discharged from the state hospitals and after involuntary hospitalizations. I was also surprised that I had not heard more about this in the local news.

The Washington Post (10/30, Tom Jackman) reported that in an "effort to reduce spending in tough budget times," Virginia "is eliminating its statewide pharmacy for the mentally ill, which obtained discounted" medications "and distributed them through local mental health boards rather than commercial drugstores." Instead, the "\$13 million the state spends on medications for the mentally ill...will be sent directly to the 40 Community Service Boards across Virginia, which are scrambling to find pharmacies that will sell them affordable medications." The Post notes that the pharmacy, which "serves about 3,300 people a month" and "assists many more Medicare patients," will "stop filling prescriptions on Monday," Nov. 2, and will "close Jan. 1."

The full article quoted CSB's officials from different parts of the state and how they will attempt to manage this challenge. It does not address the local short falls many CSB's are facing in the difficult economic times. The article reported that "Eliminating the pharmacy will save Virginia \$800,000 by cutting nine jobs and was done reluctantly by the state's Department of Behavioral Health and Developmental Services. The department was directed to reduce its central office budget by 15 percent," spokeswoman Meghan McGuire said.

The pharmacy program was part of a group of states which had negotiated a lower drug price with drug companies. The program "was allowed to send drugs to the local Community Service Boards, which could then distribute and monitor the drugs as patients came to get them, rather than have the patients visit a drugstore. The ability for the boards to distribute the drugs will be lost. And because the pharmacy was efficiently run, recycling unused or unclaimed drugs to save millions annually, it was able to pay for drugs for Medicare Plan D patients who were facing out-of-pocket costs. That also will be lost." Now unclaimed drugs are likely to be returned to stock in the retail pharmacy and benefit shareholders rather than the patients.

This program was described as "widely acknowledged as well-run and saved Virginia millions of dollars annually." The obvious question is why cut a program which saves millions annually to save less than one million?

We all recognized the difficulty with having patients comply with medications. The state-issued medications allowed for at least the first hurdle to be cleared, access to the correct medication at the time of release. Now, there will be more difficulty in avoiding delays in getting the medications to the patients. Who will be responsible for getting the prescription to the new pharmacy provider? Who will transport the medication to the patient (or the patient to the pharmacy)? Will this new process require more expensive nursing staff? The CSB staff is unlikely to have the additional man hours necessary to make this new system work.

I hope the Department of Behavioral Health and Developmental Services will track any changes in outcomes of those who would have been served by the state provided medications. I hope I am mistaken, but it seems a classic case of a budget decision which is "penny wise and pound foolish." The short term saving to the State of Virginia may well result in higher rates of readmission, incarceration and decrease in quality of care.

THE TEN MOST CONTROVERSIAL OBSERVATIONS I CAN THINK OF, AFTER SERVING AS COMMISSIONER FOR EIGHT YEARS, ABRIDGED

By James S. Reinhard, MD, DFAPA

Due to lack of newsletter space for a top ten list and at least a modicum of judgment in my editing, here are the remaining five intentionally controversial thoughts about our public mental health system and psychiatry in general:

1. We have enough public psychiatric beds in the Commonwealth of Virginia. We rank 11th in the country in the number of public psychiatric beds per capita. Only two states, New York and Texas, have more public psychiatric hospitals than the Commonwealth (yes, we have more state hospitals than California). What we don't have enough of are:

- a. Housing options for people in our state hospitals waiting to be discharged if only they had a place to live
- b. Crisis Stabilization Units that can be used in place of traditional psychiatric inpatient beds
- c. PACT teams, CSB emergency services personnel, CSB Psychiatrists, CSB Case managers, and other community resources to prevent crises and emergency admissions to inpatient beds
- d. Crisis Intervention Training (CIT) for more law enforcement officers in all jurisdictions, mental health courts, and other jail diversion resources to "intercept" individuals with serious mental illness before they inappropriately enter the criminal justice system and then need transfer to inpatient beds

2. We focus too much on the "disease burden" of psychiatric illnesses. Yes, we are talking about real and serious brain diseases that are often under or misdiagnosed, under or inappropriately treated. When this happens, lives are lost or the quality of living those lives is lost. People can get hurt. Productivity is lost, so a lot of money is lost. I get that. Having said that, we too often over-diagnose, over-prescribe, and over-emphasize the potential disabling characteristics of the illness. The concepts of "Recovery" and "Resiliency" get drowned out. We fail to instill hope (with patients, families and society) that people do get better. Our job, in part, is to restore morale. We need to help individuals develop lives that are not dominated by their illness. Calling a person a "schizophrenic" or "manic depressive" perpetuates the notion that a person is their illness, that they are totally and permanently consumed by the disability. We need to encourage individuals with mental illness, when appropriate, to take more responsibility for their illness and treatment in ways that we, as a profession, have failed to encourage in the past.

3. Containing and detaining people with mental illness to increase public safety has a low return on investment. The relatively low base rate of violence toward others and themselves by those with mental illness – coupled with the modest (but admittedly improving) ability to predict said violence means that the number we would need to detain in order to accu-

rately prevent the next violent act is too large. There are better ways to increase public safety "upstream" with better preventative community based services particularly focused on those with more risk factors for violence (substance use, history of violence, etc.)

4. We haven't made a consistently clear case to decision makers, yet, for why Psychologists should not have prescribing privileges. There are good cases to be made, and some of our psychiatric leaders are making them, I just haven't always heard them coherently and rationally articulated. We need to be more specific about what it is in our medical education that makes the difference. Furthermore, it would be helpful to our argument to have a better system of identifying and providing remediation for those with a medical degree that prescribe in patterns that don't reflect that they have had that critical education. Psychiatrists need to have a larger arsenal of pro-active responses to psychiatric shortages such as more widespread use of tele-psychiatry or more visible involvement with free clinics, providing care for uninsured, and serving those in underserved areas. Simply opposing others gaining prescribing privileges without realistic strategies for addressing the psychiatrist shortages looks very self-serving.

5. Psychiatry, and particularly public psychiatry, needs to decide whether it wants to rejoin the mainstream of medicine. Psychiatry can't have it both ways. For example, Psychiatry can't insist on parity with general medicine and then demand that every single one of its psychotropic medications be excluded from preferred drug lists for which the rest of health-care medicines are eligible. In this case, those who prescribe non-psychotropic medications understand that simply being eligible for a preferred drug list doesn't mean that the medication can't be prescribed to their patients if needed.

We should evaluate whether a separate public mental health system is necessary in the future. Why is mental health the only specialty in medicine with its own public hospitals and public mental health clinics? Are those reasons still valid 200 years after the opening of the first public psychiatric hospitals? Sherry Glied and Richard Frank have made the case in their book, *Better But Not Well*, that our patients have done better mostly to the extent that we have moved from an "exceptionalism" world view of psychiatry to one where our patients have been "mainstreamed" into more comprehensive healthcare insurance, income assistance, housing, and other social supports.

With the statistics showing that individuals with chronic and serious mental illnesses die twenty or more years earlier than the general population it is time to further explore ways to "mainstream" mental health, yes public mental health, into general medicine and healthcare.



James S. Reinhard, MD, DFAPA, MD



IN THE NEWS

WELCOME TO OUR NEW MEMBERS

GENERAL MEMBER

Sangeeta R. Chitlu, MD Leesburg, VA
Stephen I. Deutsch, MD, PhD..... Norfolk, VA
Stephanie E. Page, MDCatawba, VA
Melissa R. Robinson, DOFishersville, VA

MEMBER IN TRAINING

Matthew S. Knisley, MD.....Charlottesville, VA
Nivedita S. Nadkarni, MDCharlottesville, VA

MEMBERSHIP COMMITTEE UPDATE

The Membership Committee is concentrating on local chapter development, chapter relationships with PSV, and member recruitment through chapters.

Tidewater Chapter: Dr. Charles Devitt updated the committee members about plans for a Tidewater chapter meeting. A group of members interested in resurrecting the chapter held a teleconference meeting on September 2, 2009 to discuss their plans. Future meetings will be held at EVMS, courtesy of their new department chair.

Southwest Chapter: Dr. Jasdeep "Bobby" Miglani is the new president of the Southwest Chapter of PSV.

Richmond Chapter: Dr. Alexandru E. Trutia is the new president of the Richmond Psychiatric Society. The RPS has developed an 8 speaker program of meetings. Their meetings are now held in the Henrico Mental Health Conference Room.

PSV needs your help. If you have a friend or colleague who is a psychiatrist who might be interested in joining PSV, please contact Kim Battle at kim@societyhq.com or 804-565-6323 for more information. We will be happy to send them information about PSV and APA membership benefits.

Membership Committee: Dr. Rizwan Ali, Membership Committee Chair; Dr. Joseph Mason, Blue Ridge Chapter President; Dr. Avtar S. Dhillon, Peninsula Chapter President; Dr. Alexandru Trutia, Richmond Psychiatric Society President; Dr. Jasdeep "Bobby" Miglani, Southwest Chapter President; and Dr. Charles Devitt, Tidewater Chapter President.



SOUTHWEST CHAPTER UPDATES

*By Bobby Miglani, MD, FAPA
President, Southwest Chapter*

The Southwest Chapter of PSV comprises a vast geographical area of amazing beauty. We have the metro areas of Roanoke and Blacksburg; the beauty of Blue Ridge mountains, the vastness of Smith Mountain Lake; rugged mountains and valleys with several charming country towns in between.

It makes an interesting conversation point when I can tell some of my colleagues that there are places in this SW VA chapter where I can stand and be closer to three other state capitols (of Tennessee, Kentucky and West Virginia) than Richmond. While traditionally this area has been medically underserved; we have been making great strides in addressing that. Soon there will be three medical schools (the osteopathic schools in Blacksburg, VA and Lewisburg, WV, as well as the MD program at Virginia Tech – Carilion). We have two state psychiatric hospitals (Catawba and SWVMHI) as well as private in-patient programs affiliated with Carilion; St. Albans, Twin County Regional Hospital, Clear View Medical Center; Lewis Gale Medical Center and Bristol Regional Medical Center. There is a large comprehensive psychiatry program for Veterans at VAMC, Salem. There are some strong community health programs that offer a continuum of outpatient and partial level services.

I am proud to serve the psychiatric membership of this large and diverse region. I hope to be a liaison and spokesperson for psychiatric providers in the SW VA chapter.

TO MAKE THE VOICE OF PSYCHIATRY HEARD, WE NEED YOUR HELP.

PSYCHMD-PAC, our political action committee, is your vehicle.

We must increase our participation in politics to advance our profession and support our patients.

Thank you in advance for your support.

Please join us in making
a contribution to PSYCHMD-PAC
by visiting www.psva.org.



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Answers That Matter.

NAMI UPDATES

By Rashida Gray, MD
NAMI-PSV Liaison

NAMI (National Alliance on Mental Illness) Virginia has been very busy these last few months, wrapping up the NAMI walk, awarding the Heroes in the Fight awards, and the ongoing legislative and advocacy work.

HEALTHCARE REFORM

NAMI has been sending a strong message regarding healthcare reform including:

1. Support healthcare reform that provides quality and affordable healthcare for all
2. Ensure mental healthcare is a required basic health benefit and should be covered at parity relative to medical/ surgical benefits
3. Expand access to primary care and early intervention services for mentally ill who have a higher propensity for medical co-morbidities.

HEROES IN THE FIGHT

The award dinner co-sponsored by Eli Lilly, the Psychiatric Society of Virginia, Mental Health America of Virginia and the Virginia Association of

Community Services Boards was held September 15, 2009, at the Lewis Ginter Botanical Gardens.

NAMIWALK

NAMIWALK took place on October 3, 2009 at Innsbrook Pavilion, where there was a record attendance of nearly 800 people. New highlights for this year's event included a children's area with a clown, more seating, service dogs and expanded food options.

Over \$100,000 was raised this year. The Psychiatric Society of Virginia was a bronze level sponsor and provided an information table at the event.

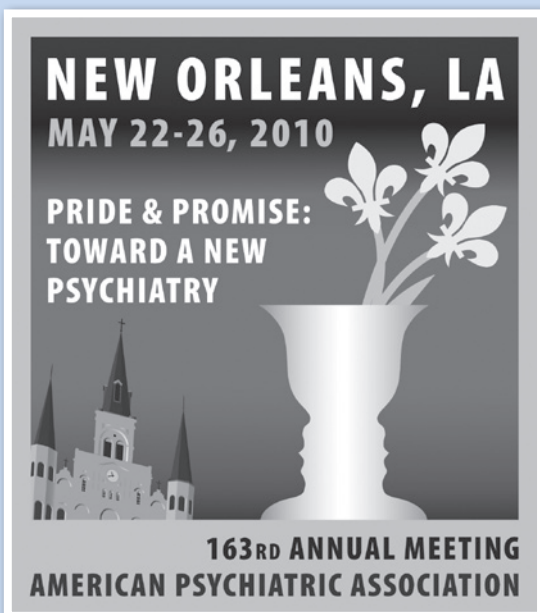
LEGISLATION

During this tight economic environment, NAMI is making an extra effort to educate the General Assembly about the devastating effects of budget cuts including two 5% budget cuts to Virginia CSBs and two 15% budget cuts to DBHDS. NAMI is encouraging the assembly to not approve any further funding cuts that reverse much of the progress made in the post-Virginia Tech tragedy environment.

NAMI PROGRAMS

(please see website for many other educational and supportive programs)

- BASICS, a new educational program for parents and other caregivers of children and adolescents. NAMI will be providing training for those interested in teaching courses for local affiliates.
- NAMI Connection Recovery Support Group, is available statewide as a support group for those suffering with mental illness.
- NAMI Virginia is the Virginia state office of NAMI. NAMI Virginia was created in 1985 to provide support, education, and advocacy for individuals and families affected by mental illness. Our mission is to promote recovery and improve the quality of life of Virginians with serious mental illness through support, education, and advocacy. NAMI Virginia's 27 local affiliates play an active role providing support, education, and advocacy at the community level.



PLAN NOW TO ATTEND THE 2010 APA ANNUAL MEETING

May 22-26, 2010 • New Orleans

2010 Meeting Information

Syllabus materials will be provided on CD-Rom to make for a less bulky registration pack and to make less of an impact on the environment. In keeping with the new environmentally friendly theme, conference bags will not be distributed this year. You are encouraged to bring a recycled older meeting bag for your conference materials. Registration is being accepted from November 17, 2009 - April 16, 2010.

TO REGISTER, VISIT www.psych.org/MainMenu/EducationCareerDevelopment/Meetings.aspx

REPORT FROM VIRGINIA REGIONAL ORGANIZATION FOR CHILD AND ADOLESCENT PSYCHIATRY

By A. Bela Sood, MD, MSHA

The Fall Meeting for the Regional Organization for Child and Adolescent Psychiatry, VA, was held September 9, 2009, at the lovely Maymont Park in Richmond and was attended by 20 child and adolescent psychiatrists. Elections were held and the following slate of officers were voted into office: President: A. Bela Sood, MD, MSHA (VCUHS); Secretary: Peggy Ebinger, MD (Sentara); Treasurer: Pooja Sabharwal, MD (fellow, UVA). Congratulations and thanks to the previous President, Dr. Dorothy O'Keefe, MD, (private practice, Richmond) for a job well done for several years!

A CME program was offered which included a keynote address by Dr. Christopher Lamps (VCUHS), on the new Code of Ethics for AACAP that he has co-authored. Dr. Ross Yaple (VCUHS) spoke about the distinction in the CAPs role as an expert or fact witness. Dr. Sood (VCUHS) reviewed current practices of the prescription of psychotropics for children younger than five. Dr. Khwaja (fellow, VCUHS) discussed his role as a child psychiatrist co-localized in a pediatric practice in an underserved area.

Another focus of the meeting was to determine how to make membership relevant to Virginia CAPs. It was suggested that members organize around committees that will get more people involved in decision making around professional issues. Future meetings will be organized around the committee structure (presentations showcasing work product). Four committees were created: 1) **Early Career CAPs Committee:** Dr. Ross Yaple: Chair; Dr. Chas Hall agreed to be a member. They would like input from more seasoned/senior CAPs to move the committee along. 2) **Legislative Action Committee:** Given that the chair be Richmond based, Dr. Sood and Dr. Wesley Carter will co-chair this committee and are seeking volunteers from the Central, Roanoke, Norfolk and Northern VA areas; 3) **Training and Education Committee:** To pool resources between the three training programs and improve collaboration. Dr. Roger Burkett (UVA program) and Felicity Adams (Carillion Program) will co-chair this committee. 4) **Clinical Committee:** Will focus on work force interface with managed care, and clinical issues that impact CAPs. Dr. Peggy Ebinger (Sentara) and Pooja Sabharwal (UVA) will co-chair.

ALL COMMITTEES ARE STILL OPEN and are looking for people to serve on them with representation from all the regions.

For each one year period, committees can meet over the phone twice and also must have at least three meetings. We will formalize the committees by December 2009 by defining charter/mission and membership.

We are very excited about the new committee structure and are planning a spring meeting in March or April 2010.

ID FOR RENT

By Niels C. S. Nielsen, MD

The "Balloon Boy"... Yes, we've all seen it. People gaping as they watched the silver contraption floating lopsidedly, fearing for the boy's life, who was never inside of it in the first place. Then, the excessively played clip where Falcon, despite his mother shaking her head in vain trying to lead him on what to say, naively admitted "We did this for the show." As he said that, his father immediately bit his own lips, confirming the hoax. It's amazing how our bodies just don't let us lie. And then the worst part: having to put up with Geraldo and all of your friends saying "I knew this was a hoax all along..."

Now, there is something really sad and disturbing about this pathetic episode. Just as a fever is not a disease, this is a symptom of something much more pervasive and concerning, illustrated by the following episode. As I was trying to help a patient explore new ways of relating to her family, I took the opportunity to model an appropriate response to her attempts to relate to me in a dysfunctional way, which resulted in her summarily dismissing all of that as something impossible, saying "this is just not the way 'real people' react." This prompted me to inquire what she meant by "real people," and to my dismay, she meant the people she watches in reality shows. (Sigh...)

It's virtually impossible to turn on the TV without running into some kind of "reality show." They come in many different flavors, but to me they have two main things in common. First, they are a lie. It doesn't matter if they call it "reality" or not. Those people are carefully selected based on the fact that their dysfunctional personality traits will be amplified by them being on TV and by the high likelihood that their interactions will result in conflict. Second, and most important, they lend an Id to the spectator, who can experience those conflicts and emotional outbursts by proxy, as it were, without needing to reenact them in their own lives. But eventually the spectators might start to assume that this is how one's Ego deals with conflict and then they incorporate that into their own lives. In case you cringe whenever you read words such as "Id" or "Ego", consider the cognitive aspect of this: Koolstra (2007) pointed out that "heavy television viewers adopt a world view congruent with how the world is portrayed in fictional television programs."¹ He also showed a blurring in the distinction between fiction and reality in persons who watch TV excessively. One can hypothesize that calling these programs "reality" could enhance that learning effect, in a way, disseminating dysfunctional behavior as normality. They then learn to use those strategies to solve problems, having a restricted repertoire of behaviors. By the way, a cool idea for a reality show would be to lock a handfull of psychiatrists of completely different theoretical orientations in the same house for a month and have them comment on each other's behaviors using their favorite jargon. But I digress...

This is upsetting. Not just because it thwarted my attempt at modeling appropriate behavior, but because it's a reflection of a very sad reality. You are what you watch.

1 Koolstra CM. Percept Mot Skills. 2007 Feb;104(1):102-10. Source confusion as an explanation of cultivation: a test of the mechanisms underlying confusion of fiction with reality on television.

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Beyond DSM-IV



2009 FALL MEETING
September 25-26, 2009
Hotel Roanoke • Roanoke, Virginia



MEETING HIGHLIGHTS



From left, Neha Thapa, MD; Roopa Sethi, MD; Paul Delapp, MD, Ram Shenoy, DLFAPA, MD, APA Assembly Representative; Rizwan Ali, MD, PSV Membership Committee Chair.



Brian Wood, MD, (right) President of the Southwest PSV Chapter talks to Pfizer representatives.



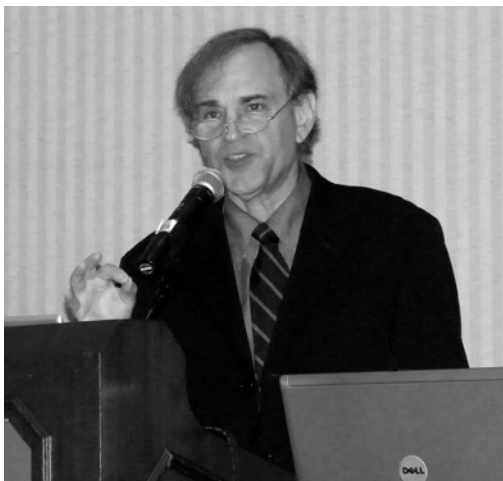
Doug Chessen, DLFAPA, MD, PSV Foundation President and J. Gregory Fisher, DFAPA, MD, Past President and his wife.



Dr. Conell, PSV Past President, presents the golf trophy to Dr. Chessen, this year's winner.



Ananda K. Pandurangi, DFAPA, MD & Jerome C. Wakefield, PhD, DSW debate on depression and take questions from the audience.



Jerome C. Wakefield, PhD, DSW



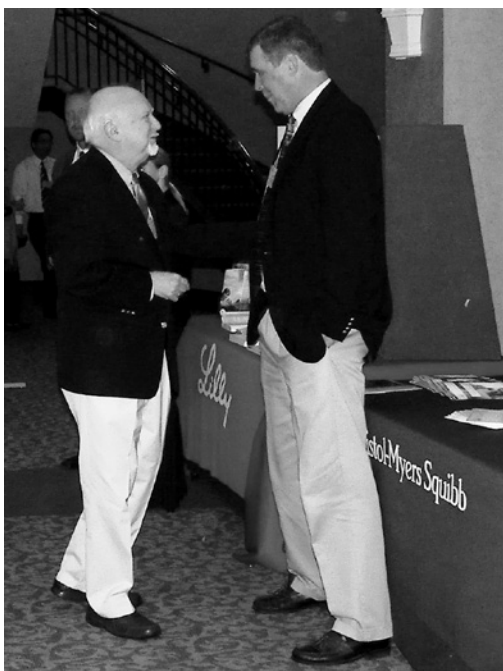
Paulette Chessen mans the PSV Foundation table



James S. Reinhard, DFAPA, MD, Commissioner, Commonwealth of VA Department of Behavioral Health and Developmental Services and Pierre H. Golpira, MD, PSV At Large Board Member.



Past Presidents Fisher & Conell; Ethics Chair & Poster Judge Rebecca Lindsay, MD; President-Elect Cheryl Jones, MD; Alternate Legislative Chair Antony Fernandez, MD.



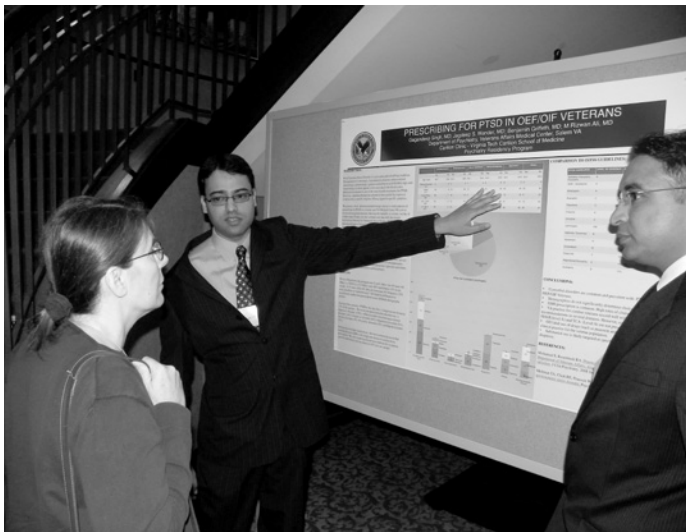
B.R. Ashby, DLFAPA, MD, Past President of PSV, discuss treatment options with Bristol Myers Squibb representative.



Wesley B. Carter, DLFAPA, MD, talks to two Eli Lilly representatives.

POSTER SESSIONS, PSV FALL MEETING, SEPTEMBER 25-26, 2009

The following paragraphs are brief descriptions of the first, second and third place winners for the poster session at the PSV Fall Meeting, held September 25-26 in Roanoke, VA. The descriptions are followed by the full list of presented posters.



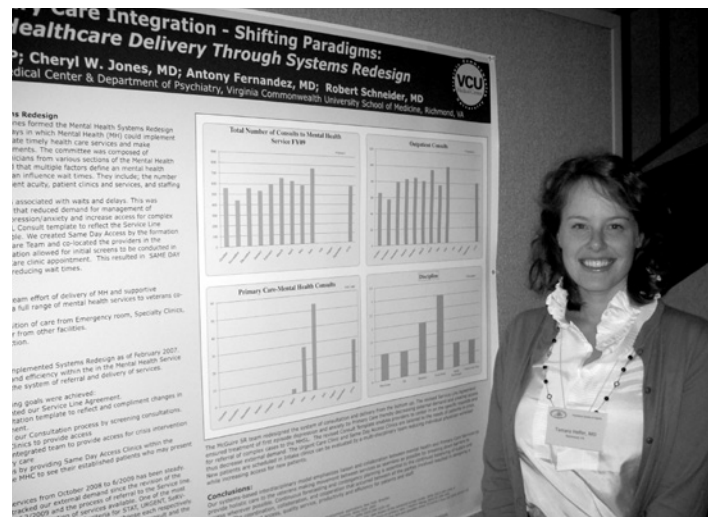
FIRST PLACE

PRESCRIBING FOR PTSD IN OEF/OIF VETERANS

By: Gagandeep Singh, MD; Jag Wander, MD;
Benjamin Griffeth, MD; Rizwan Ali, MD

Carilion Clinic - Virginia Tech Carilion School of Medicine
Psychiatry Residency Program

Post-Traumatic Stress Disorder is a prevalent and a disabling condition. Dysregulation of various neurotransmitter pathways are hypothesized as a cause of the PTSD symptoms and pharmacotherapy remains one of the most feasible treatments. However, medication management has primarily been guided by empirical evidence that a specific drug has efficacy against a specific symptom. We conducted a short pharmacoepidemiologic survey to study patterns of prescribing for PTSD at the VA Medical Center, Salem, VA. For this poster, we did a retrospective chart review for one year and looked at one hundred OEF/OIF combat veterans with at least one axis I diagnosis of PTSD. In addition to demographic information, we also collected data on co-morbid conditions and various classes of medications prescribed. In our sample, we found that there was a high rate of SSRI prescription with citalopram being the most common. Off label prescription of medications was also prevalent in our sample of patients. We then compared prescription in our sample with the current ISTSS guidelines and found that VA practice for combat Veterans accord well with standard guideline recommendations. This short study is part of our ongoing research and we aim to reveal unrecognized practices that may be valuable, or at least, worthy of further study for the effective treatment of PTSD in combat Veterans.



SECOND PLACE

MENTAL HEALTH PRIMARY CARE INTEGRATION – SHIFTING PARADIGMS: TRANSFORMING VETERANS HEALTHCARE DELIVERY THROUGH SYSTEMS REDESIGN

By: Tamara Helfer, MD; Steven Carter, FNP; Cheryl W. Jones, MD; Antony Fernandez, MD; Robert Schneider, MD

Hunter Holmes McGuire Veterans Affairs Medical Center & Department of Psychiatry, Virginia Commonwealth University School of Medicine, Richmond, VA

Systems Redesign is a patient centered, scientifically based set of tools and principles that enables staff to examine their healthcare processes and redesign them. Our redesign model emphasizes liaison and collaboration between Mental Health and Primary Care by co-locating a Mental Health team into Primary Care clinics and redesigning the consult template. As a result, we were able to reduce the demand for uncomplicated first episode depression/anxiety; thus, allowing for increased access to complex cases as well as reducing wait times, via same day patient access. Overall, our systems redesign has created a model which resulted in improved access, improved patient/staff/provider satisfaction, improved quality and efficiency, and decreased total costs.

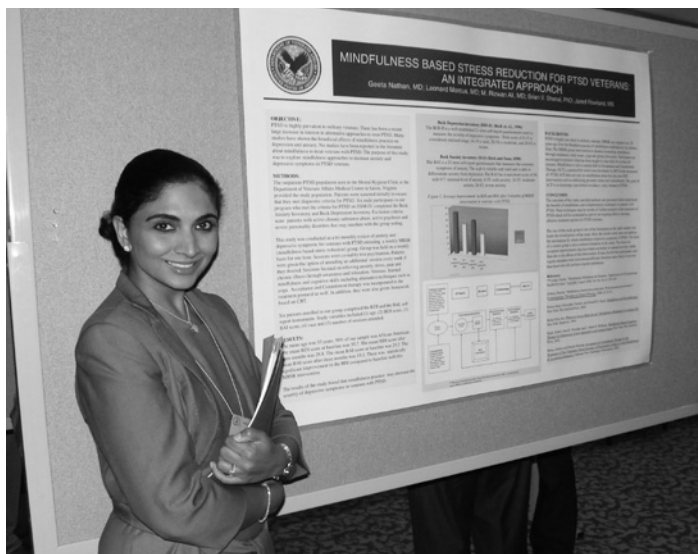
THIRD PLACE

MINDFULNESS BASED STRESS REDUCTION FOR PTSD VETERANS: AN INTEGRATED APPROACH

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PTSD is highly prevalent in military veterans. There has been a recent large increase in interest in alternative approaches to treat PTSD. The goal of this study was to explore integrated approaches to decrease anxiety and depres-



sive symptoms in PTSD veterans. This project was conducted to study the possible beneficial effects of MBSR (Mindfulness Based Stress Reduction) and related approaches such as ACT (Acceptance and Commitment therapy) for the treatment of veterans suffering from PTSD. Specifically, this study used the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI) to monitor patients' improvement using these techniques. This study was conducted as a tri-monthly review of anxiety and depressive symptoms for veterans attending a weekly MBSR group. Veterans learned mindfulness and cognitive skills, including alternative techniques such as yoga.

Results: There was statistically significant improvement in the BDI compared to baseline with this intervention. The results of the study found that mindfulness practice and related techniques may decrease the severity of depressive symptoms in veterans with PTSD.

ALL POSTER ENTRIES

1. **Gagandeep Singh, MD;** Jad Wander, MD; Benjamin Grif-feth, MD; Rizwan Ali, MD: Prescribing for PTSD in OEF/ OIF Veterans
2. **Tamara Helfer, MD;** Steven Carter, FNP; Cheryl W. Jones, MD; Antony Fernandez, MD; Robert Schneider, MD: Mental Health Primary Care Integration - Shifting Paradigms: Transforming Veterans Healthcare Delivery Through Systems Redesign
3. **Pradip Koirala, MD;** James Poindexter, ANP; Brenda Long, BS; Jerome Whitaker, CSAC; Antony Fernandez, MD; Victor Vieweg, MD; Frank Crow, PhD: Drop Out and Retention Rates in Veterans Receiving Treatment with Buprenorphine (Suboxone®)
4. **Erik Petersen, MD;** Evan Reiter, MD; Antony Fernandez, MD: Treating Sleep Apnea in a Hospital Setting – Findings from the National Inpatient Sample Database
5. **Margarita Somova, MD;** Kathleen Stack, MD - Outcome Measures in Substance Abuse Treatment
6. **Daliborka Danelisen, DO;** Amanda Roaf, BS; Frank

Crow, PhD; Antony Fernandez, MD: Promoting Recovery Through Continued Engagement in Substance Abuse Treatment - Findings from McGuire Richmond Veterans Affairs Medical Center

7. **Ehsan Habibpour, MD** - The Successful Importation of Collaborative Problem Solving to Reduce Seclusion and Restraints In An Inpatient Child Psychiatric Facility
8. **Cassandra Hobgood, MD;** Samia Sabeen, MD; Suzanne Holroyd, MD - Geriatric Psychiatric Hospitalization: An Inclusive Look at an Acute Inpatient Population on a Specialized Unit
9. **Jagadamba Pandit, MD;** James Poindexter, ANP; Scott McDonald, PhD; Antony Fernandez, MD; Victor Vieweg, MD: QTc Screening in Veterans with Opiate Dependence on Methadone Treatment.
10. **Geeta Nathan, MD** - Mindfulness-Based Stress Reduction for PTSD Veterans: An Integrated Approach
11. **Meagan Cogbill, MD;** Frank Crow, PhD; James Poindexter, PMHNP; Antony Fernandez, MD: Performance Improvement of Weekend Pass Outcomes of Veterans Enrolled in Substance Abuse Residential Rehabilitation Treatment
12. **Aidith Flores-Carrera, DO** - Videophones: A Literature Review of an Underutilized Telemental Health Vehicle
13. **Roopa Sethi, MD** - Prevalence of Vascular Dementia Among the Salem VAMC Veteran Population
14. **Abigail J. Mansfield, MD** - Institutional Continuous Medical Education (CME) Funding; Who Will Pick Up the Tab?
15. **Rabia Jafri, MD;** Jessica Mees-Campbell, MD - Another Perspective: The Management and Prevention of Post-Traumatic Stress Disorder in German Army Soldiers ("Bundeswehr") Deployed in Afghanistan
16. **Castro-Alvear, MD;** Niels C. S. Nielson, MD - Supplementation of Antidepressant with Fatty Acid Therapy (Sad Fat)
17. **Neeta Kumari, MD;** Alaa-Eldin Mahmoud, MD - Alzheimer's Dementia and Folate
18. **Tomothy Brandon, PharmD;** Martin Cruz, PharmD - Risk of Sudden Cardiac Death with Atypical Antipsychotics



Mary Shemo, DFAPA, MD and Rebecca J. Lindsay, DFAPA, MD, two of the poster judges, carefully review poster



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MSV ANNUAL MEETING & HOUSE OF DELEGATES SESSIONS

*By Victor R. Vieweg, MD, DLFAPA
PSV Delegate to MSV Conference*

I experienced the Annual Meeting of the Medical Society of Virginia as a vibrant, focused meeting, determined to meet the needs of patients and physicians in the Commonwealth of Virginia. Particularly noteworthy was the focus on the need to improve access to primary care and the need to increase the supply of primary care clinicians, coupled with the need to avoid any further increase in malpractice premiums as a means of protecting the supply of physicians in the Commonwealth. There was also considerable discussion about the changes in healthcare Congress will deliver over the next several months.

There was little in the way of mental health issues, perhaps, because few psychiatrists are presently members of the Medical Society of Virginia and/or attend the annual meeting. As best I could tell, only Owen Brodie and I came from the Richmond area. Outside the two of us, only two other psychiatrists attended the MSV Annual Meeting. In the past, we have even had a psychiatrist, Jim Shield, MD, as President of the MSV.

I believe we need to join primary care providers (family physicians, general internists, pediatricians, and many gynecologists) to find allies in protecting our patients and enhancing mental healthcare in the Commonwealth. See the table

below showing the distribution of physicians by specialty. Note that psychiatrists make up only 5.1% of the supply of US physicians. And, psychiatrists are more likely than primary care or other specialties to be in solo practice or in very small groups. This is certainly true in Richmond. Perhaps, one of our upcoming semiannual meetings can focus on finding allies among our medical colleagues to help improve mental healthcare in the Commonwealth.

Table 1

Percent distribution of active physicians in patient care by specialty, 2005

Primary Care	40.4 %
Family Medicine & General Practice	12.3 %
Internal Medicine	15 %
Obstetrics & Gynecology	5.5 %
Pediatrics	7.5 %
Specialties	59.6 %
Anesthesiology	5.2 %
Psychiatry	5.1 %
Surgical Specialties, Selected	10.8 %
All Other Specialties	38.5 %

Source: American Medical Association, Physician Characteristics and Distribution in the US, 2007.