The Winter of Our Discontent

As I am sitting at home because we had the biggest snow and ice storm this season, I am trying to decide what are the hot topics in Psychiatry this year.

The first one that comes to mind is the increasing number of suicides during the pandemic. People had trouble finding a psychiatrist and when they found one, the visit was typically virtual. This may not be the best interaction between patient and doctor but it is better than nothing. There were increased calls to the self help suicide prevention lines. Several states have approved a 988 suicide prevention call line. Missouri has not yet acted on this issue. If you are wondering why you must dial the area code in your own area, this is the answer. Several area codes have numbers that start with 988 including 314, 417,660, and 816. The 988 number will replace the current 10 digit number 1-800-273-Talk (8255). NAMI predicts that the volume of calls will increase to more than 172,000. We need funding for the staff to answer those calls.

According to Kurt Erickson of the St. Louis Post Dispatch, Missouri legislators were supposed to pass funding for the 988 project in the budget. If you have been following the legislature, you will know that the Senate is currently bogged down with the redistricting of the 8 Federal Congressional districts. There have been filibusters in the Senate. These block the progress of other bills. The passage of the budget that will hopefully have funds for 7 call centers in Missouri, is part of the backlog.

Why is this important? Most people believe that winter and the holidays are the seasons for the most suicides. Not true. Spring is the season of the most suicides. Some people blame the fact that most people feel uplifted with the increasing light and warmer temperatures and want to do more things like exercise. People with depression feel even worse. Patients with bipolar disorder also may experience a Manic episode followed by a crash into depression. They are energized and dysphoric and that is a perfect storm for suicide.

This is the time to be vigilant and question our patients about their suicidal thinking. Also, it is important to give them information about the self help lines.

This is also the time to contact your state senators and representatives to include funding for the 988 number. And while you are contacting them remind them to fund the Medicaid expansion that was passed (Continued on page 2)
President’s Message

by the Missouri citizens. This will help our rural population as well as the urban population who do not have insurance,

Missouri State Medical Association is hosting an in person White Coat Day at the Capitol in Jefferson City on Tuesday March 1. It will start at 9:00AM and end mid afternoon. I urge you to join me that day. You will need to contact MSMA to register for lunch or just come and join us in the Rotunda.

The next topic is our own CME. On Saturday April 23, MPPA will host a virtual meeting from 8:30 am to 1:00 pm on a variety of topics. Dr. Daniel Mamah from WU will talk about first episode psychosis, followed by Dr. Bredeson speaking on Dementia, followed by Dr. Doug Burgess talking about Opiate Use Disorder and finally Dr. Kim Brandt discussing Perinatal Psychiatry. I was hoping for an in-person meeting but as the planning sessions were evolving, so was the omicron surge. We decided for the sake of safety to do one more virtual meeting.

Speaking of in-person meetings, the annual APA meeting is scheduled in New Orleans from May 20-25, 2022. I hope to see old friends and get some CME. For those who do not want to travel, APA will have a virtual meeting in early June.

I wish all of you a productive spring and summer. Dr. Subbu Sarma will take over the Presidency of MPPA at the end of the APA meeting. I urge all of you to vote for our new President-Elect and Assembly Representative when the ballots arrive.

Jo-Ellyn M. Ryall, MD APADLF
President, Missouri Psychiatric Physicians Association
Central nervous system stimulants are prescribed to children and adolescents with increasing frequency for treatment of Attention-Deficit/Hyperactivity Disorder (ADHD). Due to their well-established safety profile and high efficacy, stimulants are used first-line to support learning and general well-being in children with ADHD. Caution must still be used when prescribing stimulants, which are associated with appetite suppression and weight loss in children. Since the benefits of stimulants were first established, concern has grown for stimulant-associated growth deceleration and the possibility of persisting limits on height and weight.

The Multimodal Treatment of Attention-Deficit Hyperactivity Disorder Study (MTA), sponsored by the NIMH in 1997, focused on the comparative efficacy between stimulant medication, behavior therapy, a combination of both, and usual community care. At the time the MTA was first conducted, there was little concern that use of stimulants would meaningfully affect children’s size. Children who exhibited slower growth while taking stimulants for ADHD were expected to regain their expected height and weight in accordance with the growth rebound hypothesis or overcome hypothetical delayed maturation from ADHD itself. However, more recent research has demonstrated growth deceleration in children taking stimulants without evidence of growth recovery.

A 36-month follow-up study conducted to address some of the MTA’s limitations found that newly medicated children who initiated stimulants during the surveillance period grew an average of 2.0 cm and 2.7 kg less than the children who remained unmedicated. Growth stopped decelerating by 36 months, but no growth rebound was noted. Children who were already taking stimulants at study initiation and stayed consistently medicated did not show decreases in relative height/weight but remained smaller than their stimulant-naïve peers.

An analysis of height, weight, and height velocity in a cohort of 51 children newly treated with stimulants for ADHD found that, in the first 6 months, 86% had a height velocity below the age-corrected mean, and 76% lost weight. Height velocity was diminished for the first 30 months of treatment, and the mean deficit in height was ~1 cm/year for the first 2 years. The children were followed for a maximum of 42 months, during which a pattern of growth recovery was not established for children who continued to take stimulants.

Stimulant-induced appetite suppression appears to contribute to slowing of growth. Increasing caloric intake may help to offset the decrease in weight gain in children taking stimulants. In 2020, a randomized controlled trial involving 230 children ages 5-12 with no history of chronic stimulant use examined the efficacy of weight recovery treatments (WRTs). Children were randomly assigned either to treatment with daily methylphenidate or to behavior therapy. The children who showed a decrease in BMI of > 0.5 z-units after 6 months of methylphenidate were randomly assigned to 1 of 3 WRT groups: monthly monitoring of height and weight, drug holidays (medicating for school hours only), and 150 kcal/day caloric supplementation. Although children assigned to all 3 WRT groups increased their weight velocity, recovery was greater for those who took drug holidays or caloric supplements. None of the WRTs were associated with an increase in height velocity.

If tolerated, a child with significant appetite suppression on stimulants may recover some weight by medicating only during school hours with a shorter-acting stimulant and not taking medication on days without school. However, shorter-acting formulations have the disadvantage of waning therapeutic effect later in the day. Worsening ADHD symptoms during non-medicated hours may make it...
necessary to try other weight recovery methods. To maximize caloric intake, it is important to know how the patient is taking stimulant medication in relation to mealtimes.

When a child presents with reduced appetite and/or diminished growth, a range of potential causes must be investigated even if the child is taking stimulants for ADHD. Even when stimulant medication is the likely culprit, the benefits of stimulant medication for a particular child’s overall functionality may justify continuing the medication and addressing appetite suppression by other means.

We suggest the following measures when a patient taking stimulants for ADHD presents with decreased appetite and/or growth:

1) **Thorough medical and psychiatric history including screening for substance abuse**
Medical conditions unrelated to prescription stimulant use may contribute to decreased appetite and weight loss. Decreased oral intake may be a presenting symptom in diabetes, hypothyroidism, inflammatory bowel disease, malignancy, and a variety of other causes. Loss of appetite may also be a symptom of a depression, anxiety, or eating disorders. Any history of substance abuse, especially with methamphetamine, cocaine, or other non-prescribed stimulants is particularly important to know when prescribing stimulant medication for treatment of ADHD.

2) **Complete and accurate list of prescription and non-prescription medications**
For patients prescribed stimulants, it is important to know what other medications with appetite-suppressing effects are being taken concurrently. For example, decreased appetite is associated with use of bupropion, topiramate, amantadine, spironolactone, nitrofurantoin,itraconazole, and hydroxyurea. Improved appetite and weight gain may be achieved by minimizing or replacing other medications without discontinuing the stimulant.

3) **Drug holidays and caloric supplementation**
As demonstrated by Waxmonsky et al. in the trial of weight recovery treatments (WRTs) for stimulant-associated growth restriction, increasing caloric intake by use of supplements and strategic timing of medications may help to restore weight velocity. Parents or caregivers may be encouraged to maximize the child’s caloric intake by offering food when appetite is highest. Administering medication with or after a full meal may allow for sufficient nutrient intake before the medication begins to have appetite-suppressing effects. Other helpful strategies for increasing caloric intake include offering a small bedtime snack or delaying dinnertime until after stimulant medication effects wear off.

4) **Regular monitoring of height and weight**
Although the effect was smaller in the monitoring group than the drug holiday or caloric supplementation groups, Waxmonsky et al. found that in children whose BMI decreased with initiation of stimulants, measuring weight and height on a monthly basis increased weight velocity. In theory, regular monitoring may be helpful because it keeps parents and caregivers mindful of any changes in growth. This awareness may lead caregivers to limit medication frequency and increase the child’s caloric intake.

Treatment of ADHD in children and adolescents must be individualized. If stimulant medication improves decision-making and learning ability for a child with ADHD, these benefits must be considered along with the stimulant’s potentially negative effects on growth and physical development. If appetite suppression and/or lack of growth are significant or do not

(Continued on page 5)
Managing Growth Deceleration Associated with ADHD and Stimulant-Induced Appetite Suppression

Sultana Jahan, MD, University of Missouri-Columbia
Megan Loehr, MD, University of Missouri-Columbia
Ellen O’Neill, Undergraduate Student, University of Missouri-Columbia

respond to the above recommendations, the clinician may consider a different type of stimulant or a trial of non-stimulant medication. This approach may help to optimally treat ADHD symptoms while keeping appetite and growth effects manageable.

References:

APA Announces Results of 2022 Election

At its meeting on February 14, APA’s Committee of Tellers approved the following results for the 2022 APA National Election. Please note that these results are considered public but not official until approved by the Board of Trustees at its meeting on March 12 and 13.

President-Elect: Petros Levounis, M.D., M.A.
Treasurer: Richard F. Summers, M.D.
Trustee-at-Large: Michele Reid, M.D.
Area 3 Trustee: Geetha Jayaram, M.B.B.S., M.B.A.
Area 6 Trustee: Barbara Yates Weissman, M.D.
Resident-Fellow Member Trustee-Elect: Seth L. Daly Stennis, M.D.

“I am honored and grateful to have been elected by my fellow members to help lead the APA,” Levounis said in a media release. “I look forward to helping build APA’s leadership role in mental health both within American medicine and in collaboration with our colleagues across the world.”

“Congratulations to Dr. Levounis and the other candidates on their election,” said APA President Vivian Pender, M.D. “I look forward to working with these enthusiastic and dedicated newly elected APA leaders in the coming years to advance the important efforts of the APA and its members.”

“Dr. Levounis’ leadership and commitment will greatly benefit the APA,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “APA members and the profession of psychiatry will be well served by his guidance and leadership. I also want to personally congratulate all the winners and to salute the other candidates.”

Levounis’ term as president-elect of APA will begin in May at the conclusion of the APA Annual Meeting, when current President-Elect Rebecca Brendel, M.D., J.D., begins her one-year term as president. The other winners will also take office at that time.

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I witnessed a lively debate about the psychiatrist as advocate at the annual meeting of the American Academy of Psychiatry and the Law several years ago. The image of the prototypal forensic psychiatrist is an individual who is dispassionate, unbiased, objective. Some attendees voiced concern that our role as nonpartisan expert witnesses would be undermined by pursuing advocacy work. Other psychiatrists argued that we are uniquely positioned to understand and articulate the needs of our vulnerable patients, who so often find themselves in the crosshairs of an adversarial legal system and a woefully inadequate mental health system. Every year, federal and state governments make countless decisions that impact the wellbeing and care of Americans living with mental illness. The legislative machine continues to churn with or without the counsel of physicians and other mental health professionals. By sharing our insight with legislators and other state officials, we may contribute to changes that help our patients more than single office visit or psychiatric hospitalization ever could.

I work with juveniles and transitional age youths in the criminal justice system. By the time I am involved, many of these individuals have been written off as incorrigible. Though the state views them as too young and immature to vote or buy cigarettes, they are considered old enough to face potential lifelong incarceration in an adult prison. As a forensic child psychiatrist, I am called to testify in transfer hearings. I explain the unique features of the juvenile brain, how conditions like ADHD and PTSD can exacerbate

(Continued on page 7)
impulsivity, and why a particular youth could be rehabilitated while remaining in the juvenile court. I find meaning in this work, but I hope future advancements in the juvenile justice system make my role obsolete. The youth of Missouri would be better served if the court incorporated modern understandings of neurodevelopment from the start, with no expert witness required.

The current president of the Greater St. Louis Council of Child Psychiatry, Dr. Alicia Barnes, is also passionate about the plight of juvenile offenders. We partnered with an incredible regional organization, Missouri Appleseed. As their mission statement describes, Missouri Appleseed focuses on “issues at the intersection of criminal justice reform and public health” through “research, advocacy, and education.” Our collaborators at Missouri Appleseed, Liza Weiss and Finola Prendergast, were warmly welcoming and enthusiastic about pursuing a project related to juvenile justice. Together, we applied for an Advocacy and Collaboration Grant from the American Academy of Child & Adolescent Psychiatry (AACAP). Per AACAP’s website: “This grant opportunity is intended to help regional organizations engage in advocacy activities to improve children’s mental health care in their state or community and require collaboration with allied consumer or professional organizations.” Our application explained our desire to educate lawmakers and other state officials about juvenile brain development.

We received notice of grant approval in the spring of 2021. Mindful of the ongoing COVID-19 pandemic, we explored how to best present and share the modern neuroscience. Fortuitously, Liza Weiss and Finola Prendergast had considerable experience with organizing and hosting online continuing legal education conferences for attorneys. We leveraged their knowledge to design a virtual, interdisciplinary conference titled: “Emerging Developments in Neuroscience of Juvenile Certification.” The free conference drew together five experts from different states and disciplines to discuss their professional perspective on juveniles, neurodevelopment, and the court. The recording of this conference is available for anyone to watch on Missouri Appleseed’s website (missouriappleseed.org) under the News/Events heading. The presenters included myself; Katelyn Young, J.D., an attorney for Missouri’s Children Defense Team; Fred Rottnek, M.D., professor of Addiction Medicine at Saint Louis University School of Medicine; Eraka Bath, M.D., Vice Chair for Justice, Equity, Diversity, and Inclusion at the UCLA Neuropsychiatric Institute; and Laurence Steinberg, Ph.D., Distinguished Professor of Psychology at Temple University.

Missouri recently successfully implemented “raise the age” legislation; 17-year-old offenders are now under the jurisdiction of the juvenile court rather than being tried as adults automatically. This is progress. Yet there are persistent attempts to approach delinquent children punitively rather than with an eye towards rehabilitation. One piece of proposed legislation last year would have allowed for children younger than age 12 to be transferred to the adult court. Dr. Barnes and I look forward to continuing our advocacy work in April when we will travel to Jefferson City with the Missouri Chapter of the American Academy of Pediatrics. By ongoing collaboration with other organizations, we hope to do our part to improve the future for Missouri children, especially our most at-risk youth.
Alcohol use disorder is a chronic disease, and the consumption of alcohol after treatment is an integral part of the disease process. However, drinking alcohol itself is not a disorder; persistent problematic drinking is.

The authors investigated the stability of the yearly drinking patterns of individuals with alcohol use disorder after discharge from psychiatric hospitalization. A sample of 259 men and women hospitalized in 1967-68 with a diagnosis of probable or definite alcohol use disorder by Feighner Criteria was followed for over 21 years. Of the survivors 76 had yearly drinking pattern data available for an entire 21 years.

The yearly drinking patterns were analyzed for the proportions maintaining them for >5 years and for the mean maximum number of consecutive years for each pattern. This follow-up cohort represented a less severely affected group of problem drinkers than had been admitted to the study.

Abstinence, occasional-social drinking (<3 drinks/day, 1-2 days/week or intoxication <3 times/year), regular-heavy drinking (<3 drinks/day, 5-7 days/week or ≥ 3 drinks/day, ≥ 3 days/week or intoxication ≥ 12 times/year but < weekly), and very-heavy drinking (≥ 7 drinks/day, ≥ 1 day/week, or ≥ 52 intoxications/year) or binge drinking (intoxication for ≥ 2 days with abstinence for weeks or months before the next ≥ 2 day binge) were the most stable patterns of consumption over the 21 year follow up.

Forty three percent had maintained abstinence; 21.1% had maintained occasional-social drinking; 19.7% had maintained regular-heavy drinking; and 44.7% had maintained very-heavy or binge drinking for ≥ 5 consecutive years. The mean maximum consecutive number of years were: 6.7 for abstinence, 2.7 for occasional-social, 2.5 for regular-heavy, and 7.3 for very-heavy or binge drinking.

Frequent-social (<3 drinks/day, 3-4 days/week or ≥ 3 drinks/day, 1-2 days/week intoxication 4-11 times/year and regular-light drinking (1 drink/day 5-7 days/week and 0 intoxications/year) were the least stable patterns over the 21 year follow up. Only 6.6% had maintained frequent-social drinking, and 0% had maintained regular-light drinking for ≥ 5 consecutive years. The mean maximum consecutive number of years were: 0.9 for frequent-social and 0.0 for regular-light drinking.

In summary, occasional-social drinking was the most stable, non-abstinent, drinking pattern even though the definition included < 3 intoxications/year. Frequent-social and regular-light drinking were the least stable patterns in that they had a high likelihood of leading to more serious, pathological consumption. Even though regular-light drinking, defined as 1 drink/day 5-7 days a week and no intoxications/year, is below the NIAAA guidelines for heavy drinking for the general population, it was the least sustainable pattern for individuals in recovery from alcohol use disorder. This marked instability of regular-light drinking suggests that both tolerance and alcohol-related cue exposure are important components of relapse for those in recovery.
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Director: Dr. Daniel Mamah

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The Association of American Medical Colleges has projected that by 2025 there will be a shortfall of between 14,900 and 35,600 doctors. Additionally, with the aging Boomer generation and a projected 45 percent increase in those over the age of 65, this shortage presents a tremendous future burden [1]. Compared with the rest of the U.S., Missouri has a low provider per capita ratio. Roughly 37 percent of individuals living in Missouri reside in rural areas, yet only 18 percent of physicians in the state practice in these rural regions [2]. According to the NC Rural Health Research Program, there are seven rural hospitals that shut down within the past decade, indicating a desperate need for healthcare providers.

Not only does Missouri have underserved areas, but it also has some of the worst health outcomes in the country, ranking 38 out of the 50 states. In line with these statistics, approximately 11.2 percent of adults in Missouri have chronic conditions (including mental illness) compared with the national average of 9.5 percent. Many of these chronic conditions can be prevented or treated in the primary care setting [2]. This is likely due to individuals’ poor lifestyle choices, which may include things such as inadequate diet, limited physical activity and smoking. Further, less accessibility to healthcare services plays a significant role in their lifestyle choices. This fact is even more pronounced when comparing counties within Missouri itself, with Missouri’s rural areas having worse health outcomes compared to urban areas.

Despite the shortage of providers, at least ten percent of medical graduates do not match with a residency program [1]. Unfortunately, those numbers are even higher for international medical graduates (IMGs). Specifically, of 5,300 IMGs who were U.S. citizens, 40 percent did not match with a residency program [3]. For internationally trained doctors, it can be incredibly difficult to maneuver the career space without having a residency under their belt. With Missouri being the state with the sixth-highest number of physician shortage areas in the U.S., a new position was created in 2014, known as an “assistant physician (AP)”, through a legislative bill (SB 710). It makes provision for these highly educated but underutilized professionals to practice in underserved areas of Missouri where American-trained providers may not want to work barring certain requirements [4]. Moreover, primary care providers serve as main managers of psychiatric disorders in one-third of their patient panels and 70% of patients with depression receive treatment in the primary care setting [5]. This is extremely important in Missouri where 60% of counties have no practicing psychiatrists.

Many U.S.-citizen and foreign national IMGs have undergone rigorous residency training in their home countries and/or have had over 6,000 hours of clinical training in medical school. The Assistant Physician program provided a platform for IMGs to use their skills to assist in communities throughout our state. For example, the Disaster Medical Assistance Team under the State of Emergency Management Agency employed Assistant Physicians (APs) to aid with the urgent need for medical staff. Many of these APs left their own states and communities to help serve areas in Missouri, where the pandemic only caused more of a burden to areas already struggling. These APs have actively administered thousands of COVID-19 tests and vaccines throughout Missouri, amongst other duties the situation necessitated. APs are also helping with patients who are often overlooked such as inmates of correctional facilities, mentally disabled patients and residents of long-term care facilities.

This state program was a huge step towards the fight to overcome the crisis of the shortage of community healthcare providers in Missouri. Attempts have been made to evolve and validate the assistant physician career pathway. The House Bill S50 attempted to create an alternative to residency, where assistant physicians could work under a collaborative practice for five years before achieving full licensure. The House Bill S750 was

(Continued on page 11)
also proposed, which would allow physician assistants and APRNs to collaborate with an assistant physician. Similar to House Bill 550, it would have created a pathway for an assistant physician to become fully licensed. However, both bills did not pass and were opposed by state legislators [3].

As IMGs currently licensed and practicing in Missouri, we believe that the AP program should expand beyond primary health care (PHC) and include community-based mental health and psychiatric emergencies — which include services to treat mental health conditions and substance use disorders (SUD) — at a time when the need for these services is high and increasing. This mutually beneficial arrangement provides an opportunity to strengthen the U.S. healthcare systems in Missouri and beyond. APs may already provide opioid addiction treatment and prescribe buprenorphine for up to a 30-day supply without refill in certain circumstances. While the WHO is actively trying to integrate mental health services into the PHC setting, APs can potentially provide direct care for both physical and psychological needs of patients in a primary care setting across the state and especially in the rural communities.

The current requirement does not simply state ‘graduate of any medical school’ but “any medical school graduate” who “has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination”. This refers to a graduate that is ECFMG certified. It refers to a graduate that has successfully passed through the “effective screening mechanism for ensuring that IMGs in patient care situations have met minimum standards”. It refers to a medical school graduate who is “ready to enter residency or fellowship programs in the United States”. Thus, the current requirements for AP licensure have successfully selected a cohort of medical graduates whose medical schools, training curricula, certifications and knowledge have been verified, tested and determined to meet US standards. By restricting the requirements to ‘a graduate of an accredited North American medical school’ we may miss the opportunity to have these graduates who have survived the meticulous ECFMG process and completed USMLE Step 2, serve the people of Missouri.

While there has been a lot of criticism in terms of implementation and the implications of SB 710, the benefits of employing APs to rural areas far outweigh the disadvantages. This bill allowed access to basic healthcare to those who otherwise would never meet their health needs. Currently, more states are following in Missouri’s steps, implementing the AP model such as Washington State and Arizona. We believe that the position of an AP should be secured rather than stalled with limitations that have been set with the current revisions stipulated with SB938.

References
It’s that time of year again – the time when we take stock and reflect upon where we have been and where we are headed. Physically, you may have traveled far less in the last 21 months than ever before, but you have, nonetheless, been on quite a journey!

Many of you have likely made changes to the way you practice. You may have decided to give up the expense and hassle of working in an office in favor of practicing telemedicine from your home. You may have elected to cut back on your hours or to close your practice entirely and join a group. You may have realized that there are particular conditions you have a special interest in treating or types of patients and situations you want to avoid going forward. Even if you haven’t made dramatic changes yourself, you’ve no doubt been reminded of the unpredictability of life and practice.

This 2022, here are a few New Year’s Resolutions from PRMS Risk Management to consider:

1. Get control of your charts. Those who have temporarily given up office space or relocated completely may have been forced to make hasty arrangements for their charts. If you’ve left part of them behind as you work out of a temporary space, or have boxes stuck in your basement, now is the time to get a handle on them. Make sure you know where all charts are located, determine whether older charts may be destroyed, and ensure everything you keep is securely stored. For additional information see “Retaining and Discarding Psychiatric Records” and “Medical Record Storage Company Agreements.”

2. Determine who your active patients are. Since the onset of the pandemic, a number of your patients have likely fallen out of treatment due to relocation or changes to their financial situations or health insurance plans. You’ve likely also had a few patients who saw you remotely for a visit or two but didn’t follow through with treatment. In order to ensure that there is a clear understanding between yourself and the patient as to the status of your relationship, consider sending them a letter to either confirm their decision to end treatment or make them aware that their chart will be closed if you do not hear from them within a given timeframe. Sample letters may be found in “Termination of the Physician-Patient Relationship.”

3. If you are unable to see patients in person at your current practice location, consider making arrangements to borrow space from a colleague in the event a face-to-face visit is needed at some point in the future. During the PHE, the DEA has waived the Ryan Haight Act’s requirement for an in-person visit prior to prescribing a controlled substance; however, it is anticipated that this requirement will be reinstated once the PHE has expired. Many states follow this rule as well, but others may have a state requirement in effect for an in-person visit. Beyond the need to satisfy prescribing requirements, there may also be other patients for whom you believe an occasional face-to-face appointment would be beneficial. If you do not have a colleague with extra space, consider seeing if your local hospital can accommodate you.

4. Develop a contingency plan to allow someone to either take over your practice during your unexpected absence or shut it down completely in the event you are not able to return. For more information see “Initiating My Contingency Plan.”

From all of us at PRMS, we wish you a safe and healthy new year!

*Website links for all resources can be found at www.PRMS.com/Resolutions
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Important information for those providing care in outpatient settings to patients who are uninsured or self-pay or shopping for care.

The “No Surprises Act” (the Act), which allows for patient financial protections that impact health plans, physicians, and facilities, will apply to psychiatrists in certain circumstances. Psychiatrists working in group practices or larger organizational settings and facilities will likely receive direction from their compliance department or lawyers on how to satisfy these new requirements. The following information is geared toward solo/small group practices.

The most significant change for psychiatrists providing care in the outpatient setting is a new requirement to provide a good faith estimate (GFE). Beginning January 1, 2022, psychiatrists and other health care providers will be required to give new and established patients who are uninsured, or self-pay, or patients who are shopping for care, a good faith estimate of costs for services that they provide.

The following is a summary of the key requirements of the good faith estimate (GFE) along with links to templates. You can find more information in our responses to questions sent by APA members to the APA’s Practice Management Helpline, including a sample GFE. If you have additional questions, please send them to: Practicemanagement@psych.org. We will update this information as we learn more.

**The Good Faith Estimate**

**What providers and what services are subject to this rule?**

“Provider” is defined broadly to include any health care provider who is acting within the scope of the provider’s license or certification under applicable state law. Psychiatrists meet that definition.

The definition of “items and services” for which the good faith estimate must be provided is also broadly defined to encompass “all encounters, procedures, medical tests, … provided or assessed in connection with the provision of health care.” Services related to mental health and substance use disorders (E/M services, psychotherapy, etc.) are specifically included.

**Do I have to do this for all my patients?**

At the present time, the requirement for a good faith estimate applies to these categories of patients:

1. Patients who do NOT have health insurance of any kind, (i.e., commercial insurance, HMOs, union health plans or government health plans.)
2. Patients who DO have health insurance that would pay for all or part of your treatment, but who DECLINE to use their insurance for the cost of your treatment.
3. Patients who are shopping for care.

For now, federal law requires that you provide ONLY these patients (in these three categories) with a written notice regarding the cost of expected services.

**What steps do I need to take and when?**

Under the new rule, psychiatrists and other providers must take the following steps for their uninsured or self-pay patients (Note that the rules and templates are written to address care provided by a range of clinicians and are not specific to psychiatry):

1. Ask if the patient has any kind of health insurance coverage (including government insurance programs like Medicare, Medicaid, or Tricare), and, if so, whether the patient intends to submit a claim to that insurance for the service. If patients are covered by insurance and intend to submit a claim then they are not considered an uninsured or self-pay patient.
2. Inform all uninsured and self-pay patients through a prominently displayed notice (office, website) that a good faith estimate of expected charges is
   - available in a written document that is clear, understandable; and
   - will be orally provided when the service is scheduled or when the patient asks about costs; and
   - available in accessible formats, and in the language(s) spoken by the patient.

While use of CMS’ model GFE notice is not required, CMS views its use as making a good faith effort to

(Continued on page 15)
comply with the new regulations.

3. Provide a good faith estimate of expected charges for a scheduled requested service, including services that are reasonably expected to be provided in conjunction with such scheduled or requested service. For routine care this could be done once a year (i.e., annually to coincide with changes in fees):
   • If the service is scheduled at least three business days before the appointment date, no later than one business day after the date of scheduling; or
   • If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling; or
   • If the uninsured or self-pay patient requests a good faith estimate (without scheduling the service), no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified timeframes if the patient reschedules the requested service.

If any information provided in the estimate changes, a new good faith estimate must be provided no later than 1 business day before the scheduled care. Also, if there is a change in the expected provider less than one business day before the scheduled care, the replacement provider must accept the original good faith estimate as their expected charges.

**What information should the good faith estimate contain?**
The Centers for Medicare and Medicaid Services (CMS) have provided instructions and a sample good faith estimate template. It must contain the following information in clear and understandable language:
   • The patient’s name and date of birth;
   • A description of the primary service (i.e., E/M, psychotherapy) being furnished to the patient (and if applicable, the date (or date range if recurring) the primary service is scheduled);
   • An itemized list of services that are “reasonably expected” to be furnished (this could be what is captured in your standard fee schedule depending on patient need);
   • Applicable diagnosis codes (if established; otherwise create standard language such as “TBD pending evaluation for MH/SUD”), expected service codes, and expected charges associated with each listed item or service (this may already be captured in your fee schedule);
   • The name, National Provider Identifier (NPI), and Tax Identification Number (TIN) of each provider or facility represented in the good faith estimate, and the state(s) and office or facility location(s) where the items or services are expected to be furnished. (Solo psychiatrists would list their name, NPI/TIN and address; APA recommends using a business TIN rather than your SSN);
   • A list of services that the provider or convening facility (the provider or facility that handles the

(Continued on page 16)
scheduling of the service) anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service (this may be less applicable in psychiatry; for services that fall outside the routine care);

- A disclaimer that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate;
- A disclaimer that the information provided in the good faith estimate is only an estimate and that actual items, services, or charges may differ from the good faith estimate; and
- A disclaimer that informs the patient of their right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. This should include instructions for where the patient can find information about how to initiate the dispute resolution process, as well as a statement that the initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the patient; and
- A disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the services from any of the providers or facilities identified in the good faith estimate.

The required disclaimers are included in the CMS template cited above. Make a good faith effort to provide all the information.

**Do these requirements apply to existing/ongoing patients?**
Yes, the rule makes no distinction between current and future patients.

**When am I required to provide these estimates to patients?**
You should provide this estimate to all of your current patients in the two groups listed above on (or about) January 1, 2022. You can use email on the 1st of the year. Otherwise, we suggest mailing the notice to all current patients (in the three categories).

The law also requires you to provide notice to all new patients (in the three categories) when they start treatment on or about January 1, 2022. The law also requires that all of these patients (in the three categories) receive a new notice every year or if your fees change. We suggest for the sake of simplicity and to avoid confusion, that you provide all patients (in the three categories) with a notice on (or about) January 1st of each year (or to coincide with any scheduled rate increase) including new patients who started treatment during the past year.

**The Prohibition Against Surprise Billing for Emergency Care**

**What else does the No Surprises Act do that could impact psychiatrists?**

NSA also aims to address situations in which patients receive surprise medical bills when they inadvertently or unknowingly receive care from an out-of-network provider. These new protections for patients do not apply in physician offices but may apply in other settings:

- The Act bans surprise billing for emergency services. Emergency services, even if they’re provided out of network, must be covered at an in-network rate without requiring prior authorization.
- The Act bans balance billing and out-of-network cost-sharing (such as out-of-network coinsurance or copayments) for emergency and certain non-emergency pre-scheduled care. In these situations, the consumer’s cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.

Read on for answers to FAQs that apply to practicing psychiatrists who treat patients in facilities.

**What is considered emergency care?**
Under the NSA, the definition of emergency services

*(Continued on page 17)*
includes care provided in emergency departments of hospitals and in independent, freestanding emergency departments. Emergency care is not considered care provided in a physician’s office, such as the office of a psychiatrist.

What is considered non-emergency care?
Under the NSA, the definition of non-emergency care includes care provided in hospitals, hospital outpatient departments, critical-access hospitals and ambulatory surgical centers. Non-emergency care, for the purposes of this new law and corresponding regulations, does not include care provided in a physician’s office, such as the office of a psychiatrist.

When do these new rules go into effect?
They go into effect Jan. 1, 2022

How do these rules really impact doctors of psychiatry?
These rules are targeted foremost at facilities such as hospitals. Psychiatrists providing care at facilities that provide emergency or non-emergency care, as delineated above, could be impacted by these new rules. If you are in such a setting, you should consult with your facility or clinic’s compliance officer or attorney about your personal obligations under this new regulation.


APA Coronavirus Resources
If you are a patient, a family member or a friend in need of immediate assistance.

Disaster Distress Helpline
https://www.samhsa.gov
Call 1-800-985-5990 or text TalkWithUs to 66746

National Suicide Prevention Lifeline
https://suicidepreventionlifeline.org
Call 800-273-8255
Chat with Lifeline http://suicidepreventionlifeline.org/chat/

Physician Support Line
https://www.physiciansupportline.com
Call 1-888-409-0141

Crisis Textline
https://www.crisistextline.org
Text TALK to 741741

Veterans Crisis Line
https://www.veteranscrisisline.net
Call 800-273-8255 or text 838255
A third of Americans reported that social media does more harm than good to their mental health and more than 40% said that social media has hurt society at large and that it has damaged political discourse, according to the results of an APA poll released today.

At the same time, most respondents reported feeling positive about their own use of social media. Eighty percent of social media users said they felt interested while using social media, 72% felt connected, and 72% said they felt happy. In contrast, 26% said social media made them feel helpless, and 22% said it made them feel jealous.

The findings are from APA’s Healthy Minds Monthly, a poll conducted by Morning Consult. The poll—which asked respondents about their mental health and social media use—was fielded online from January 19 to 20, among a nationally representative sample of 2,210 adults. Data were weighted to approximate a target sample of adults based on gender, educational attainment, age, race, and region.

The results reflect ambivalence about a now ubiquitous phenomenon. “Twenty-five years into what almost feels like a giant psychological experiment, most Americans are interacting with social media daily, and many are concerned about its effects on mental health and society,” APA President Vivian Pender, M.D., said in a media release. Additional findings from the poll include the following:

- Most adults rated their mental health as excellent (27%) or good (46%).
- Moms were more than twice as likely as dads to rate their mental health as fair or poor (31% vs. 15%), while dads are far more likely than moms to rate their mental health as excellent (40% vs. 18%).
- 31% of adults said social media has helped their relationships with family and friends, but 44% said it has hurt society at large, 38% said it has damaged civil discourse, and 42% said it has harmed political discourse. Adults who do not use social media were more likely than social media users to say social media has harmed society at large (59%), political discourse (56%), and civil discourse (57%).
- 80% of adults used social media during the COVID-19 pandemic to connect with family and friends, and 76% used social media for entertainment.
- 23% of adults used social media to find mental health resources during the pandemic.
- Although 67% of adults said they were confident in their knowledge of how to help a loved one who indicated mental health struggles on social media, only 22% of adults were very confident they would know what to do.

“We know that social media can be very harmful for some individuals,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “It has the effect of turning up the volume on conversations and connecting people in ways that can have a negative impact. That said, these poll results seem to indicate that many Americans are finding an ability to use social media in a way that feels harmless if not helpful to their lives.”

Reprinted from Psychiatric News
Addiction to digital technology is bound to become an increasing focus of psychiatrists, wrote addiction psychiatrist Petros Levounis, M.D., M.A., in a recent Psychiatric News special report. Levounis is a professor and chair of the Department of Psychiatry and associate dean at Rutgers New Jersey Medical School.

“Just as happens with substances like alcohol or opioids, some people become so caught up in their virtual world that their real world—jobs, finances, relationships, physical health—begins to suffer,” Levounis wrote. “As smartphones and other modern devices become more and more integrated into all facets of life, understanding, identifying, and treating these technological addictions will become a significant aspect of psychiatric care.”

Diagnosing technological addictions accurately requires more research. “Only one technological addiction has been semi-officially recognized by APA as of DSM-5: internet gaming disorder is in Section III of our manual as a condition for further study,” he wrote. However, Levounis said that the framework used to define internet gaming disorder could be extended to other online behaviors that addiction specialists agree may be of concern: online gambling, online shopping, cybersex, internet surfing, texting/emailing, and social media.

Under the current DSM-5 entry, internet gaming disorder is likely present if someone meets five of the following nine symptom criteria over a 12-month period:

- Being preoccupied with video games.
- Experiencing withdrawal symptoms when video games are inaccessible.
- Requiring more and more playing time to gain the same level of satisfaction.
- Being unable to cut down on game playing despite efforts to do so.
- Giving up other activities to play more frequently.
- Deceiving family members about how much time is spent gaming.
- Using video games to alleviate negative moods.
- Jeopardizing jobs or relationships due to gaming.
- Continuing to play video games despite knowledge of adverse consequences.

Just as psychiatrists’ ability to diagnose technological addictions requires further research, guidance on how to treat patients will as well. “The best advice currently is to rely on what works well across the broad addiction sphere: providing patients an integrated treatment that incorporates addiction psychotherapy, pharmacological treatment of other psychiatric disorders, and possibly mutual-help (otherwise known as 12-step) facilitation,” he wrote.

No medications are approved for any behavioral addiction, technology based or otherwise. “The optimal use of medications for most patients is in the management of common psychiatric comorbidities like depression or anxiety, which have been shown to worsen the problematic behavior,” Levounis wrote.

Recognizing, diagnosing, and treating people with technological addiction is a field just being born. “Research on the phenomenology and nosology of these illnesses will help us further elucidate the distinction between problematic and nonproblematic use of technology, especially in children and young adults,” he wrote. “[W]e will need to be ready to guide our patients, our colleagues, and the general public on how to best handle technology with an eye on maximizing its enormous potential for fulfillment, gratification, and happiness while minimizing its significant risks for dissatisfaction, misery, and despair.”

Reprinted from Psychiatric News
MPPA had a very successful virtual fall conference on September 25, 2021.

Fred Rottnek, MD, Director of the SLU Addiction Fellowship Program, shared his innovative ways of enhancing substance use treatment to the homeless population by expanding telehealth services and creating mobile treatment units in collaboration with the local faith leaders. His talk was highly inspiring and solution focused in addressing racial health disparities.

Who would have thought that our gut could control our brain? Emily Severance, Ph.D., Assistant Professor of Pediatrics at John Hopkins University of Medicine discussed the various dietary, microbial and immune factors that may trigger disruptions in the gut-brain axis and its impact on the brain.

Suicide has been on the rise for the last decade, especially among the youth. Rhonda Boyd, Ph.D., from the University of Pennsylvania Perelman School of Medicine discussed the prevalence of suicide and suicide-related behaviors among Black youth, explained the common risk and protective factors for suicide along with the health disparities in access to care among Black youth, and discussed innovative interventions to decrease suicide in this population.

Climate psychiatry: What is it and how does it affect my practice? This great question was answered by psychiatrists Benjamin Liu, MD from Oregon Health and Sciences University and Rahul Malhotra, MD from New Jersey. They discussed the impact of slow-moving disasters such as air-pollution, drought, sea-level rise etc. on the mental health of vulnerable populations.

Will Newman, MD, Forensic Psychiatrist and the SLU Forensic Psychiatry Fellowship program director taught the audience strategies in conducting threat assessment in clinical practice and discussed the recent duty to warn case law.

We have been battling COVID and its sequelae since Spring of 2020. Angeline Stanislaus, MD discussed the known long-term psychiatric sequelae of COVID and the hypothesized pathophysiological mechanisms resulting in these sequelae.

MPPA is preparing for its Spring 2022 psychiatric conference and has a line-up of wonderful speakers. It is again a virtual conference scheduled for April 23, 2022 from 8.30 am to 1 pm and offering 4.5 hours of CME.

Daniel Mamah, MD from Washington University will be presenting on the topic of early psychosis and his talk is titled “The Prodrome and Schizophrenia Risk States: Assessment, Management and Treatment Resources”.

Dale Bredesen, MD, Chief Science Officer of Apollo Health will be discussing lifestyle changes to prevent dementia and its progression.

Douglas Burgess, MD, Addiction Psychiatrist from UMKC will be discussing the chronic disease model of addiction and its implication for treatment of Opioid Use Disorder. He will discuss the biological underpinnings and neuroadaptations associated with transition to drug addiction and the importance of low threshold medication first model of care.

Kim Brandt, DO, Psychiatry Residency Program Director from University of Missouri- Columbia will share knowledge on the new developments in perinatal psychiatry.

MPPA CME committee would like topic suggestions from its members. Please email MPPA any recommendations for speakers they would like to hear at future conferences.
VIRTUAL SPRING EDUCATIONAL WEBINAR
Saturday, April 23, 2022

JOINTLY PROVIDED BY THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE MISSOURI PSYCHIATRIC PHYSICIANS ASSOCIATION

AGENDA
Angeline Stanislaus, MD - Moderator

8:30 - 9:30 am  “The Prodrome and Schizophrenia Risk States: Assessment, Management and Treatment Resources”
Learning Objectives:
1. Identify the difference between clinical high risk for psychosis and the prodrome.
2. Identify the types of clinical high-risk syndromes, and their assessment.
3. Describe intervention for those with prodromal symptoms, and local treatment resources.
Speaker: Daniel Mamah, MD, MPE, Director, Washington Early Recognition Center, Associate Professor of Psychiatry, Washington University School of Medicine-St. Louis

9:30 - 10:30 am  “Network Medicine: Treatment and Prevention of Alzheimer’s”
Learning Objectives:
1. Learn a network medicine approach to treat and prevent cognitive decline.
2. Learn subtypes of Alzheimer’s disease.
Speaker: Dale E. Bredesen, MD, Professor, Department of Molecular and Medical Pharmacology, David Geffen School of Medicine, UCLA, Founding President and CEO, Buck Institute for Research in Aging, Author of the New York Times Bestseller, The End of Alzheimer’s

10:30 - 10:45 am  Break

10:45 - 11:45 am  “Chronic Disease Model of Addiction: Implications for Treatment of Opioid Use Disorders and Measuring Success”
Learning Objectives:
1. Identify three similarities between substance use disorders and other chronic diseases.
2. Identify three neuroadaptations associated with transition to drug addiction.
3. Describe the general principals of a Medication First, Low Threshold model of care.
Speaker: Douglas M. Burgess, MD

11:45 - 12:00 noon  Break

12:00 - 1:30 pm  “Challenging Cases in Perinatal Psychiatric”
Learning Objectives:
1. Learn the basic treatment principles for treating pregnant and postpartum patients with common psychiatric problems.
2. Become familiar with resources to enhance your knowledge and continuing education in perinatal psychiatry.
3. Gain clinical pearls for formulating a risk/benefit conversation for each unique patient in this population.
Speaker: Kimberly Brandt, DO, PMH-C, Perinatal Psychiatrist, Associate Professor of Clinical Psychiatry, Psychiatry Residency Training Director, University of Missouri-Columbia School of Medicine

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- Reimbursement and Medicare/Medicaid
- Health Information Technology
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- Practice Guidelines

PsychPRO is APA’s national mental health registry—a flexible tool that captures data to help psychiatrists and all behavioral health providers make optimal patient care decisions, further research and develop new measurements of quality.

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The Missouri Psychiatric Physicians Foundation was established in 2018 by the MPPA as its IRS-approved charitable arm. The MPPF has its own officers and board and was organized exclusively in scientific, educational and charitable activities within the meaning of section 501(c)(3) of the Internal Revenue Code, including:

A. **PROFESSIONAL EDUCATION.** The Foundation will develop and fund educational offerings and projects, including in collaboration with others, designed to improve and enrich professional knowledge and skills of psychiatrists and other medical and mental health professionals in the prevention, diagnosis and treatment of psychiatric brain disorders. This may include programs to encourage healthier personal and professional lifestyles.

B. **PUBLIC EDUCATION.** The Foundation will encourage and sponsor educational programs, including in collaboration with others, to increase awareness and advance knowledge of psychiatric brain disorders and effective treatments available today. The Foundation may support educational efforts aimed at employers, the media, persons living with a mental disorder and their families, to encourage a better understanding of the causes, treatment and prevention of psychiatric disorders and their treatment. The Foundation may also support efforts to remove barriers to access to psychiatric care.

C. **RESEARCH AND DISCOVERY.** Support of research projects by members of the MPPA which aim to advance the biopsychosocial understanding and management of psychiatric disorders. This will include identification and remediation of the social determinants of mental health.

D. **RECOGNITION OF ACHIEVEMENT.** The Foundation may provide some recognition of achievement to individuals or groups who have excelled in advancing the purposes of the Foundation.

E. **SUPPORT OF MPPA.** The Foundation will provide support to the Missouri Psychiatric Physicians Association in its efforts to achieve the Foundation’s objectives such as education and research.

The Missouri Psychiatric Physicians Foundation is a 501(c)(3) exempt organization and all donations made to the MPPF are tax deductible under IRS Section 170.

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*Donations payable to Missouri Psychiatric Physicians Foundation (MPPF)*

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573.635.5070 ~ visit www.missouripsych.org
Online Donations: https://missouri.psychiatry.org/advocacy/mppa-foundation
Driving Under the Influence Common Among People Who Use Both Alcohol and Cannabis

More than 2 in 5 drivers who use alcohol and cannabis have driven under the influence of one or both substances in the past year, a study in the *American Journal of Preventive Medicine* has found.

Priscila D. Gonçalves, Ph.D., of Columbia University and colleagues examined data from drivers aged 16 years or older who participated in the National Survey on Drug Use and Health between 2016 and 2019. The researchers specifically focused on 34,514 survey participants who reported using alcohol and cannabis, albeit not necessarily at the same time, in the previous year.

Overall, 42% of participants in the sample reported driving under the influence of alcohol, cannabis, or both in the past year. Eight percent reported driving under the influence of only alcohol, 20% reported driving under the influence of only cannabis, and 14% reported driving under the influence of both alcohol and cannabis.

Furthermore, 27.5% of those in the sample reported simultaneous alcohol and cannabis use, defined as using the two substances at the same time or within a couple of hours of one another. These participants had 2.88 times the odds of driving under the influence of only cannabis and 3.51 times the odds of driving under the influence of both alcohol and cannabis compared with participants who did not drive under the influence. Daily alcohol and cannabis use increased the likelihood of driving under the influence of both alcohol and cannabis, respectively, and daily simultaneous use was associated with driving under the influence of both substances.

“From a harm reduction perspective, identifying which population subgroups are at high risk for DUIs could assist the development of more focused prevention strategies, considering risk patterns of substance intake,” the researchers wrote.

“Prevention strategies targeting specific behaviors, such as simultaneous alcohol/cannabis use, should be tested to reduce DUI burden.”

Reprinted from *Psychiatric News*

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**MoPPPAC MEMBERSHIP form**

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Employer* ____________________________________________________
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City, State, Zip* ________________________________________________
Phone _______________________________________________________
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*State law requires that we use our best efforts to collect and report the name, mailing address and employee of individuals who contribute to MoPPPAC.

Enclosed is my check or money order for: $ __________________________

Contributions to the PAC are not tax deductible. Make checks payable to MoPPPAC and return to 722 E. Capitol Avenue, Jefferson City, MO 65101.
What is the MO Psychiatric Physicians PAC?
MoPPPAC is an organization that accepts volunteer contributions to help strengthen the Missouri Psychiatric Physicians Association’s (MPPA) participation in elective processes at state and local levels.

Why does MoPPPAC exist?
1. State and local candidates who will advocate for Missouri Psychiatrists need the financial support of the medical community to win elections.
2. The Missouri Psychiatric Physicians Association advocates in the legislative arena with other organizations that have PACs. As long as organizations with interest adverse to those of the Missouri Psychiatric Physicians Association have PACs, the MPA needs one, too.
3. A PAC is part of a balanced strategy for legislative advocacy and political action.

How does your PAC investment affect your bottom line?
Lawmakers’ decisions in areas such as taxation, regulations and health care directly affect the profitability of your practice. Government policy affects not only your business; it affects your patients. MoPPPAC can contribute to a significant number of pro-medicine candidates. By pooling your political contributions with other Psychiatrists, you receive a greater return on your investment.

Who may contribute?
Anyone who wants to help elect candidates who support Psychiatry can contribute to the MoPPPAC.

Who directs MoPPPAC?
MoPPPAC operates under the direction of PAC officers and directors who are members of the American Psychiatric Association and the Missouri Psychiatric Physicians Association. The MoPPPAC Board of Directors may elect other members from time to time to serve as PAC officers and directors.

Who decides how MoPPPAC funds are spent?
The Board consists of officers and directors who serve on behalf of the Missouri Psychiatric Physicians Association. The Board approves all disbursements over $500. The PAC president approves disbursements of $500 or less.

What factors determine MoPPPAC’s support of a candidate?
- MoPPPAC membership input.
- A candidate’s strong voting record on mental health care and other issues affecting the practice of psychiatry and psychiatric patients.
- A candidate’s willingness to support the goals and mission of the Missouri Psychiatric Physicians Association.
- MoPPPAC funds are used for purposes that are consistent with the goals and missions of the Missouri Psychiatric Physicians Association and the American Psychiatric Association.

How to Join?
Complete and return the Membership Form to MoPPPAC with your contribution. Note: MoPPPAC can accept only checks and money orders at this time, no credit cards. Maximum contribution is $5,000. Contributions to the PAC are not tax deductible.
## MISSOURI PSYCHIATRIC PHYSICIANS ASSOCIATION
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Media Benefits for MPPA Members

Your membership in the Missouri Psychiatric Physicians Association entitles you to several key media benefits:

1. Free ad listings on the MPPA website. MPPA Members can post their research studies, job listings, events or books for 6 months on the MPPA website at http://missouri.psych.org. The listing can repost again after that period.

2. Reduced newsletter ad rates. MPPA members may place any size ad in Show-Me Psychiatry, MPPA’s quarterly newsletter, for 50% off the regular rate. Show-Me Psychiatry reaches nearly 500 MPPA members and associated healthcare professionals in the state and appears online at the MPPA website. It is the only publication dedicated to psychiatrists in the state of Missouri.

3. Free “Upcoming Events” listings. There is no charge for members to post upcoming meetings and special events of interest to the behavioral health community.

All ads must be camera ready in an electronic format and should include a link to the advertiser’s email address or website. Web ads may be submitted in color or black & white. Newsletter ads will print in black and PMS 294 Blue inks regardless of submission format.

Letters to the Editor

We invite readers to submit letters of not more than 500 words. Show-Me Psychiatry reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Letters should be sent by postal mail to Show-Me Psychiatry, Missouri Psychiatric Physicians Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to adamb@health.missouri.edu. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

We strive to offer content in Show-Me Psychiatry that represents our membership and encourage members to participate in its creation. For communications regarding the newsletter or to submit articles, letters to the editor or upcoming events, please contact: Editor, Show-Me Psychiatry, 722 E. Capitol Avenue, Jefferson City, MO 65101, or missouripsych@gmail.com.

Newsletter Disclaimer: The opinions expressed herein are those of the authors and do not necessarily state or reflect the views of Missouri Psychiatric Physicians Association. Publication in this newsletter should not be considered an endorsement.

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Guidelines for Submission to Show-Me Psychiatry Newsletter

1. All submissions will be sent via email to Sandy Boeckman at missouripsych@gmail.com who will then forward the submission to the newsletter editor.

2. The length of the article should be between 600-1200 words. In addition to the article, up to five references may be added.

3. At the end of the article, the author should include a statement clarifying the presence or absence of a conflict of interest related to the article.

4. If the article includes clinical information, the author should make a statement that the identifying information of the patient has been changed and he/she has obtained the permission of the patient and/or guardian prior to publication.

5. The article will be edited by the newsletter editor. The author may be asked to clarify some information, and address comments made by the editor. The revised article will be emailed back to the editor for final review and approval.

Submission Deadlines

February 15
May 30
August 15
November 15

Advertisement Information

For advertisement information or questions, contact Sandy Boeckman by email at missouripsych@gmail.com.
Calendar of Events

Executive Council Meeting
CONFERENCE CALLS (Zoom) at 7:00 pm
March 15, 2022
April 2, 2022
June 7, 2022
August 16, 2022
September 23, 2022
November 15, 2022

Spring Meeting
VIRTUAL SPRING EDUCATION WEBINAR
Saturday, April 23, 2022

APA Annual Meeting
NEW ORLEANS, LA
May 21-25, 2022

Fall Conference
COLUMBIA, MO
September 24, 2022