MENTAL HEALTH IN THE POST PANDEMIC ERA

It is clear the new corona virus pandemic is causing a worldwide crisis in mental health as it makes its way around the globe, destroying lives and livelihoods. The United Nations has urged governments to take mental health consequences seriously. Previous infectious disease outbreaks, from Ebola to SARS, are now informing present-day virus responses. It helps that the global spotlight on mental health has grown in recent years.

The world is at risk of a mental health crisis, the United Nations warned on Thursday. The corona virus pandemic has forced many people into isolation and out of work as they face the constant anxiety of dealing with death and disease. The situation is compounded by decades of ignoring and under investing in mental health needs, the UN said, calling on countries to commit to improve the ways they treat psychiatric illness.

People with current or past COVID-19 symptoms are more likely to develop general psychiatric disorders and experience loneliness, according to a study published online in Psychiatry Research.

Researchers analyzed 15,530 respondents in the United Kingdom who participated in the first large-scale, nationally representative survey of COVID-19 in a developed country, which was conducted at the end of April. Although previous research has looked at particular psychiatric disorders associated with the COVID-19 pandemic, such as anxiety, depression, and insomnia, this investigation focused on the broader psychological impact.

“Only focusing on specific disorders underestimates the psychiatric burdens of the pandemic in more subtle forms and overlooks the needs for psychiatric care of the people who have not been clinically diagnosed,” researchers wrote.

Will we see a big jump in mental health spending in 2021 because of the corona virus pandemic’s aftermath? That was the question that came to mind when I read our recent analysis of U.S. mental health spending.

Mental health spending rose to $225 billion in 2019—an increase of 52% in the past decade, from 2009 to 2019, this is notable because the medical inflation rate was 34% and the U.S. population increased by 6.9% during that period.

The distribution of spending did not change much. In 2019, public payers accounted for the majority (62.7%) of mental health spending at $149.5 billion, while private payers accounted for the remaining $88.9 billion (37.3%). In 2009, public payers accounted for the majority (60%) at $88 billion, while private payers accounted for the remaining $59 billion (40%). The increase in spending and the modest change in payer distribution were likely because of behavioral health parity.

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**President’s Message**

The question is whether the pandemic will cause a big jump in behavioral health spending in 2021—for both mental health and addiction treatment. What we do know is that demand will likely increase. An early April poll by the Kaiser Family Foundation shows that nearly half (45%) of all U.S. adults say the pandemic has affected their mental health, while 19% say it has had a “major impact.”

Prescriptions for anti-anxiety drugs spiked 34% between February 16 and March 15, and also increased for antidepressants (18.6%) and anti-insomnia drugs (14.8%), according to a report from Express Scripts

A Health Affairs blog notes that social distancing and self-quarantine are risk factors for relapse for people with addiction disorders. Trauma is another behavioral health challenge expected to be exacerbated by COVID-19.

But an increase in demand does not necessarily translate into an increase in spending. There are some mitigating factors to consider in projections about behavioral health treatment spending. There are the demographics of the crisis. Mortality in the crisis is heavily skewed toward individuals with compromised immune systems and those with diabetes, hypertension, obesity, and heart disease—a group in which there will be a high proportion of consumers with behavioral health conditions. Then there is the rising proportion of the U.S. population that is uninsured (from 7.9% to 8.5% in the years 2017 to 2018). That will likely increase as the number of unemployed Americans surges past 30 million. Typically, the uninsured population in the U.S. does not get the basic services they need for any type of health care.

We are also seeing a changing model for delivering services. Use of inpatient and residential treatment settings for behavioral health are on the decline with growing use of intensive outpatient and home-based models. The use of virtual services is on the increase. Outpatient services—and particularly virtual outpatient services—are less expensive than other models of treatment. Combine that with the use of artificial intelligence-driven computer-based therapies, and per-consumer spending on behavioral health treatment will likely drop. Finally, there is the “big picture” budget issue. The U.S. government debt was $17 trillion before the crisis—and the four CARES Act bills added $2 trillion to the deficit. States are so short of funds that there are serious proposals to let them go bankrupt.

Just yesterday, Politico reported on how states have been cutting Medicaid budgets over the past few weeks, States did receive a

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temporary six percent increase in the federal portion of Medicaid spending in an earlier CARES Act relief package. The states that have accepted the temporary relief are prohibited from cutting enrollment but do have the option of cutting benefits or provider organization payments. Overall, lower tax collections and higher federal and state government spending will compress the funding available for all government services with education and health care likely to take the largest cuts.

Taken together, these four factors—all of which are in flux—make it difficult to predict what behavioral health spending will look like in 2021. But we will track the shifts in market trends as they happen.

A turning point came in the late 2000s, when The Lancet, a leading medical journal, established a major commission on global mental health. The United Nations and the World Health Organization have made mental health a priority on their global agenda, and they’ve issued guidelines on recognizing and treating psychological distress from COVID-19.

A growing body of research shows mental health interventions can be effective around the globe in a variety of settings, from refugee camps to urban centers.

In June, more than 36 percent of U.S. adults reported symptoms of anxiety or depression, an increase of roughly 25 percent from the same time last year. That’s according to data from the Kaiser Family Foundation.

Fortunately, for people feeling socially isolated and in need of mental health assistance, there are options right now. A waiver passed in March by Congress expanded Medicare coverage to include more forms of telehealth, an increasingly common avenue for mental health care during the pandemic.

But given that experts are expecting social distancing measures to remain in place at least through the end of the year, more work will have to be done by legislators and health care providers to fully address the mental health crisis in our country.

“The widening of inequalities in countries, the continuing uncertainties about future waves of the epidemic and the physical distancing policies begin to bite deeper into our mental health,” “Mental health care systems in most countries will be ill-equipped to deal with this surge, not only because of the paucity of skilled providers but also because the pandemic presents a tremendous opportunity to improve our society, technology, and social fabric—and we are missing out if we don’t look for those opportunities.

We also feel it is important to reframe thoughts about the pandemic and other current events to keep them from leading to anxiety, anger, and depression. A sense of not being in control leads to such emotional reactions.

Experts hope the pandemic will permanently change how technology is used in society:

“We had so many changes in March—telehealth, prescribing, the ability to see people remotely”

“Technology has become our PPE. Ensuring that it stays with us past the pandemic is absolutely important. Advocating for these changes, advocating for reforms that will benefit society is absolutely important.”

“This is a lot for anybody to handle…this is unlike any time in world history, we have to reframe and from our vulnerabilities find new opportunities.”

The last decade has seen a shift in mental health. Awareness has increased worldwide.

And we will see a lot of changes in the next few years on how we deliver care, this is time to prepare ourselves to change and be innovative in delivering care to our patients.

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Finding Hope in Trying Times: COVID-19, Structural Racism and Accelerating Climate Disruption
James Fleming, MD

In the last edition of this newsletter, Dr Azfar Malik identified several “silver linings” to an otherwise very troubling storm of the coronavirus pandemic which continues to show no sign of receding. (1). In this article I will identify some other “positives” which could emerge but first need to sound some alarms about other seemingly disconnected but concurrent crises: e.g. the ongoing scourge of structural racism and the ongoing, accelerating crisis of climate change.

On Memorial Day, May 25, America and the world was shocked by a horrific video of the police homicide of George Floyd who knelt on Mr. Floyd’s neck for approximately 8 minutes until he died of asphyxiation. The officer was soon charged with murder but widespread protests and expressions of outrage around the country and internationally continued for weeks, even months in some areas. Tragically, this wasn’t an aberration but rather yet another tragic incident in a 400 year history in our country, beginning with slavery, of anti-black and institutional racism. A wide range of sectors of society seemed to wake up to the reality of this history and there seemed to be an unprecedented degree of self-examination of structural racism in American society. Within days of George Floyd’s death, the APA issued a statement condemning “this blatant act of police brutality” which “threatens to undermine the sense of stability of so many Americans” (2).

The re-traumatization of the African American community stemming from the death of George Floyd and other black Americans around the same time, was yet another acute stressor added the subacute stressors related to the disproportionate number of deaths from COVID-19 among blacks in the U.S., a finding also noted in several other minority groups. While genetic predisposition (3) may be a factor in this expression of health inequity, biological factors should not blind us to the more preventable social determinants of health, embedded as they often are in systemic racism. These factors can lead to poor access to health care and nutrition and crowded living which make social distancing more difficult if not impossible and clearly impact on biological variables, e.g. exacerbation of co-occurring medical conditions, clearly a risk factor of morbidity and mortality associated with the virus that causes COVID-19 (SARS-CoV-2).

One other factor, often ignored, is the effect of the natural environment when impacted by pollution—most notably by air pollution. There are several layers and connecting factors to this which must be understood: a. air pollution exacerbates the same diseases which increase the risk of severe illness and death from this novel corona virus; b. poor, minority communities tend to live in urban areas which have higher levels of particulate matter in the air as well as higher temperatures and often less access to air conditioning which further exacerbates breathing difficulties and other physiological stressors. A recent cross-sectional study of 3,000 U.S. counties representing 98% of the population found that very small increases in small particulate matter (PM$_{2.5}$) resulted in significant increased mortality from COVID-19 (4). The impact of climate change, characterized by steadily rising temperatures only serves to exacerbate these problems further.

There is another layer of connection here which brings into clearer focus the overlapping crises of COVID-19, structural racism and climate disruption: careful research has documented that polluting industries and toxic wastes sites have been intentionally placed in poor minority communities, representing a manifestation of structural racism referred to as “environmental racism” (see below for further explanation) (5,6).

Prior to the violent death of George Floyd, the concepts of environmental racism and environment justice were not something either mainstream media or prominent medical organizations such as

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Environmental organizations have been ahead of medical groups (with the possible exception of NMA) in making connections between the overlapping crises of the pandemic, structural racism and climate change but the connection between racial justice and environmental justice was not made prominently and forcefully until after the death of George Floyd. The Sierra Club, the largest (and one of the oldest) of these groups in the U.S. has issued strong statements of condemnation of structural racism including internally by trying to take “down its own monuments to white supremacy” (8).

On June 2, Sierra Club addressed another interconnecting issue which has added additional stressor to minority and non-minority Americans alike: the differential, contradictory and disturbing, if not dangerous responses of the current Administration to the current crises: an inadequate protective response to the pandemic; a militaristic response to what were primarily peaceful protests in support of the assertion that “black lives matter” and hypocritical failure to enforce “law and order” when white supremacists have employed militarized intimidation.

This public statement also put the goals of all environmental advocates in a crucial, timely context:

“We can’t fulfill our mission to ‘enlist humanity’ to protect the planet while racism continues to divide us. There can be no climate justice without an end to the anti-Blackness and white supremacy that empowers polluters to create environmental sacrifice zones” (9).

“A sacrifice zone “ is a geographic area that has been permanently impaired by environmental damage or economic disinvestment...most commonly found in low-income and minority communities” (https://en.wikipedia.org/wiki/Sacrifice_zone). Hop Hopkins, director of strategic partnerships for the Sierra Club director uses the term while putting the intersecting crises of systemic racism and climate change in perspective (10).

“...we will never survive the climate crisis without ending white supremacy.

Here’s why: You can’t have climate change without sacrifice zones, and you can’t have sacrifice zones without disposable people, and you can’t have disposable people without racism.”

Hopkins acknowledges that many people in the environmental movement are struggling with the idea that in addition to trying to deal with climate change, pollution, etc. now their work now must involve dismantling white supremacy.

Similarly psychiatrists may feel reluctant about taking on structural racism in either our own organizations or society at large, let alone tying in concerns about the pandemic, climate change and environmental justice. The APA has started to address racial disparities in relation to COVID-19 and does have a Position Statement on climate change and mental health (11) but organized psychiatry has yet to connect all the dots. Some psychiatrists though, notably leading members of the Climate Psychiatry Alliance (https://www.climatepsychiatry.org/) have started to make these connections (12).

Allowing ourselves to feel overwhelmed with the immensity of these connections could lead us to throw up our hands and retreat into the seeming safety of our psychiatric practice. But we can’t escape these issues for long. Here is where we can choose to “see the glass as at least half full”. Once we recognize

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Finding Hope in Trying Times:
COVID-19, Structural Racism and Accelerating Climate Disruption
James Fleming, MD

these issues really are connected and that we can’t make true or lasting progress on any one issue without addressing all of them, then we have “hit bottom”: i.e. we have discovered deeper roots of our collective problems bringing the crucial insight that they are in fact our problems and thus we are in this together. This is the biggest and most comprehensive “positive” to emerge at this time. Here are a few others:

1. Social distancing fortunately has not prevented people from becoming more connected to nature: many people have begun gardening not only as a “food security” measure in the event of food shortages but as a healthy hobby which provides both exercise and fresh air.

2. Many people have started going for walks more frequently or for the first time. In my neighborhood, I started to see whole families, on walks together including black and brown neighbors whom I hadn’t known lived in the area before; and neighbors are finally getting to know each other rather than just waving (or not) as they get in and out of their cars.

3. Social distancing and quarantine have caused an expanded use of video conferencing which has in some cases resulting in more frequent and meaningful interpersonal connections. I’ve heard both friends and patients remark that they have been in closer contact with family members since the pandemic hit than prior to it.

4. Reduced fossil fuel usage resulted in dramatic improvement in visibility and air quality as many noticed in “before and after” photos of Los Angeles, New Delhi and elsewhere (13). Besides healthier air, we also now recognize the falsity of the often cited reason for avoiding a transition to clean energy: namely that it’s not “practical”; we know now that we can quickly and dramatically reduce fossil fuels when we have to. It doesn’t matter why we had to do it. What matters is that we did it.

Hopefully, the emerging insights into how these crises are connected will help us recognize the importance of being unified. The voices of division, even when the arise from leaders—or perhaps especially when they arise from leaders—must be drowned out by the visible actions of those who realize more fully than ever before that we are all in this together.

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10. Racism is Killing the Planet, Hop Hopkins, June 8, 2020, SIERRA, (https://www.sierraclub.org/sierra/racism-killing-planet)
(Continued on page 7)
In the first quarter of 2020, Dr. Azfar Malik wrote a piece about Psychiatry and Technology. As he describes many available technologies to improve mental health, there are also many opportunities to use technology to improve virtual residency recruitment this year, including the use of social media.

While Missouri is a beautiful state in the Midwest, some may lack a full understanding of the benefits of residing in this region. Due to COVID-19, residency recruitment efforts are now virtual, making it more challenging for applicants to visit our state. From our lower cost-of-living comparative to some cities in the United States to the friendliness of the “Show Me State”, we have many positive offerings, but these need to be promoted. Whether it is a beautiful area to hike and bike like Forest Park or free museums in St. Louis, MO, to the college football games at Mizzou in Columbia, MO, or the beautiful Nelson Atkins barbecue in Kansas City, MO, programs in each region of the state have so much to promote.

Virtual recruitment comes at a time when so many psychiatry departments have limited budgets due to the impact of COVID-19, but this should not hinder the amount of time and money spent on recruitment. From creating a recruitment committee with trainees and faculty representatives, to managing social media accounts, to updating websites with new recruitment tools, programs must put in time to see results. Whether through a professional video or one organized by a faculty member or resident with video production skills, it is important that Missouri psychiatry residency programs increase their efforts to attract applicants.

We must join together as a state to bring applicants to Missouri. We all have one common goal, to continue to grow the number of psychiatrists who practice medicine here. In July 2020, both the Washington University Psychiatry residency program and the child and adolescent psychiatry program started Instagram pages, providing ways for us to spotlight residents and display the benefits of our area. Although programs in our state may compete for applicants, virtual recruitment is a time we can come together to support each other by following each other on social media and promoting our beautiful state. Whether you “like” a post on a program’s page or leave a comment, we can all interact virtually.

As the resident managing the Washington University in St. Louis Psychiatry Instagram page, I hope to see all Missouri psychiatry residency programs on social media so we can connect. Whether you’re a private practice psychiatrist in Missouri or at a community institution, we can also support our state residency programs by following them on social medias at a time when virtual residency recruitment is novel for everyone.
Each year, medical graduates from all over the world seek residency positions in the United States as International Medical Graduates (IMG’s). IMG’s constitute 25% of total practicing physicians in the United States. Within psychiatry, 30% of practicing psychiatrists and 33% of psychiatry residents in the United States are IMG’s; and psychiatry as a specialty has the second largest number of IMG resident physicians on a visa, second only to internal medicine. Through basic science work, research, and delivery of health care, IMGs make considerable contributions to the United States healthcare system despite the unique challenges that they face.

In addition to the challenges faced by all psychiatrists in the current environment, the challenges faced by IMG’s are amplified during the current pandemic. COVID-19 infections and the expected mental health fallout, as well as burnout and immigration related issues, exacerbate immigrant-related stresses for immigrant psychiatrists. Many IMGs do not have local family support in the United States, essential during self-quarantine, illness, hospitalization, mental stress, or unemployment. Additionally, many IMGs feel helpless as they are unable to provide support for families in their native countries. Should an IMG lose their job (due to being furloughed), a stressor for any physician, immigrant physicians have to secure another job (and complete associated formalities such as state licensing, credentialing, and government approval processes) that meet the requirements of government departments. This uncertainty also extends beyond medicine, to the difficulty maintaining legal status. During the pandemic, the United States Citizenship and Immigration Services has initially stopped all premium processing which is used by physicians for visa renewal. In the case of loss of legal immigrant status, or death of an IMG, dependent family members are at risk of being uprooted due to deportation.

Through this pandemic, support for IMGs remains a crucial part of our working healthcare system. Legislation has been proposed to address issues affecting IMGs. Bipartisan efforts seeking to enhance the healthcare workforce during the COVID-19 global pandemic by recapturing 15,000 unused immigrant visas for foreign doctors, as well as additional visas for family members of the principal beneficiaries, have been introduced. Additional legislation supporting reauthorization of immigrant physicians to practice for three years in the United States after residency on a J-1 visa while working in underserved areas has also been proposed. Several psychiatric organizations including APA and AACAP have signed a letter sent to urge the United States Citizenship and Immigration Services to temporarily extend visas for one year, resume premium processing (was put on hold March 20, 2020), and expedite approvals of extensions and changes of status for non-citizen IMGs practicing or lawfully present in the United States. MPPA members can support their IMG colleagues by supporting legislation [(Senate Bill S.3599/ H.R.6788 http://cqcengage.com/psychorg/app/onestep-write-a-letter?0&engagementId=508036) and (Reauthorization of visa waiver program http://cqcengage.com/psychorg/app/onestep-write-a-letter?0&engagementId=507417)]. Please also check with your IMG colleagues to see how they are doing and if they need any support.

Special appreciation to the APA IMG caucus for taking the lead in increasing awareness and providing support to IMGs.

References:
1. https://www.psychiatry.org/psychiatrists/international/international-trainees/international-medical-graduates-guide-to-u-s-residency

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A Pandemic Without Enough Doctors: Limitations Placed on IMGs During COVID-19
Juee Phalak MD, MPH, Affinia Healthcare
Amanie Salem DO, MPH, New York-Presbyterian
Balkozar Adam, MD, University of Missouri - Columbia

7. https://paha.us/policy-advocacy/

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### Calendar of Events

#### Executive Council Meeting

**~ CONFERENCE CALLS ~**

- September 25, 2020
- November 17, 2020
  - (7:00 pm)

#### MPPA Fall Conference

**~ VIRTUAL ~**

- September 26, 2020

#### MPPA/MSMA Spring Conference

- April 10, 2021
- Westin Crown Center
- Kansas City, MO

#### American Psychiatric Association Annual Meeting

- May 1—May 5, 2021
- Los Angeles, California

#### MPPA Fall Conference

- September 25, 2021
Yoga May Help Relieve Anxiety Symptoms, But CBT is More Effective

Yoga may help relieve symptoms for patients with generalized anxiety disorder, but group cognitive-behavioral therapy (CBT) should remain a first-line treatment, suggests a study in *JAMA Psychiatry*.

Naomi M. Simon, M.D., M.Sc., of New York University Grossman School of Medicine and colleagues compared the six-month response rates of 155 patients who were randomized to 12 weeks of Kundalini yoga, CBT, or education about stress. Stress education included lectures on the physical and psychological impact of stress, the effects of lifestyle behaviors such as smoking or drinking alcohol on stress, and the importance of exercise and diet. All interventions were delivered to groups of four to six patients by two instructors during 12 120-minute sessions. Patients also had 20 minutes of homework each day. The researchers measured the patients’ response using the Clinical Global Impression-Improvement Scale, which assesses a patient’s functioning, before and after initiating treatment. Patients whose scores were 1 or 2 were considered to have responded to treatment.

At three months, response rates were 70.8% for the CBT group, 54.2% for the yoga group, and 33% for the stress-education group. At six months, the response rate was 76.7% for the CBT group, 63.2% for the yoga group, and 48% for the stress education group.

The researchers wrote that overall, this finding confirms the effectiveness of group CBT for general anxiety disorder as a first-line treatment, but that Kundalini yoga may have some short-term anti-anxiety benefits for some patients.

“Given the increasing costs of health care and barriers to accessing trained mental health care professionals, ... yoga may still have a role to play in [generalized anxiety disorder] management as an intervention that is more easily accessible,” the researchers wrote. “Future studies should identify individual characteristics that make a patient more prone to respond to yoga vs. CBT, including treatment preference and attitudes toward mental health care, which could inform how yoga might be integrated into a stepped-care personalized approach to anxiety disorders.”

APA, AACAP Release Recommendations for School Reopening

In a press release on July 15, 2020, the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) emphasized the importance of precautions during the coming school year given the ongoing coronavirus disease 2019 (COVID-19) pandemic.

The APA and AACAP offered 8 recommendations for school reopening plans. The first recommendation stated that public health agencies need to tailor their plans to the needs of students, teachers, and staff based on the available scientific evidence. The press release noted that any return to school necessitates appropriate protections for all community members.

The statement also called for school systems to maintain social interactions in the absence of classroom-based education. Additionally, school systems need to ensure fairness and equity in terms of “sufficient access to equipment, services, and technology, to address systemic and/or cultural disadvantages in educational and mental health supports.”

The APA and AACAP highlighted the need to provide specific resources to children with special needs, including those with emotional, learning, or physical disabilities, who may be at higher risk of slipping behind or falling through the cracks. They noted that children in foster care, as well as those experiencing poverty or for whom English is a second language, ought to receive special attention. The joint press release also emphasized the necessity of addressing student mental health, as well as the wellbeing of staff, educators, and parents coordinating home learning.

Lastly, the recommendations included a call for greater financial support for schools and their communities during the COVID-19-related school closures. The press release also noted that schools need to create “effective systems for the early identification of and intervention for the increased number of high-risk students” due to the COVID-19 pandemic.
Adult Anxiety and Poorer Function Linked to Childhood Depression But Can Be Prevented

Children or teenagers with depression are more likely to have higher rates of anxiety and worse social functioning as adults than those without a history of depression, according to a report in the *Journal of the American Academy of Child and Adolescent Psychiatry*.

However, children who receive specialty mental health services have a significantly reduced risk of adult psychiatric diagnoses, particularly anxiety, wrote William E. Copeland, Ph.D., a professor of psychiatry at the University of Vermont, and colleagues.

“In our study, children/adolescents who had met criteria for depression and had also received specialty mental health services were almost half as likely to receive an anxiety diagnosis as adults compared to their depressed peers who did not receive specialty mental health services,” they wrote.

A total of 1,420 participants in the Great Smoky Mountains Study were interviewed up to eight times between the ages 9 and 16 to assess for depressive disorders, associated psychiatric comorbidities, and childhood adversities (including low socioeconomic status, family dysfunction, abuse and neglect, and peer victimization) using the structured Child and Adolescent Psychiatric Assessment. They were interviewed again at ages 19, 21, 25, and 30 using the structured Young Adult Psychiatric Assessment Interview for psychiatric outcomes and functional outcomes.

A total of 7.7% of participants met criteria for a depressive disorder in childhood/adolescence. “Childhood/adolescent depression status was strongly associated with all types of other childhood psychiatric disorders and with most types of childhood adversities,” Copeland and colleagues wrote.

They found that childhood/adolescent depression was associated with higher rates of adult anxiety and depression and substance use disorders later in life. It was also associated with worse adult functional outcomes including poorer physical health, risky and/or criminal behavior, poorer financial status and/or educational performance, and poorer social function.

However, Copeland and colleagues also found that specialty mental health services for children could have long-term effects: Just 31.8% of children who had received mental health services had anxiety as adults, compared with 57.5% of those who did not. (The effects of mental health services did not extend to other functional outcomes.)

“[E]fforts to reduce the public health burden of depression should focus on reducing children’s cumulative exposure to depression and depressive symptoms,” they wrote. “The optimal strategy will likely involve public policies that target psychosocial risk factors associated with depression symptoms (for example, caregiver instability, maltreatment).”

Reprinted from *Psychiatric News*
Missouri Psychiatric Physicians Association presents
“Facing Challenges During an Epidemic: What Can We Learn in Psychiatry”
VIRTUAL FALL CONFERENCE
Saturday, September 26, 2020
Jointly Provided by the American Psychiatric Association and the Missouri Psychiatric Physicians Association

Agenda

FRIDAY, SEPTEMBER 25, 2020
7:00 - 9:00 pm Executive Committee Meeting

SATURDAY, SEPTEMBER 26, 2020
9:00 - 10:00 am A New Frontier in Critical Care: Saving the Injured Brain
(Pre-recorded Video)
We will unpack the real life implementation of bedside patient management concepts derived from over 40 NEJM, JAMA, and LANCET papers that went into the ABCDEF Bundle that has now been shown to save lives, reduce length of stay, reduce bounce backs, and ICUs globally revamp their service to the world’s sickest patients.
OBJECTIVES
1. To teach the robust evidence that delirium is a risk factor of excess mortality, length of stay, cost of care and dementia following critical illness.
2. To discuss acquired dementia following ICU care as a global public health problem that dismantles our patients’ lives as part of PICS (post-intensive care syndrome).
3. To reinforce new data-driven mechanisms embodied in the ABCDEF Bundle by which to improve patient-centered outcomes (survival, length of stay, successful discharge home) as employed within the ICU Liberation Collaborative in over 15,000 patients.
4. To learn strengths and pitfalls of ABCDEF implementation in order to change culture and care successfully so that ICU teams can better serve patients.
Speaker: E. Wesley Ely, MD, MPH, Vanderbilt University Medical Center, Nashville, Tennessee

10:00 - 11:00 am Will Civil Unrest Increase Health Equity in Psychiatry?
(Pre-recorded Video)
The presentation will examine structural competence, including how structural racism in U.S. medicine affects psychiatrists, patient care and organized psychiatry. The history of discrimination in psychiatry will be examined along with the present state of affairs, including civil unrest in the U.S. and in psychiatry. Efforts to address health disparities, including the APA’s response to structural racism will be presented along with recommendations for increasing health equity in psychiatry.
OBJECTIVES
1. Participants will appreciate how structural competence in medicine can improve the quality of healthcare delivery in underserved communities.
2. Participants will understand how structural racism can adversely affect patients and healthcare professionals of color.
3. Participants will be able to identify ways that they can increase health equity in psychiatry.
Speaker: Cheryl D. Wills, MD, DFAPA, Associate Professor of Psychiatry, Case Western Reserve University, Chairperson, APA’s Presidential Task Force
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Agenda

11:00 - 12 noon  Telepsychiatry in the Time of COVID
(Pre-recorded Video)
This will be a practical description of how to deliver telepsychiatry services to patients in their homes or other community settings.

OBJECTIVES
1. Understand how to deliver telepsychiatry consultations safely and appropriately
2. Be aware of the clinical skills required for telepsychiatry
3. Understand the range of technologies and models of care available for telepsychiatry

Speaker: Peter Yellowlees, MBBS, MD, Chief Wellness Officer, UCD Health, Alan Stoudemire Endowed Professor of Psychiatry, Department of Psychiatry, UC Davis

Noon - 12:30 pm  Break for Lunch

12:30 - 2:30 pm  Racism and COVID-19: A Race Equity Framework for a Community in Crisis
(Live Streamed Video)
We will examine the COVID-19 racial disparities through the lens of structural racism and detail the numerous contributions to unique vulnerabilities to transmission, psychological trauma and death among Black, Indigenous and Person of Color communities. We will then explore the utility of approaching the COVID-19 racial disparities, focusing on mental health care, with a reliance on the foregrounding of racism as a public health crisis. We will also discuss the importance of a race equity framework to shape interventions in the psychiatric community.

OBJECTIVES
1. To list the three part definition of racism including internalized, interpersonal and institutional racism
2. To discuss the psychiatric community’s role in addressing the public health crisis of racism as it relates to Black, Indigenous and Persons of Color patients accessing the mental health care system and reimagining the professional community that serves them
3. To apply a race equity framework that can shape interventions to reduce racial mental health inequities as we adopt new care models

Speaker: Jessica E. Isom, MD, MPH, Codman Square Health Center, Dorchester MA

2:30 - 3:30 pm  Doctor Burnout: Navigating Moral Injury in Healthcare
(Live Streamed Video)
Redefining and reframing the concept of physician burnout as not just an internal individual struggle but as a symptom of a deeper moral injury due to the many double binds of the American healthcare system.

OBJECTIVES
1. To reframe the concepts of burnout and self care as applicable to physicians.
To introduce the concept of moral injury as a more accurate and more productive definition of the
Missouri Psychiatric Physicians Association presents

“Facing Challenges During an Epidemic: What Can We Learn in Psychiatry”

VIRTUAL FALL CONFERENCE
Saturday, September 26, 2020

Jointly Provided by the American Psychiatric Association and the Missouri Psychiatric Physicians Association

Agenda

1. physician emotional experience.
2. To discuss practical solutions to moral injury at the personal, institutional, and legislative level.
   
   Speaker: Mona Masood, DO, Physician Support Line

Accreditation Statement: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and Missouri Psychiatric Physicians Association (MPPA). The APA is accredited by the ACCME to provide continuing medical education for physicians.

Designation Statement: The APA designates this virtual activity for a maximum of 6.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Completing the Evaluation, Claiming Credit, and Receiving a Certificate: At the conclusion of the conference through December 2020, physician participants will be provided with an opportunity to evaluate the conference and receive a CME credit certificate by completing an online evaluation accessed through the American Psychiatric Association Learning Center at education.psychiatry.org. Non-physician participants will have the opportunity to receive a certificate of attendance.

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Virtual attendees will be sent a confirmation email within a week before the conference. The seminar will start at 9:00 am, be sure to check the program agenda for ending times, lunch break, etc. For security reasons you will need to have a Zoom account before you can register in the Zoom webinar interface. Links for the conference will be sent to you ahead of time. Handouts for the conference will also be sent ahead of time to the email provided on the registration page. All sessions, with exception of the last, will be pre-recorded sessions. The last session will be live streamed with a Q&A section at the end. Please note that you cannot get credit for the webinar if you log in with a listen only phone. Use the links sent to ensure you receive a video link and an audio link. However any links to the webinar using internet on your smart phone, tablet or computer will be logged and tabulated and used to generate the number of CEU’s that will appear on your certificate. Be sure that you have a minimum download speed in the 7-10 Mbps range. MPPA is not responsible for your inability to connect and attend if your device or Internet connection are inadequate. If you have issues with Zoom during the webinar, enter your questions in the Q&A resource as well. We will do our best to fix things and/or respond to you. But our help will be limited.
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Deadline for registrations is September 15, 2020.
The results of what Ottawa researchers suggest is the largest study of its kind have found that children of mothers who reported using cannabis during pregnancy had a 50% increased risk of developing autism spectrum disorder (ASD), compared with children who weren’t exposed to cannabis in utero, even after controlling for confounding factors.

The new results highlight that women who are thinking of using cannabis during pregnancy should be aware of the potential risks of the drug, and talk to a healthcare provider. “In the past, we haven’t had good data on the effect of cannabis on pregnancies,” said Daniel Corsi, PhD, epidemiologist at the Ottawa Hospital and BORN Ontario, which is affiliated with the CHEO Research Institute. “This is one of the largest studies on this topic to date. We hope our findings will help women and their health-care providers make informed decisions.”

Corsi is first author of the team’s paper, which is published in *Nature Medicine*, and titled, “Maternal cannabis use in pregnancy and child neurodevelopmental outcomes.”

Recreational use of cannabis is now legalized in Canada, and expectant parents may think that cannabis can be used to treat morning sickness. However, legalization of cannabis doesn’t mean it’s safe for people who are pregnant or breastfeeding. Health Canada and the Society of Obstetricians and Gynaecologists of Canada recommend against these populations using cannabis, and health warnings to this effect appear on cannabis packaging.

Cannabinoids, including tetrahydrocannabinol in cannabis, readily cross the placenta and can enter the fetal bloodstream, the authors commented. Human and animal studies suggest that disruption of endocannabinoid signaling may interfere with normal neuronal wiring, and this could have implications for fetal neurodevelopment. “Exposure to cannabinoids while in utero can disrupt the fetal endogenous cannabinoid signaling system, which has several roles in embryo development.”

While previous studies have indicated that maternal cannabis use during pregnancy is linked with decreased concentration and attention in their offspring, “...data on long-term follow-up of children with exposure to cannabis in utero are currently limited,” the team continued. “There is a need for larger studies that can adequately control for confounding in cannabis-outcome associations.”

“Despite these warnings, there is evidence that more people are using cannabis during pregnancy,” said Mark Walker, MD, chief of the department of obstetrics, gynecology and newborn care at the Ottawa Hospital, professor at the University of Ottawa, and senior author on the study. “This is concerning because we know so little about how cannabis affects pregnant women and their babies. Parents-to-be should inform themselves of the possible risks, and we hope studies like ours can help.”

(Continued on page 17)
To look for any association between cannabis exposure in pregnancy and neurodevelopmental outcomes in childhood, the research team turned to the BORN birth registry, and reviewed data from every birth in Ontario between 2007 and 2012, before recreational cannabis was legalized. Of the half a million women in the study, about 3,000 (0.6%) reported using cannabis during pregnancy.

The researchers had previously found that cannabis use in pregnancy was linked with an increased risk of preterm birth. In that study, they saw that women who used cannabis during pregnancy often used other substances including tobacco, alcohol, and opioids. So, for the study reported now in *Nature Medicine*, the researchers specifically looked at 2,200 women who reported using only cannabis, and no other substances, during pregnancy.

Their results showed that babies born to this group still had an increased risk of autism compared with those who did not use cannabis. The incidence of ASD was 4 per 1000 person-years among children exposed to cannabis in pregnancy, compared to 2.42 among unexposed children. “... the primary association between maternal cannabis use and ASD persisted in sensitivity analyses by other substance use, income, and preterm birth,” the team reported.

Interestingly, there was also a tentative link between prenatal cannabis exposure and an increased risk for children developing intellectual disabilities, learning disorders, and ADHD. However, the associations were smaller in magnitude—11–22%—than those between maternal cannabis use and offspring autism, and “did not attain statistical significance at conventional levels are matching and covariate adjustment,” the authors stated.

The researchers don’t know how much cannabis the women were using, how often, at what time during their pregnancy, or how it was consumed. They also noted that while they tried to control for other factors that could influence neurological development, their study showed an association, and could not demonstrate cause-and-effect. “Although findings of an increased risk for childhood neurodevelopmental disorders are of substantive interest, we emphasize a cautious interpretation given the likelihood of residual confounding,” they wrote.

As cannabis becomes more socially acceptable, healthcare researchers are aware that some parents-to-be might think it can be used to treat morning sickness. The Ottawa team suggests that women who are thinking about or currently are using cannabis during pregnancy should talk to their healthcare provider to help make an informed choice about what is best for them and their baby. And while the researchers acknowledged a number of limitations to their study, they nevertheless concluded, “In this large retrospective cohort, we found that children with mothers who reported cannabis use in pregnancy were at higher risk for ASD diagnosis ... Further study is needed on the amount and timing of cannabis use in pregnancy and childhood health outcomes and following the legalization of cannabis in many jurisdictions.”

Reprinted from *Psychiatric News*
On Tuesday August 4th, Missourians voted by a 6-point margin to approve the federal government’s Medicaid expansion initiative. Overcoming fierce opposition from Republican leadership, the state joins 37 states and the District of Columbia in expanding Medicaid coverage eligibility. A wide range of interests including the Missouri Hospital Association, NAACP, AFL-CIO, AARP, Planned Parenthood and Catholic Charities of St. Louis united in unlikely partnership and support. Local campaigners found success by de-emphasizing phrases such as “Affordable Care Act,” “Obamacare,” and even “Medicaid Expansion,” which had previously polled poorly in the state.

Voters outside of the urban centers largely opposed the amendment despite disproportionate rates of poverty and uninsured status, with McDonald, Morgan and Scotland counties opposing the measure by margins approaching 2 to 1. The measure, which approves a state constitutional amendment, is estimated by researchers from Washington University to bring coverage to 230,000 residents and save the state $932,000,000 by 2024. Nationwide, initiatives to expand Medicaid have brought nearly fifteen million people under coverage since 2013. The Missouri State Medical Association endorsed expansion, stating that “increased access to health care is linked to better health outcomes in patients of all ages.”

As the nation continues its struggle with the rising tide of Coronavirus infections, Missouri’s casualties have numbered in excess of 60,000, a number which disproportionately represents Missourians of color and of lower socioeconomic status. Early indicators have projected a dramatic increase in anxiety and trauma-related disorders associated with the current pandemic. Low income individuals are more likely to work jobs which cannot be performed remotely, and which are less likely to offer sick days. According to an analysis by the Economic Policy Institute, while 90% of top-quartile American wage earners have paid sick leave through their employer, only 47% of bottom-quartile earners have this protection. The United States, the only developed nation that does not guarantee paid sick leave, has a unique vulnerability to spread within this population. These populations find themselves at heightened risk for contracting and spreading COVID-19, and may bear the full brunt of its mental sequellae. Health providers’ core messaging of “avoid crowded areas, keep six feet of distance” has been additionally difficult for low-income and multigenerational families who find themselves in smaller homes with shared bathrooms and kitchens.

In our current health insurance environment, low-income individuals are less likely to follow with a general practitioner, which introduces bottlenecks in monitoring individuals with fever, cough, shortness of breath, or signs of heightened anxiety. With a recent American Community Survey finding 9.7% of Missourians to have no health insurance of any kind, Medicaid expansion represents the first of many necessary steps to protect Missourians.

- Over 200,000 Missourians Will Get Covered with Medicaid Expansion https://www.ama-assn.org/delivering-care/patient-support-advocacy/over-200000-missourians-will-get-covered-medicaid
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I grew up in South India and graduated with a medical degree from Tirunelveli Medical College. I was unsure of what I wanted to do for a specialty and moved with my husband to the United Kingdom in 1991. It was while working in the Emergency Department (ED) in the UK that I discovered that my true calling was to become a psychiatrist. While caring for post-suicide attempt patients in the ED, I was drawn to the possibility that I could have made a difference if I had intervened prior to this incident.

In ‘94, I began my psychiatric training in the UK. I learned one of my first lessons in psychiatry during my residency interview. The interviewer, a psychoanalytically trained psychiatrist with a long white beard, asked me why I believed I was suited to become a psychiatrist. I explained that I had good verbal skills, interpersonal skills, and can communicate effectively with everyone. He asked me, “Do you know what is the single most important skill to become a psychiatrist?” He continued, “The ability to listen and have the person in front of you be heard.” To this day, when I have the urge to interrupt a patient, I remember those words.

During my training in the UK, I learned the importance of team work in restoring patients to full recovery. I was taught that unless a patient with a serious mental illness, such as schizophrenia, is in full recovery and restored to a level of independent living, the work of a psychiatrist and her team was not complete. Absence of symptoms did not equate to recovery. Recovery was measured by the sustained improvement in the functional ability of the patient. This became my yardstick to measure treatment progress to this day.

In ‘97, we moved to the United States to pursue American residency training. It was during my second year of psychiatric residency training at Southern Illinois University (SIU) that I discovered the field of forensic psychiatry. I interviewed a patient who had murdered his father and was found “Not Guilty by Reason of Insanity.” The interview lasted well over 4 hours, and I was hooked. How can a person not know he was killing his own father? How could I know he was not feigning psychotic symptoms to abdicate responsibility? There began my love for all things related to forensic psychiatry.

I finished my forensic psychiatry fellowship at SIU in 2002. I was truly blessed to be trained by some of the best minds in the field. Dr. Parwatikar pushed me to conceptualize forensic and legal issues from a 360-degree point of view; Dr. Felthous laid a strong foundation in the forensic sciences. I then sought out my niche.

I was particularly curious and fascinated by serial sex offenders and murderers and wanted to understand how they do the unthinkable repeatedly. I worked part-time in a sex offender civil commitment program in Illinois for 8 years. Engaging in lengthy interviews month after month with these individuals allowed me to understand the workings of a paraphilic mind. Around the same time, I worked part-time at Potosi Correctional Center with some of the most violent offenders in the state, including several on death row. I asked candid questions such as why they did what they did, what experiences in their own life influenced their behaviors, and what decision point could have changed the trajectory of their life. These 8 to 10 years of my professional life were the most transformative. My perception of good and evil changed. The resilience and positive attitude of inmates, despite knowing they will die in prison, was truly inspiring. I experienced a lot of personal and professional growth during this period.

I started my private practice in forensic psychiatry in 2006, while continuing my prior work in part-time

(Continued on page 21)
positions. The knowledge and expertise I had gained by working with sex offenders and violent offenders gave me a professional edge to serve as an expert witness in civil and criminal legal matters. I found testifying in court to be both challenging and exciting, and I was rewarded for my passion with more opportunities to polish my skills as an expert witness.

In 2014, despite having no previous administrative or leadership experience, I became the Chief Clinical Officer for the Missouri Department of Mental Health. The past six years in this position have challenged me to enrich my leadership and problem-solving skills. I have worked with many experts to combat the opioid epidemic in Missouri by focusing on medication assisted treatment of opioid use disorder. I have implemented Zero-Suicide initiatives across the state, integrated trauma-informed care into mainstream mental health treatment, continually met with community mental health providers to identify ongoing gaps in care, and developed guidelines to mitigate COVID related risks in our long-term psychiatric facilities. There is never a dull moment! I have the opportunity to make a difference in the lives of so many Missourians, and I do not take that responsibility lightly.

My curiosity to learn and grow has kept me motivated, helped me maintain my passion for the profession and prevent burn out. Each job, with its rewards and challenges, has prepared me to grow professionally. The advice “to listen and have the person in front of you be heard” has served me well and has been the key for my professional growth and success.
Women with posttraumatic stress disorder (PTSD) associated with childhood abuse improved significantly with both dialectical behavior therapy for PTSD (DBT-PTSD) and cognitive processing therapy (CPT), with DBT-PTSD resulting in slightly more favorable outcomes, according to a study published Wednesday in JAMA Psychiatry.

“Currently, treatment for [PTSD associated with childhood abuse] mostly relies on established treatments that were developed for survivors of adult-onset trauma,” wrote Martin Bohus, M.D., Ph.D., of Heidelberg University in Germany and colleagues. “Most treatment guidelines recommend prolonged exposure, cognitive processing therapy [CPT], or trauma-focused cognitive behavioral therapy, but there is debate on whether these treatments are sufficient for [these] patients.”

From January 2014 to October 2016, women who sought treatment were recruited from three sites in Germany and randomly assigned to receive DBT-PTSD or CPT. The participants were aged 18 to 65, were diagnosed with PTSD following sexual or physical abuse before age 18, and met three or more criteria for borderline personality disorder. Forty-eight percent of the participants also met the threshold for a diagnosis of borderline personality disorder.

DBT-PTSD is based on the principles of DBT, which was originally developed to treat borderline personality disorder by giving patients skills to manage painful emotions and regulate their emotions. DBT-PTSD includes supplemental trauma-focused cognitive-behavioral interventions. CPT is an established, trauma-focused therapy that challenges patients to face dysfunctional emotions related to trauma.

The 193 participants received up to 45 weekly individual sessions of DBT-PTSD or CPT within one year, plus three additional sessions in the three following months. Both treatments included individual therapy, plus homework and telephone consultations as needed. Participants were assessed using the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) before the start of therapy and again after three, six, nine, 12, and 15 months.

Although the women in both groups showed significant improvements in CAPS-5 scores over the course of the study, the improvements were more pronounced in the group receiving DBT-PTSD, the authors noted. “The same results were seen for other aspects of psychopathology closely associated with a history of [childhood abuse], such as dissociation, self-harm, and high-risk behaviors,” they wrote. “[P]articipants in the DBT-PTSD group were more likely to achieve symptomatic remission, reliable improvement, and reliable recovery and were less likely to drop out of treatment,” the authors wrote.

“The study shows that even severe forms of [childhood abuse]-associated PTSD that include multiple co-occurring mental disorders and emotion dysregulation can be treated efficaciously,” the authors concluded. “Future studies should strive for a better definition of patient groups that might profit from current therapies.”

Reprinted from Psychiatric News
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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What is the MO Psychiatric Physicians PAC?
MoPPAC 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.

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

Who directs MoPPPAC?
MoPPAC operates under the direction of PAC officers and directors who are members of the American Psychiatric Association and the Missouri Psychiatric Physicians Association. The MoPPAC 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?
- MoPPAC 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.

MoPPAC funds are used for purposes that are consistent with the goals and missions of the Missouri Psychiatric Physicians Association and the American Psychiatric Association.

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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, please contact Sandy Boeckman by email at missouripsych@gmail.com.
Mark your Calendar
Missouri Psychiatric Physicians Association
Fall Conference
~ VIRTUAL ~
Saturday, September 26, 2020