Welcome Fall: A Time For New Beginnings and Some Endings

Summer is over and it is time to get back to work for our patients and psychiatry.

There is a bill, HR 3753: The Parity Implementation Assistance Act, that provides states with resources to ensure Mental Health Parity is enforced. As you may remember Mental Health Parity passed in Missouri in May and should be law on August 28. Write to your US Representative to support HR 3753.

The next big issue is the COVID crisis. Since the Delta variant has reared its ugly head, the number of Missourians who are positive for COVID is rising to scary heights. Unvaccinated persons are 97% of patients in the hospitals and ICU. I urge you to talk with your patients who are reluctant, resistant, or anti-vaccine. Let them know how important it is to get vaccinated to protect all of us. Children under 12 are not yet eligible for the vaccine but hopefully will be able to get the vaccine by the end of the year. The new school year is starting and the mask vs. no mask debate is on. Urge your patients to be protective of their children.

This is the time of year when we welcome new Residents in Psychiatry. I hope they will join Missouri Psychiatric Physicians Association and contribute their energy and skills.

We are extremely fortunate to have Sandy Boeckman as our Executive Director and Randy Scherr as our Lobbyist. The legislature will resume in January unless there is a special session. 2022 will be an election year for all the Missouri Representatives and one-third of the Senators, so please support our Political Action Committee (PAC) so we can support those who help us.

Our Fall Conference on September 25, 2021 is Virtual again because of the surge in COVID cases. It is my hope that we will be able to resume face to face meeting in 2022 both in our local cities and statewide. It is important to get to know each other.

As for endings, after working in the office since 1980 and at Malcolm Bliss for two years after my residency, I am leaving the office. I will still have my finger in the pie since I will supervise a nurse practitioner who is

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President’s Message

getting many patients from me. Yes, I will continue my term as President of MPPA since I am staying in St. Louis. As I mentioned in my first column this is not my first time as President. When I was a sweet young thing, I was president of Eastern Missouri Psychiatric Society (EMPS) in 1983 and then I followed Dr. Daniel Mamah as the second president of Missouri Psychiatric Association and re-upped for a second term after Bob Batterson so I could concentrate on issues rather than paperwork to get us established from three district branches of APA to one.

Jo-Ellyn M. Ryall, MD, DLFAPA

Wilbur H. Gearhart, MD
August 26, 1925 - July 10, 2021

Wilbur H. Gearhart, M.D. of Ballwin, Missouri died July 9, 2021 at the age of 95. Dr. Gearhart was born August 26, 1925 in Central City, Pennsylvania. Following high school he joined the Marine Corps and served in the Pacific Area in WWII from 1943 to 1946. He obtained a B.S. degree from Butler University in Indianapolis, Indiana, and then attended Hahnemann Medical School in Philadelphia, Pennsylvania. Completing this he interned at Polyclinic Hospital in Harrisburg, Pennsylvania followed by a two year surgical residency. He moved to St. Louis, Missouri where he completed a three year residency in Psychiatry at Washington University School of Medicine. He founded the Psychiatric Associates Group in St. Louis and practiced psychiatry for 25 years, retiring in 1989. During this time he served on the clinical staff of Washington University School of Medicine and was Chief of Staff of Missouri Baptist Hospital in 1979. Dr. Gearhart was a member of the St. Louis Medical Society, the American Psychiatric Association, and the Christian Medical and Dental Society. He is survived by his wife of 73 years, Jane; two children, Linda (Garrett) Doak and William (Lori) Gearhart; four grandchildren, Jeffrey (Katie Funkhouser) Doak, Kevin (Caitlin) Doak, Elizabeth Gearhart, William Jason (Sarah) Gearhart; two great grandchildren, Eric Doak, Riley Doak. He was devoted to his family, his church and his patients. A private memorial service was held at Jefferson Barracks National Cemetery.
Returning to a workplace after telecommuting for more than a year can be stressful for employees. They may need to establish new routines for commuting and family caregiving, they may have concerns about COVID-19 variants, and some may still be processing grief from losing loved ones to the pandemic. To help employers assist their employees with the transition, the Center for Workplace Mental Health, a program of the APA Foundation, has developed a guide for returning to the workplace.

The guide offers insight into the concerns employees may have and tips on communicating with employees throughout the transition. The key recommendations, among others, include the following:

**Understand concerns:** Consider conducting a survey or hosting a town hall discussion to better understand how this historic time has impacted employees and their concerns related to returning.

**Communicate often and be transparent:** Keep employees informed about plans and changes in policies and procedures and encourage open discussion about experiences and concerns with transitioning back.

**Make employees’ mental health a visible priority:** Make sure employees are aware of the mental health services and resources available to them and create an environment where people are comfortable talking about mental health and accessing services when needed.

**Stay flexible:** Anticipate the need to be flexible as people transition to new schedules, new commutes, and new routines.

**Promote resiliency:** Offer opportunities for mindfulness practices and create a healthy work environment, prioritizing reasonable limits on work hours and promoting physical health.

“Everyone’s situation and experience will be different, but for those of us who spent the last 16 months at home, we’re not just going back to ‘normal,’” said APA President Vivian Pender, M.D., in a statement released by APA. “We’ll all be dealing with new logistical and emotional challenges, and different people will have different burdens.”

The new guide “is essential reading for managers who are seeking actionable steps to support employees returning to the workplace,” said Saul Levin, M.D., M.P.A., APA CEO and medical director and chair of the APA Foundation. “Everyone is dealing with new life circumstances, and some of it will involve trauma, and not all will be evident. It’s important that we check in on and take care of each other.”

For related information, see the Psychiatric News article “Expect a ‘Long Tail’ of Mental Health Effects from COVID-19.”

Reprinted from Psychiatric News, 8/6/21
Medical marijuana, CBD, hemp products, “green dispensaries”, edibles, vaping and “legal THC” (Delta 8 and 10 THC vs Delta 9 THC which is associated with the marijuana “high”). As tempting as it may be to ignore the culture and the trends behind the push for expanded use of cannabis products, which may seem contrary or irrelevant to our day to day psychiatric practice, psychiatrists would do well to gain familiarity with these terms and concepts.

Missouri approved medical marijuana in late 2018 and began accepting applications in July 2019. Since then the cannabis industry has grown exponentially in Missouri, much faster than most of medical professionals have had time to keep up with. Important aspects of Missouri’s marijuana regulations can be found at the MO Dept of Health and Senior Services (DHHS) website(1). The website lists numerous “qualifying medical conditions” by name (e.g. cancer, epilepsy, glaucoma) but there are also general statements such this: “debilitating psychiatric disorders, including, but not limited to, post-traumatic stress order, if diagnosed by a state licensed psychiatrist”. The DHHS website also mentions autism and “agitation of Alzheimer’s disease” (2).

Our efforts to learn about the relevant medical aspects of cannabis use are complicated by conflicting laws of neighboring states along with lack of regulatory uniformity for legal cannabis products between states. Another factor becomes readily apparent as one begins to delve into this subject matter: emotion often predominates over critical thinking. Advocates for expanded cannabis use (including patient groups) are passionate and motivated and quote certain data (3) while others such as medical groups are adamantly opposed to cannabis use (even “medical marijuana”) and quote other data sets. Fortunately, a new coalition has recently emerged which seeks to bring uniformity and clarity to cannabis research in the interest of both patient safety and potential benefits (4). The group known as the Medical Research Advocacy Alliance (MCRAA) held its first virtual symposium last March and identified the primary obstacle to reliable information on cannabis: the designation of cannabis a Schedule I Controlled Substance means that only one strain is approved for research purposes. While this allows for direct comparison between studies from different labs, it does not reflect the vast array of strains that are available to the public at dispensaries throughout the U.S. There is also a need for more rigorous, controlled trials beyond the predominance of observational and retrospective studies.

One of the most important, yet unrecognized fact which we need to alert the public to including legislators is that the common understanding of marijuana as a natural and therefore relatively mild substance with few health and mental health risks compared to other drugs of abuse is based on an outdated, romantic notion of the marijuana from the 1960s and 70s. In truth, the marijuana of today has been systematically cultivated to contain up to 10-15 times the THC concentration as that of that prior period. Besides risks of intoxication and addiction, research has shown that THC is associated with risk of psychosis in young developing brains (5). Earlier versions not only had much less THC but the neurotoxic effects were more easily counteracted by higher amount of CBD (cannabidiol) which appears to attenuate effects of THC (6). CBD is one of the more over 100 cannabinoids in the marijuana plant and one of the more evidence-based therapeutic components.

As is often the case among clinicians, the impetus for me to learn more about cannabis related terms and issues arose from discussions with patients some of whom asked if I could help them to approved for a “medical card” (permit to purchase and use marijuana for medical purposes). Others informed me that they already obtained their medical card and still others mentioned vaping with either marijuana or CBD. Deciding how to handle this information with our patients obviously will vary from patient to patient. In some cases we may want to limit or discontinue control substances which we have been prescribing for anxiety or insomnia especially when the patient is convinced that marijuana helps with these symptoms or they indicate they plan to continue using it. In my experience, it is pointless to try to convince patients to stop using cannabis by referring to standard phrases often noted in organized psychiatry settings such as: “there is no scientific evidence of benefit for any psychiatric condition”. This may or may not be true but we won’t talk patients out of trusting their own experience. However it does make sense to warn them about potential neurotoxicity and psychosis risk of THC especially in younger patients and also when not balanced by adequate ratio of CBD to THC.

Here is a notable vignette: a 68 year old male professional

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reported a period lasting over an hour of disorientation, dissociation, short term memory disturbance and dysphoria starting about 90 minutes after taking a few puffs from a vaping pipe containing vial of delta 9 THC which he purchased at a local cannabis/CBD store. He was told by a clerk in the store where he purchased it had a calming effect, that did not result in the usual marijuana high due to regular THC (which is Delta 9 present in marijuana) and that it did not require a “medical card”.

This latter statement was (and is) true since Delta 8 and 10 THC are derived from hemp (which has lower THC content than marijuana) and are not regulated by MO DHHS but rather by MO Dept of Agriculture. But here is a disclosure as well as a call to action: the 68 y.o. male professional in this vignette was me. I was not interested in seeking a “high” but did want to understand what drew many of my patients to the experience of vaping with what appeared to be a benign product. However, after this rather disturbing experience it’s clear to me that these particular poorly regulated cannabis products have the potential to precipitate significant psychiatric symptoms and could even trigger an episode of destabilization in vulnerable patients. This is but one example of our need as psychiatric physicians to increase our knowledge about cannabis and its various forms also to expand our efforts to raise public awareness of medical and psychiatric implications of rapidly expanding cannabis use.

REFERENCES:

6. Stuart Tomc, Cannabis Educator: Staying in Step with the State of the Research (Interview by Craig Gustafson), Integrative Medicine, Vol 14, N0. 2, April 2015
My name is Sultana Jahan. I was born in Bangladesh. Currently, I serve as an Associate Professor at the University of Missouri–Columbia.

During my early childhood, I lived in Chittagong, the second-largest city in Bangladesh. It is a place that will take your breath away. It is surrounded by mountains, forests, lakes, and sea beaches. The nearby hills and jungles are laden with waterfalls, fast-flowing river streams, and elephant reserves. Even though Chittagong is the second-largest city, I grew up with animals—cows, chickens, pigeons, and many others. My father was fond of animals, and he treasured gardening. Through his example, I inherited and emulated these qualities of compassion, attentiveness, and immersion in my environment.

My early childhood was joyful until I turned 13, when my father passed away. He was a government official working in Chittagong. After his death, my family moved to a small town. At that time, my mother was only 30 years old with four children. I was the eldest, and my youngest brother was only two and a half years old. She battled countless obstacles to raise us. Only once I grew older did I realize how many financial difficulties she faced. She did not have higher education, but she was a strong, intelligent, brave, kind-hearted woman. Without her support, determination, and dedication, I would not have become a doctor. Many times, my grandfather asked my mother why she bothered to pay for my education. Every time, my mother assured me that I would always be able to study. She encouraged me not to pay attention to my grandfather but rather to focus on my study. Her trust in my abilities inspired me to persevere in learning and look toward future education.

Throughout my higher secondary education and medical school, I received the Bangladesh government’s merit scholarship. I graduated from Dhaka University, Bangladesh, and earned my Bachelor of Medicine and Bachelor of Surgery degree in 1987. Then, I took the Bangladesh Civil Service (BCS) examination, a nationwide competitive assessment conducted by the Bangladesh Public Service Commission (BPSC) for recruitment to the various BCS cadres. It was conducted in three phases: the preliminary examination, the written examination, and the viva voce (interview). I successfully passed all three portions and was offered the most prestigious job in Bangladesh as a Medical Officer.

Within 3 months of our marriage, my husband moved to the USA to pursue a Master’s degree in civil engineering from Texas A&M University. A few months later, I joined him, despite our severe financial difficulties at that time. Amidst these challenges, we also had to learn an entirely new environment, culture, and language. Meanwhile, I gave birth to two of our daughters, two and half years apart. Then, I turned my attention to my USMLE examinations. I had to prepare with no resources besides my commitment, as no guidance or instruction was available to me at that time. Due to financial difficulties, I could not afford to take any USMLE preparatory courses or practice exams.

Once I cleared USMLE Steps 1 and 2, I worked seven days a week for more than a year. I started as a mental health worker at a major, 110-bed private psychiatric hospital in Dallas, Texas. I worked there five days a week, and I also volunteered two days a week at the VA Hospital’s Department of Psychiatry in Dallas. I knew I needed to work hard to gather experience and navigate the US health care system, especially mental health care, before applying for my psychiatry residency program. Then, I cleared my USMLE Step 3 exam. I obtained strong recommendation letters from different psychiatrists at my workplace and the VA hospital.

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In 2000, I had applied for and received 15 interviews from different psychiatry residency programs. I was honored to receive a pre-match offer from the University of Missouri-Columbia for the general psychiatry residency program. I started my residency in July 2001 at the University of Missouri–Columbia. Throughout my USMLE studying and residency training, my husband provided immense support and inspiration. To encourage my dream, he selflessly resigned from his well-established engineering job in Dallas and moved with my daughters and me to Columbia, Missouri. He also inspired me to further my training in child and adolescent psychiatry after my residency in general psychiatry.

In 2006, I completed my residency in general psychiatry and fellowship in child and adolescent psychiatry at the University of Missouri–Columbia. Right after my training, I was offered the position of Assistant Professor at the institution. In 2014, I was promoted to Associate Professor.

Today, I am involved in patient care, teaching medical students, resident physicians, and child fellows. In recognition of my teaching excellence, I received the Outstanding Child and Adolescent Psychiatry Faculty Award in 2007, 2008, 2012, and 2014. I also take great pride in my administrative diligence and reorganization of existing clinical services to improve patient care and patient satisfaction. I am deeply interested in child psychopharmacology, and I am enthusiastic about learning and teaching new advancements in this area. Every year, I attend Dr. Stephen Stahl’s psychopharmacology conference, enriching my knowledge and understanding of this discipline by learning alongside and from many renowned psychiatrists from across the US.

I was elected as an advisor of the Bangladesh Student Association (BSA) at the University of Missouri for six years. During my leadership term, BSA organized different cultural events on campus year-round. With my guidance, BSA arranged the annual welcome party at the MU Student Center to greet newly recruited MU students with other student organizations. For the past several years, I served as an executive member for the regional APA branch. Currently, I am a chairperson of the Child Psychiatry Committee for the Missouri Psychiatry Physicians Association.

While working as a full-time clinician, I have conducted multiple IRB-approved studies as a principal investigator. I believe that “curiosity creates cures,” and I prioritize the value and impact of research. For these reasons, I have led and supported various research activities throughout my career. Recently, I completed a study entitled Telepsychiatry and In-Person Care for Pediatric Patients during COVID-19: Patients’ Perspectives. Currently, I am working on a project to assess how hyperprolactinemia affects the skeletal system in children and adolescents.

Once I was selected to serve as a chairperson of the Committee on Student Organizations Governments and Activities (SOGA) at the University of Missouri—Columbia, I led the committee to approve the creation and funding of various campus organizations.
NOTE: We are operating in uncharted territory and there are very few clear answers currently. This is a very fluid situation and the risk management recommendations below may change. This document will be updated on our FAQ page (www.PRMS.com/FAQ), and should be checked regularly. Nothing presented here is legal advice.

While we do not know exactly what will happen next in terms of the country re-emerging from the COVID-19 Public Health Emergency (PHE), psychiatrists should be prepared to address at least the following issues:

1. **RE-OPENING YOUR PSYCHIATRIC OFFICE**
   In addition to your local community guidelines, review guidelines and best practices from the AMA, MGMA (Medical Group Management Association), CMS, and others. **Tip:** Links to these resources are in our FAQs.

2. **FOR PATIENTS THAT REMAINED LOCAL, DETERMINE WHETHER THEY NEED TO BE SEEN IN-PERSON, REMOTELY, OR A COMBINATION OF BOTH**
   This determination should be based on your assessment of the patients’ clinical needs, not on the patients’ preference for telepsychiatry.

3. **FOR PATIENTS CURRENTLY OUT-OF-STATE, DETERMINE IF THEY HAVE IMMINENT PLANS TO RETURN TO YOUR AREA**
   Manage patient expectations – let them know that the rules may be changing soon and you may not be allowed by law to continue to treat remotely.

4. **TRACK STATE LICENSURE WAIVERS IN YOUR PATIENTS’ STATES**
   They may expire on specific dates, or be extended, or withdrawn at any point. **Tip:** PRMS will continue to track these licensure waivers in our FAQs.

5. **ONCE LICENSURE WAIVERS HAVE EXPIRED IN STATES WHERE YOUR PATIENTS ARE LOCATED, DETERMINE WHAT IS NEEDED TO CONTINUE TO TREAT YOUR PATIENT VIA TELEMEDICINE**
   States may require full licensure, a telemedicine registration, or there may be no requirements other than licensure in your own state to treat existing patients. PRMS will help our insureds find this information.

6. **IF AFTER THE WAIVER ENDS, YOU ARE ALLOWED TO CONTINUE TO SEE THE OUT-OF-STATE PATIENT, DETERMINE AND FOLLOW THAT STATE’S STANDARD TELEMEDICINE RULES THAT WILL LIKELY BE BACK IN EFFECT**
   States can have laws addressing requirements for in-person visits, informed consent, documentation, etc. If your patient’s state does not have such laws, follow the telemedicine guidelines developed by the Federation of State Medical Boards.

7. **IF AFTER THE WAIVER ENDS, YOU ARE NOT ABLE TO CONTINUE TREATING THE OUT-OF-STATE PATIENT (I.E. FULL LICENSURE IS REQUIRED), TERMINATE TREATMENT**
   Although this should be done quickly, do not abandon your patient—consider giving 30 days’ notice.

8. **IF AFTER THE WAIVER ENDS YOU WANT TO CONTINUE TREATING YOUR PATIENT REMOTELY AND HAVE DETERMINED THAT YOU ARE IN COMPLIANCE WITH LICENSING REQUIREMENTS, ENSURE YOU ARE ALSO IN COMPLIANCE WITH THE PATIENT’S STATE’S PRESCRIBING LAWS**
   There may be specific state laws, particularly for controlled substances. You should also register with and use, to the extent possible, the state prescribing drug monitoring program.

9. **IF YOU ARE PRESCRIBING CONTROLLED SUBSTANCES FOR OUT-OF-STATE PATIENTS, BE ALERT TO WHEN HHS DECLARES THE END TO THE PHE**
   The current federal COVID PHE is “likely” to be renewed every 90 days throughout 2021. We should get 60 days notice prior to its expiration. **Tip:** PRMS will be tracking this in our FAQs.

10. **WHEN THE PHE ENDS, EXPECT HHS TO REINSTATE THE REQUIREMENT THAT TELEMEDICINE MUST BE CONDUCTED VIA A HIPAA-COMPLIANT PLATFORM**
    This generally means that you will need a Business Associate Agreement (BAA) from the vendor.

For additional information, see our Telepsychiatry Checklist at PRMS.com/FAQ

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How to Survive a Heatwave

**Keep Rooms Cool**
- Lower shades to reduce heat
- Maintain cross air ventilation
- Avoid fans if room is >95 degrees as they no longer cool the air

**Wear Loose Clothing and a Hat**
- Loose cotton (non-synthetic) is best
- Wear a wide-brimmed hat outside

**Cool Down with Showers**
- Or cool, wet towels

**Drink Lots of Water**
- Hydrate before you feel thirsty
- Avoid alcohol, caffeine, and sugary drinks

**Find Cool Shelter**
- Don’t wait out the heat at home*
- Cool down in libraries, malls, movie theaters, and local cooling centers

**Never Leave Kids or Pets in Cars**
- Not even for a quick minute
- Cars heat up fast and can kill children and pets

**Take Meds as Prescribed**
- BEFORE heat waves, ask your health care provider about any changes to your medications during hot weather

**Make a Plan for Help**
- BEFORE heat strikes, ask a friend/neighbor to check on you 2x/day
- Seek health care IF throbbing headache, dizziness, nausea, or feel confused
- Call 911 for emergencies

*Many heat-related deaths happen by waiting out heat waves in ever-heated apartments.*
**SIGNS AND SYMPTOMS OF HEAT STROKE**

Heat stroke is serious but preventable. Watch for early signs to prevent dangerous impacts.

- **Early Signs**
  - Increased sweating
  - Muscle cramps

- **Heat Exhaustion**
  - Heavy sweating
  - Thirst
  - Fatigue
  - Decreased urine
  - Headache
  - Nausea or vomiting
  - Cold, clammy skin
  - Dizziness or fainting

- **Heat Stroke/SEVERE**
  - Throbbing headache
  - Fast strong pulse
  - Hot flushed dry skin (skin may be damp)
  - Confusion and loss of consciousness (passing out)

**SIGNS/RISKS ARE DIFFERENT FOR DIFFERENT PEOPLE**

- **Young Children**: whimpering, crying, cranky, listless. Infants and young children can easily become dehydrated.

- **Young Athletes**: can be reluctant to inform coaches of trouble and push beyond safe levels; should not participate in strenuous athletic activities during extreme heat.

- **Older Children and Teens**: angry, aggressive, trouble concentrating.

- **Older Adults**: confusion and more extreme lethargy.

- **Frail and Chronically Ill**: cooling mechanism of sweating less effective, medications and illness make risks more significant.

- **Pregnant Women**: Risk of pregnancy complications as body heat increases due to additional fluid and weight.

- **Low Income**: Substandard housing, lack of air conditioning.

- **Outdoor Workers**: Greater exposure to heat, pressure to continue to work in extreme heat.

- **Homeless**: Greater exposure to heat and lack of ability to find protections; homeless mentally ill at even greater risk.

- **People with mental illness or substance abuse**: May have difficulty monitoring and caring for themselves.
Early Psychosis Intervention Can Be as Effective in Real World as in Clinical Trial Environment

An intervention for patients with first-episode psychosis known as OPUS is as effective—and in some cases superior—in real-world clinical practice as was found when the intervention was tested in clinical trials, according to a report in AJP in Advance.

“Early intervention services for psychosis are, by definition, a complex psychosocial intervention, and, once implemented, they may not be delivered with the same rigorous attention to program fidelity, low caseload, motivation, and so on as they had in the controlled environment of a randomized trial,” wrote Christine Merrild Posselt, M.Sc., of Copenhagen University Hospital and colleagues. “The study results provide further evidence in support of implementation and funding of early intervention services worldwide.”

OPUS is a modified form of assertive community treatment for psychosis that includes family involvement and social-skills training provided by a multidisciplinary team of psychiatrists, psychologists, nurses, social workers, physiotherapists, and vocational therapists. A clinical trial of 547 adults showed OPUS was superior to standard care, which led to broad implementation of this program in Denmark in 2003.

For the current study, Posselt and colleagues compared the five-year outcomes of 3,328 patients who received OPUS after this implementation—identified using Danish health registers—with the five-year outcomes of 545 of the original clinical trial participants. This period included two years of OPUS intervention and three years of follow-up.

The researchers found that patients receiving OPUS had lower odds of a psychiatric hospital admission than the clinical trial participants across the five-year time span, as well as lower rates of psychotropic medication use. Rates of suicide or death by any cause were similar for patients receiving OPUS as well as the clinical trial participants. OPUS patients were less likely to work or attend school than their clinical trial counterparts during the first three years after initiating OPUS, but by year five, had higher odds of being in work or school.

“Positive effects beyond those observed in the randomized trial may be due to more flexible setups, improved experience with delivering the intervention, or other factors,” Posselt and colleagues wrote. “We accounted for potential differences in patient characteristics in the analyses, which suggests that this is not likely to have been a confounder in our results.”

To read more on this topic, see the Psychiatric Services article “Implementing Evidence-Based Interventions to Improve Vocational Recovery in Early Psychosis: A Quality-Improvement Report.”

Reprinted from Psychiatric News, 8/2/21

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

Disaster Distress Helpline Call 1-800-985-5990 or text TalkWithUs to 66746
National Suicide Prevention Lifeline Call 800-273-8255
Physician Support Line Call 1-888-409-0141
Crisis Textline Text TALK to 741741
Veterans Crisis Line Call 800-273-8255 or text 838255
WERC is a specialized treatment clinic for young people who are experiencing early signs of psychosis or who have recently been diagnosed with a psychotic disorder, such as schizophrenia.

WERC offers a variety of comprehensive services to meet the unique needs of our patient and families, including:

- Psychiatric care
- Psychological assessment
- Individual and group psychotherapy
- Case management
- Family support and psychoeducation
- Research opportunities

4444 Forest Park Ave.
St. Louis, MO 63110
Werc.wustl.edu
314-362-6952
Introduction:
Lamotrigine is an antiepileptic drug (AED) of the phenyltriazine class with inhibitory effects on voltage-sensitive sodium channels, leading to an inhibition in the release of glutamate and resulting in a general inhibitory effect on cortical neuronal function. Lamotrigine is also a weak dihydrofolate reductase inhibitor (1, 2). Its chemical name is 3,5-diamino-6-(2,3-53 dichlorophenyl)-as-triazine, its molecular formula is C9H7N5Cl2, and its molecular weight is 54256.09 (1). The structural formula is (1):

![Structural formula of Lamotrigine](image)

The drug is approved by the US Food and Drug Administration (FDA) for Epilepsy as an adjunctive therapy in patients aged 2 years and older: partial-onset seizures, primary generalized tonic-clonic seizures, generalized seizures of Lennox-Gastaut syndrome; it is approved for Epilepsy as a monotherapy in patients aged 16 years and older. FDA also approved Lamotrigine as a maintenance treatment of bipolar I disorder in patients aged 18 years and older to delay the time to occurrence of mood episodes in patients treated for acute mood episodes with standard therapy (1).

Common side effects attributed to lamotrigine include headache, dizziness, insomnia, nausea, vomiting, and rash. Approximately 10 to 15% of patients taking lamotrigine may develop a rash, which in most of cases, is dose dependent (7). Lamotrigine can cause serious rashes requiring hospitalization and discontinuation of treatment. There have been reports of blood dyscrasias that may or may not be associated with the hypersensitivity syndrome. These have included neutropenia (4), leukopenia, thrombocytopenia (3), anemia (7), pancytopenia, and, rarely, aplastic anemia and pure red cell aplasia (1). This case report describes a 16-year-old adolescent female who developed profound anemia while on lamotrigine therapy.

Method:
Ms. X was a 16-year-old African-American female with sickle cell trait and mood disorder placed at a residential facility. Her medication regimen included lamotrigine 200 mg in the morning, aripiprazole 5 mg in the morning, and mixed amphetamine salts extended-release 30 mg in the morning and cetirizine 10 mg at bed time. While at the residential facility, she developed fatigue and headaches with exertion. Her blood work detected a very low hemoglobin level of 3.1 g/dL and a very low hematocrit of 10.9%. Her MCV, MCH, and MCHC were within the normal range. The patient’s blood pressure was 105/70 mm Hg, and her pulse was 109. The patient was sent to the local Emergency Department (ED) immediately. In the ED, her hemoglobin level was 3.3 g/dl, but there was no decrease in other cell lines. She was admitted to the hematology/oncology service for further management. Upon hospital admission, she received total 4 units of packed red blood cells via transfusion.

Initial lab work ordered also showed Coombs negative, negative urine hCG, HIV nonreactive, negative CMV and EBV antibodies. Iron studies showed elevated iron, iron saturation, and ferritin and low TIBC. Vitamin D levels were on the lower end of normal, so she received vitamin D supplementation. The remainder of her blood count and other labs were within normal limits.

Results:
After packed red blood cells transfusions, the patient’s hemoglobin level improved to 9.7 g/dL. The
patient’s symptoms had improved significantly; her headaches and fatigue with exertion were gone. It was suspected that her profound anemia was induced by lamotrigine. She was discharged from the hospital with instructions to taper off lamotrigine and visit a hematology specialist. Several weeks later, she underwent a hemato logic evaluation, including a bone marrow biopsy and genetic testing, which were unremarkable. Her hemoglobin level remained stable.

The patient’s anemia resolved after the discontinuation of lamotrigine. The patient was followed for 1 year with blood work performed every few months. Her hemoglobin level did not drop further and in fact slowly increased to 13.9 g/dL spontaneously over the next year. One day after receiving packed red blood cells via transfusion, her hemoglobin level was 9.7 g/dL and rose to 12.7 g/dL after 40 days. 70 days post-transfusion, the patient’s hemoglobin level was 14.0 g/dL, which rose even further reaching 14.4 g/dL at the 6-month mark. Finally, 12 months after transfusion the patient’s hemoglobin level read 13.9 g/dL (Fig: A & B).

lamotrigine. There was a case report of normocytic normochromic anemia and asymptomatic neutropenia in a 40-day-old infant breastfed by an epileptic mother treated with Lamotrigine. Rapid progressive normalization of the blood tests occurred once breast feeding was stopped (8). There are case reports on agranulocytosis associated with Lamotrigine (5, 6).

There are published reports of lamotrigine-induced neutropenia, and agranulocytosis have demonstrated normalization of blood counts with drug discontinuation alone (2).

There was a case report of a 25 year old woman with epilepsy who developed combined leucopenia and thrombocytopenia eight weeks after starting lamotrigine. Within weeks after lamotrigine was discontinued, all of the haematopoietic abnormalities had disappeared (3)

Although the mechanism of action of lamotrigine-induced hematologic abnormalities is unknown, according to literature a combination of

(Continued on page 16)
immunoallergic, direct medullary toxicity, and granulopoiesis-inhibiting effects has been suggested (2). There are also reports on lamotrigine-associated macrocytic anemia, leukopenia, and thrombocytopenia (3), which suggest a common possible mechanism involving enzymatic inhibition of dihydrofolate reductase by lamotrigine (2).

Conclusions:
To our knowledge, this is the first case report of Lamotrigine induced profound anemia where hemoglobin level dropped down to 3.1 g/dL. Considering hematologic adverse effects, it may be prudent to consider a baseline blood count before starting lamotrigine and repeat this test every few weeks initially and then every few months and then yearly after treatment initiation. It remains unclear whether lamotrigine use with a background of sickle cell trait in this patient put her at an increased risk of profound anemia. Further studies are required to explore the effects of this commonly used medicine.

To conclude, it is valuable for the clinician to be aware of the possibility of an occurrence of severe anemia or any blood dyscrasias, although it is very rare, and this condition was reversible in our case.

References:

Profound Anemia Induced by Lamotrigine in a 16-Year-Old Female with Sickle Cell Trait and Mood Disorder: A Case Report and One-Year Follow-Up
Sultana Jahan, MD, University of Missouri-Columbia
Ellen O’Neill, Undergraduate Student, University of Missouri-Columbia
Lauren Drainer, Completed Undergraduate Study, University of Missouri Columbia
When patients receiving mental health care were asked to complete a standardized questionnaire that asked whether they had access to guns, most provided a response, reports a study in JAMA Health Forum. A positive response can help clinicians identify and provide appropriate follow-up care for patients at risk of suicide.

“Firearms are the most common method of suicide, one of the ‘diseases of despair’ driving increased mortality in the U.S. over the past decade,” wrote Julie E. Richards, Ph.D., M.P.H., of Kaiser Permanente Washington in Seattle and colleagues. “However, routine standardized questions about firearm access are uncommon, particularly among adult populations, who are more often asked at the discretion of health care clinicians.”

In August 2015, Kaiser Permanente clinics in Washington state began incorporating a question about firearm access— “Do you have access to guns?”—to the standard mental health monitoring questionnaire. Richards and colleagues compiled data on 128,802 patients who completed these questionnaires at either a primary care or mental health clinic between 2016 and 2019.

Overall, 83.4% of patients in primary care clinics and 91.8% of those in mental health clinics answered the question on access; in both settings those who did not respond were more likely to be older, male, live in a rural setting, and/or have a recent substance use disorder diagnosis. Richards and colleagues noted the rates for nonresponse were much higher than rates for other sensitive questions like alcohol or drug use (between 2% and 3%).

In terms of access, 20.9% of patients in primary care clinics and 15.3% in mental health clinics reported having access to firearms. Those with access were more likely to be male and live in a rural or suburban setting. Patients who reported a previous suicide attempt were far less likely to report firearm access than those without a suicide attempt history.

“This novel study demonstrates that standard assessment of access to firearms is feasible in the context of [mental health] monitoring in [primary care] and outpatient [mental health] specialty settings,” Richards and colleagues wrote. “Asking patients to routinely self-report firearm access can help clinicians identify and engage patients at risk of suicide in dialogue regarding storage of firearms and/or ammunition (i.e., increasing time and/or distance required to access firearms), which is a recommended component of evidence-based safety planning interventions for suicide prevention.”

1. To read more on this topic, see the Psychiatric Services “What Will Happen If I Say Yes?” Perspectives on a Standardized Firearm Access Question Among Adults With Depressive Symptoms.”

Reprinted from Psychiatric News, 8/9/21
Assisted Recovery Centers of America (ARCA) not only kept the doors open during COVID-19, we expanded services to include virtual care throughout the state, treatment at homeless encampments, and creation of a mobile treatment unit at the request of local faith leaders. This presentation will include how interprofessional collaboration and leadership has allowed a quick pivot to innovative, sustainable services during the intersection of the pandemic, the overdose epidemic, and the movement to address racial inequities in healthcare.

OBJECTIVES
1. Identify disparities in prevention, treatment, and thriving in individuals and families in their communities who have been impacted by substance use disorders in Missouri
2. Describe how telehealth and in-person care can be blended in effective care models
3. Commit to identifying new ways to engage with under-resourced and overlooked individuals and families in their communities who have been impacted by substance use disorders

Speaker: Dr. Fred Rottnek, Family and Community Medicine-Administration, Saint Louis University, Director of Fellowship Program

“Mining the Gut-Brain Axis for Therapeutic Clues to Improve Mental Health”
Psychiatric researchers are looking beyond the central nervous system for novel ways that the body’s peripheral cellular and molecular pathways might be harnessed into effective treatments of brain disorders. The concept of a gut-brain axis relevant to psychiatry is gaining traction and is based on the idea that the largest immune organ in the body, the gastrointestinal tract, is an important source of comorbid dysfunction with direct and indirect brain effects. Exposure to pathogens, food antigens and other factors that disrupt the body’s microbiome leads to local and systemic inflammation, autoimmunity, endothelial cell permeability and synaptic miscommunications. Dr. Severance will talk about the origins of the gut-brain axis in psychiatry, the current major findings propelling the field forward and the future of translating this research into clinical applications and treatments.

(Continued on page 19)
OBJECTIVES
1. Identify dietary, microbial and immune factors that may trigger disruptions in the gut-brain axis in psychiatric disorders.
2. Understand the mechanisms by which a dysbiotic microbiome might impact the brain.
3. Synthesize results from clinical studies regarding the efficacy of gut- and inflammation-related therapies as adjunctive psychiatric treatments.

Speaker: Emily Severance, PhD, Assistant Professor of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, MD

11:15 - 12:15 pm  “Black Youth Suicide Risk: Current Trends and Clinical Implications”
This presentation will cover trends in suicidal behaviors among Black youth as well as risk and protective factors unique to this population. Presentation will highlight screening, treatment disparities, and strategies that are relevant for provision of culturally appropriate services.

OBJECTIVES
1. Describe prevalence of suicide and suicide-related behaviors among Black youth across age and gender.
2. Explain common risk and protective factors for Black youth.
3. Discuss health disparities, screening, and intervention approaches for treatment of Black youth.

Speaker: Rhonda C. Boyd, PhD, Department of Child and Adolescent Psychiatry and Behavioral Sciences at the Children’s Hospital of Philadelphia and University of Pennsylvania Perelman School of Medicine

12:15 - 1:15 pm  Luncheon and Poster Award Winner Presentations

1:15 - 2:15 pm  “Climate Change and Social Determinants of Mental Health: Mitigating Risks and Increasing Resilience in Vulnerable Populations”
Climate psychiatry: what is it and how does knowing about it affect my practice? Great questions! Slow-moving and acute disasters both have great effect on mental health. We will cover these questions with an eye towards both populations and individuals.

OBJECTIVES
1. Recognize the unique elements of mental health impacts of slow-moving disasters including drought, sea-level rise, and air pollution.
2. Expand our awareness of what may be considered acute disasters including but beyond wildfires and droughts, especially when the indigent are disproportionately impacted by disruptions in housing & transportation infrastructure.
3. Recognize the outsized risks of extreme heat on populations with mental illness.
4. Consider actions for clinicians to increase resilience in vulnerable populations in all the above threats of climate change.

Speaker: Benjamin Liu, MD, Department of Psychiatry, Oregon Health & Sciences University, Portland, OR; Rahul Malhotra, MD, Private Practice, Summit, NJ

2:15 - 2:30 pm  Break

2:30 - 3:30 pm  “Threat Assessment and Duty to Warn”
This presentation will review the risk factors for violence and discuss how to do a thorough threat assessment in clinical practice. We will also review the recent duty to warn case law and its impact on clinical practice.

OBJECTIVES
1. Review the risk factors for violence
2. Learn to do a thorough threat assessment in clinical practice
3. Review duty to warn case law

(Continued on page 20)
AGENDA

4. Understand the duty to warn legal requirements in clinical practice
   Speaker: William Newman, MD, Forensic Psychiatry Fellowship Director, Saint Louis University Medical School, Past President of American Academy of Psychiatry and Law

3:30 - 4:30 pm  “Long Term Psychiatric Sequelae of COVID”
Several long-term mental health effects have been identified in individuals who have recovered from COVID-19. The role of the virus and the immune response it elicits are being researched as possible reasons for the neurological, psychiatric and cognitive problems. The effect of social isolation due to COVID is also contributory to some of the mental health issues. In this presentation, Dr. Stanislaus will review the literature on the prevalence of psychiatric sequelae due to COVID and the underlying pathophysiological processes.
   OBJECTIVES
   1. Review SARS-CoV-2 and its mechanism of action
   2. Develop an understanding of the pathophysiology and effects of COVID-19 on the brain
   3. Learn to identify the neurocognitive disorders and psychiatric disorders post-COVID
   4. Understand the role of social isolation in mental health due to COVID
   Speaker: Angeline Stanislaus, MD, Chief Medical Officer, Missouri Department of Mental Health

Virtual Conference Information
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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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 Association. The APA is accredited by the ACCME to provide continuing medical education for physicians.

The APA designates this live activity for a maximum of 6 AMA PRA Category 1 Credits(TM). 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 2021, 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.
Missouri Psychiatric Physicians Association presents

“Psychiatric Update: The Focus of Social Determinants of Mental Health”
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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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Political Action Committee
Jo-Ellyn M. Ryall, MD, DAPALF

Our Missouri Psychiatric Physician Association has a Political Action Committee that raises funds so we can support Missouri legislators who have been helpful to Mental Health issues and psychiatric issues. We can donate to campaigns of Senators, Representatives and County Executives.

Our PAC has been in existence for several years. At the last report in April, we had a total of $3772. This is not sufficient money to support the legislators who have helped us and whom we hope will support our causes in the future. Remember 2022 is an election year for all Representatives and 1/3 of the Senators. Our lobbyist Randy Scherr helps us pick the legislators for our support, since he knows them better than we do.

This year we had some victories. The statewide Physician’s Drug Monitoring Program passed. Senator Heidi Roeder was the main supporter of this bill that failed many times in the past. The Mental Health Parity language was amended on another bill that passed in the last days of the session.

I urge you to join me in contributing to our PAC by sending your check to Sandy Boeckman at the MPPA office.

Missouri Psychiatric Physicians PAC

Help elect candidates who will represent your interests in the Missouri General Assembly, and state and local campaigns. Join the Missouri Psychiatric Physicians Political Action Committee, MoPPPAC, the political voice of the Missouri Psychiatric Association.

MoPPPAC MEMBERSHIP form

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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.
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Form and Payment must be received before the ad is placed in the newsletter.
Submission Deadlines are February 15, May 30, August 15 and November 15.

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Show-Me Psychiatry

Newsletter of the Missouri Psychiatric Physicians Association (MPPA)
A District Branch of the American Psychiatric Association
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
September 21, 2021
November 16, 2021

“Psychiatric Update: The Focus of Social Determinants of Mental Health”
FALL CONFERENCE
VIRTUAL
Saturday, September 25, 2021
Jointly Provided by the American Psychiatric Association and the Missouri Psychiatric Physicians Association