It Is The Time Of Year To Give Thanks

As we approach the end of the calendar year, we can reflect on the past year.

2021 was the year of trying to wrestle the beast called Covid 19. Many of the medical professionals were able to receive their vaccines early in the year and by now may have the boosters. We still have a long way to go since there are many in Missouri who will not get vaccinated for a variety of reasons. My favorite excuse is that the vaccine kills. Well, Covid has killed over 755,000 in the US since early 2020. I am delighted that the children 5-11 are now eligible for the first shot of the Pfizer vaccine. That may return the schools to normal soon. The reservations for the first week in St. Louis County were all filled.

We can be thankful for our patients. Without them we would not have work. We can be thankful for Sandy Boeckman and our MPPA which was flexible and provided our virtual spring and fall meetings so we could collect our CME Credits for our license.

We are grateful to Randy Scherr, our lobbyist who keeps us informed about the proceedings in Jefferson City Legislature. He is keeping us informed about the new Mental Health Committee which held four meetings with witnesses from organizations, institutions, practitioners, and members of the Department of Mental Health. The report is coming.

We are thankful for our families and maybe this year we will be able to get together and see each other in person rather than on Zoom or Skype. I will travel by plane to North Carolina to see my brother and his family and the new twins born in January. I met their big sister who is two and a half last year.

We are grateful to the APA who provides us with information that we need in our practices and hopefully in May 2022 will have an in person meeting in New Orleans. That will be a sign that live is returning to a near normal.

Of course, we are grateful for all the computers that let us carry on virtually with patients, pharmacies, CME meetings and keeping in touch with friends, colleagues, and family.
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**President’s Message**

I am thankful for all the members of our Executive Board who make MPPA strong. I am glad we have members who support us and attend our meetings. I may even get used to virtual meetings.

Most of all I anticipate January 1, 2022, since that will mean that 2021 is in the books and we survived it.

So, enjoy your Thanksgiving and holidays and be grateful that we all are alive.

Jo-Ellyn M. Ryall, MD, DLFAPA
President, Missouri Psychiatric Physicians Association

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**APA Coronavirus Resources**

If you are a patient, a family member or a 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
Rawle Andrews, Jr., Esq., named executive director of the American Psychiatric Association Foundation (APAF) effective September 27, 2021. Andrews comes to APAF from AARP, where he served for 15 years, most recently as vice president and a member of the national leadership team overseeing the organization’s field operations in the seven largest and most diverse states in the country, including the states of California, Florida, New York and Texas.

The APAF is the charitable foundation of the American Psychiatric Association. As executive director, Andrews will oversee its efforts to raise awareness about mental health, overcome barriers to access, invest in the future leaders of psychiatry, support research and training to improve care and lead partnerships to address public challenges in mental health.

“Rawle Andrews’ record of results and action, coupled with his passion for health equity, will make him an excellent leader for the APA Foundation,” said APA CEO and Medical Director and APAF Board Chair Saul Levin, M.D., M.P.A. “He joins a strong organization that does so much to improve our nation’s mental health, and I’m excited to see what the Foundation will achieve with him at the helm.”

“I am honored and humbled to be joining the APA Foundation at such a dynamic time in this country and beyond. I am also grateful to Amy Porfiri for her service as the Foundation’s interim leader during the pandemic. Mental health awareness and the need for medical help are growing exponentially. Working together, our Board, staff, fellows and community partners will continue to meet this moment with focus, determination and consistency while introducing the Foundation to new communities where our neighbors in need live, learn, work, worship and play,” said Andrews.

During his 15-year tenure at AARP, after joining as Managing Attorney, Legal Counsel for the Elderly, Andrews led business, financial and external affairs for the Maryland state office. He then was named a vice president in 2011, and moved into his current role in 2015, where he launched a new strategic business unit which represents nearly half of AARP’s membership.

A psychology major at Texas Southern University and an honors graduate of the Howard University School of Law, Andrews spent 16 years practicing law before joining the AARP management team. He was honored with the D.C. Bar’s Pro Bono Lawyer of the Year Award in 2006, and the Distinguished Healthcare Leadership Award by the National Association of Healthcare Services Executives in 2018. Andrews serves as President-Elect of the Bar Association of D.C., an adjunct professor at Howard Law, a member of the Board of Directors of the Thurgood Marshall Center Trust, and as national chair of the public policy committee for Kappa Alpha Psi Fraternity, Inc.

Amy Porfiri, M.B.A., has been serving as the organization’s interim executive director and will return to her position as the foundation’s managing director.

The American Psychiatric Association Foundation is the philanthropic and educational arm of APA. The APA Foundation promotes awareness of mental illnesses and the effectiveness of treatment, the importance of early intervention, access to care, and the need for high-quality services and treatment through a combination of public and professional education, research, research training, grants, and awards.
In the last issue of Show Me Psychiatry, I raised concerns about the expanded use of cannabis products in Missouri since the legalization of medical marijuana in 2018 (1). I ended that article with a vignette of a 68 y.o. male who had an adverse reaction to a form of THC (delta 8) not regulated by either the DEA or the Missouri agency (DHHS) which regulates medical marijuana*[see Footnote]. Delta 8 THC along with delta 10, both derived from hemp are being promoted widely as “legal deltas” implying that they are safe, but there is evidence that delta 8 has similar effects as delta 9 THC (which is prominent in marijuana including toxicity and addiction potential (2). Further, delta 8 THC can be synthesized from Cannabidiol (CBD) a compound with clear therapeutic benefit but when converted to “legal delta” can also be concentrated and put in various forms including “edibles” which can get into the hand of small children for whom results can be serious, even fatal. One potential protective factor for the usual source of “legal deltas” is that—being derived from hemp—they must be much lower concentration than the delta 9 form of THC in marijuana for which there does not appear to be any legal limits raising the risks intoxication, addiction and—in young developing brains—predisposition to chronic psychosis. There is also growing evidence of a correlation between cannabis use and suicidality (3).

This is not to say that THC compounds have no therapeutic benefits (e.g. analgesic anti-nausea effects (2)) but the markedly increased concentration of THC and markedly decreased amount of CBD which protects against THC toxicity is highly problematic. The popularity and growing momentum nationwide is certainly related to both the psychoactive “high” and the incredible financial incentive: medical marijuana sales in Missouri exceeded $10 million in August 2021 alone and since 4% sales tax is earmarked for veterans services, this translates as $4.52 million for veterans since the program launched one year ago, obviously a politically favorable factor (4). As physicians however, we should appreciate the biological underpinnings of cannabis popularity: the endocannabinoid system is a vast psychoneuroimmunological network with its primary receptor (CB1) being the most abundant G-protein coupled receptor in the brain (5). So it should not be surprising that our patients may gravitate toward use of cannabis related products which activate this system. We need to both listen and ask about this.

Here is a vignette of a patient I recently evaluated. A 38 y.o. female had been having difficulty for several months after being switched off of escitalopram by her primary care physician which had stopped working after almost 20 years of use. She was experiencing exacerbated mood swings which she thought became even worse on new “cocktail” (sertraline and clonazepam). The suicide of a long term friend two days prior to calling my office precipitated a crisis with panic attacks and profound distress. Her mood swings would have met criteria for mania except for their short duration of only 2-3 days but there was also a family history of Bipolar Disorder. Near the end of the initial evaluation as we were discussing the need for mood stabilizing medication she mentioned---almost in passing---that her gastroenterologist approved for her to have a “medical card” (common expression in Missouri for Medical Marijuana permit) and said that smoking marijuana helped her sleep at night. Note that she regarded marijuana as safe and effective vs the pharmacologic “cocktail” which—presumably due to the SSRI component—probably did exacerbate an underlying bipolar spectrum disorder which only recently had begun to be expressed.

Having the “medical card” allows our patients to go to one of approximately 200 dispensaries in Missouri and purchase up to 112 grams of marijuana for her personal use per month. This amount is 32 MMEs (“Missouri Marijuana Equivalency Units) and is equivalent to 32 grams of marijuana concentrate or 100mg of “THC infused product” (6). However even if we assume that there is an effective tracking system for purchases, there is one major problem that

(Continued on page 5)
presents risks to our patients and the public: there does not appear to be any consistent concentration or limits of delta 9 THC in any of these products. Marijuana grown in the 1980s had only 2-3% THC content with gradual increases by 2017 to 28% (3). Another patient of mine who works for a Missouri-certified cannabis grower said they had some varieties with up 35% THC content! My 38 y.o. female patient confirmed that in the dispensaries, various strengths are available and originally she had tried one that was “too strong” and caused dysphoria.

Our patients must rely on the knowledge and integrity of staff in the dispensaries as well as the reliability of certified growers supplying them to determine the potency of the cannabis products they are allowed by law to purchase. And there are other risks such as this: combusted cannabis products could release toxic compounds into the lungs of users which have been converted from chemicals applied by growers in an attempt to save their high investment crop from mold or pests. To its credit, a magazine devoted to promotion of the use and business aspects of marijuana use in Missouri carried an article by cannabis cultivation consultant who described a case of 72 y.o. male who initially had significant relief from chronic pain and insomnia from a single use of smoked marijuana but by the next day became very short of breath requiring treatment in a local ER where hydrogen cyanide was found in his blood (7). Hydrogen cyanide is a combustion breakdown product of fungicides which are sometimes sprayed on crops. These and other agents are also known carcinogens. Similar problems can occur with vaping which has other risks such as heavy metal toxicity.

Even with just medical marijuana, psychiatrists and other health care professionals face many challenges to keep with all the aspects of the growth of the cannabis industry. And now a ballot initiative for the fall of 2022 which aims to legalize recreational marijuana will—if it passes—will present further challenges public health which we all must rise to meet. So let’s stay tuned, keep our eyes open and continue to listen to our patients carefully.

*FOOTNOTE: There was an error in the text of that vignette: the unregulated THC referred to was delta 8 THC but was incorrectly identified as delta 9 THC.

REFERENCES
1. Sorting Through the Haze: Risks and Challenges of Expanding Cannabis Use in Missouri, J Fleming, Show Me Psychiatry, 2021, 3rd Quarter
It is great to join the psychiatry community in Missouri and get to share with you some of my background and interests. I was raised in Brazil where I completed my medical training on a research scholarship. During my medical education that interest in research had me look at the epidemiology of schizophrenia in northern Brazil as it pertains to the season of birth effect. Following up on that interest, I pursued my residency training at the combined Sheppard Pratt/University of Maryland program in Baltimore. As part of the research track in residency I was mentored by Brian Kirkpatrick at the Maryland Psychiatric Research Center (MPRC) headed at the time by William Carpenter. The MPRC at the time was – and still is – a major hub for schizophrenia research with faculty that also included – besides Will and Brian: Bob Buchanan, Carol Tamminga, Bob Conley, Rosy Roberts, and Robert Schwarcz. It was a great place to be and learn about the neurobiology and treatment of schizophrenia. As a resident, I published several papers on season-of-birth in schizophrenia in Brazil as well as relating to the deficit syndrome patients.

Realizing and want further research methodology training I joined the Preventive Medicine residency training at the Johns Hopkins Bloomberg School of Public Health – one of the few schools of public health in the country that has a department of mental health. At the time, the department chair was Bill Eaton, a sociologist who worked on schizophrenia research, and he became my advisor and mentor. With Bill Eaton I moved my research focus to public health and service utilization – keeping some interest in risk factor identification. At Hopkins I finished the preventive medicine training along with a master’s in public health and a PhD in psychiatric epidemiology. My thesis used data from the Baltimore wave of the Epidemiological Catchment Area study to measure unmet needs for mental health care in the general population. At the time I was on faculty at the Hopkins department of psychiatry working at the community psychiatry program under Annelle Primm and Bernadette Cullen.

Reaching the crucible of graduating residencies and a doctoral program my wife and I decided to return to Brazil and start our professional career there. That lasted for two years. In Brazil I was running a busy private practice and teaching at my alma mater and the local school of public health. Our career however busy, were elsewhere. Brian Kirkpatrick, my mentor at MPRC, had moved to the Medical College of Georgia in Augusta so we relocated back to the US where I took the job of Associate Program Director for their psychiatry residency. The years in Augusta were intense with my clinical time dedicated to the inpatient unit and a leadership position in medical student education. After three great years in Georgia my wife – who is a renal pathologist – was recruited to join the largest renal pathology private lab in the country, located in Little Rock, Arkansas.

Arkansas has a beautiful and diverse geography,

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stretching from the Ozarks to the Mississippi delta—with a friendly people to match. Our careers and our family flourished in Arkansas for over 11 years. At first, I was charged with the outpatient clinic at the University of Arkansas for Medical Sciences (UAMS). As medical director I supervised residents, worked closely with therapists, and oversaw the clinic’s operations. I continued some research activity mostly using CDC data on US high school students. Eventually I was also asked to direct the psychiatry and neurology course for medical students – Brain and Behavior. After five years at UAMS I was recruited by Beacon Health Options to oversee the Quality Assurance contract for Arkansas Medicaid. That position provided me with a firsthand opportunity to observe the mental health system outside the shining ivory tower. Those two years at Beacon became an eye-opening and formative experience for me. After those years overseeing Medicaid, I was recruited back to UAMS as the Associate Dean for Faculty Affairs. Back to academics my job became to oversee the promotion and tenure process for the College of Medicine as well as oversee faculty development and professionalism. In that position I developed a literary journal for the campus – Medicine and Meaning – and continue to care for my outpatients – people that had followed me when I left UAMS and were now coming back to the clinic with me. In the Associate Dean position, I had the gentle but compelling mentorship of Dr. Jan Shorey who helped me understand the responsibilities and duties of faculty in schools of medicine.

Over the years, I have developed two major passions: advocate for diversity, equity, and inclusion in academic medicine and professional wellbeing in healthcare. On the DEI front I have spoken on the neurobiology of implicit bias and lectured on the history of integration of medical education in Arkansas. On the professional wellbeing side, I have conducted surveys of professional burnout in the academic healthcare environment and advocated for an organizational approach to addressing the challenge of burnout. I believe we psychiatrists can, and should, be leading the conversation given our knowledge about human nature, our understanding of human behavior, and our deep caring for our fellow humans. I also believe those in leadership have a responsibility to mentor and coach those starting their careers into becoming the best they can be. Looking back now, it makes sense that having such amazing mentors – Kirkpatrick, Eaton, Primm, and Shorey – I have aspired to become a mentor myself. And I believe the Chair of Psychiatry position should be exactly that: a place where I can work with early career medical students, residents, and faculty, to bring out the best in them. I hope to honor my diverse pantheon of mentors by doing for other what they did for me. And that is how I find myself grateful and honored to serve as chair of psychiatry at Saint Louis University (SLU) today.

Here at the SLU department of psychiatry and behavioral neuroscience I found a group of highly talented and dedicated fellow psychiatrists who run a welcoming residency program along with fellowships in geriatrics, forensic, and neuropsychology training. I am working with each of them to develop a vision for success for the department counting on each of their many individual talents. Our priorities include re-establishing the child psychiatry division, re-organizing the research programs, and expanding our training opportunities. We are also working on expanding access to our services and collaborating with other departments at SLU and across the state in all three academic missions of research, education, and clinical care. As you know, this is a very exciting time in psychiatry and mental health, as people realize the role behavior plays in the morbidity and mortality of populations. It is incumbent on us to do our part and lead the change needed so that our mental healthcare system rises to the occasion.

I hope we get to meet in person soon and that I get to learn about you and how you became a psychiatrist – practicing in Missouri.
Seeing Patients in Your Office: Four Issues
Professional Risk Management Services

The top four issues to address when seeing patients in-person are:

1. Masks
2. Vaccinations
3. Consent to be seen
4. Ventilation

NOTE: These are very fluid issues; the requirements, particularly related to masks and vaccines, are frequently changing.

ISSUE #1: MASKS IN THE OFFICE
- Unvaccinated providers, staff, and patients in the office need to be masked
- Masks for vaccinated providers and staff
States may require or recommend that all healthcare workers, including all staff in physician offices, be masked. For example, Massachusetts requires masks for both vaccinated and unvaccinated individuals at all times in health care facilities, specifically including physician offices. The mask requirement applies to patients, staff, vendors, and visitors. Other states, such as Virginia, recommend masks wearing by staff in healthcare facilities, pursuant to CDC guidelines. Note that private businesses may be able to impose greater requirements, such as requiring masks for all.

Masks for vaccinated patients—Some states, such as Oregon, are requiring all people to wear masks indoors, regardless of vaccine status.

- Risk Management thoughts:
Given the CDC’s guidelines for everyone to be masked in health care facilities, those not following the guidelines, if not required to by the state, may have to explain to patients why they are deviating from CDC guidelines. Some psychiatrists have found clear plastic face shields useful when seeing therapy patients in person.

ISSUE #2: COVID VACCINATIONS
- Vaccinations for providers and staff
States can require all who work in healthcare to be vaccinated. For example, California requires all who work in healthcare, including doctors’ offices (specifically including behavioral health) to be vaccinated. Other states vary in the exact healthcare facilities that requirement applies to, such as only applying to hospitals and long-term care facilities.

Given the recent full approval of a COVID vaccine, more of these vaccine requirements may be enacted.
- Vaccinations for patients
Given the COVID Delta variant surge, and the possibility of breakthrough infections, psychiatrists can choose to see only patients who are vaccinated in their office if: The reason for the policy is based on the obligation to keep everyone safe, including staff and patients, and the offer is made to continue treatment via telepsychiatry.

ISSUE #3: CONSENT TO BE SEEN IN-PERSON
Consider having patients sign a consent form to be seen in the office. Such a document can spell out patient responsibilities (such as not coming into the office with a fever or other symptoms), what the psychiatrist is doing to minimize risk, and a statement that the patient is assuming the risk by choosing to be seen in person.

ISSUE #4: OFFICE VENTILATION
In addition to physical distancing, wearing masks, hand hygiene, and vaccination, ventilation improvements can be useful in mitigating the risk of COVID transmission.

TO DO:
- Determine state requirements for masks and vaccines
- Develop office policies and procedures
- Communicate policies to staff
- Communicate policies to patients
- Re-evaluate as requirements and recommendations change

Resources:
- The Littler law firm is tracking state masking orders and monitoring states.
- State medical associations may have state-specific resources.
- The local health department
- Contact your professional liability insurance company for a template.
- CDC and/or OSHA
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October 2021, was an important month for child psychiatrists. Three major things took place.

First, on the 19th day of October, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children’s Hospital Association (CHA) declared a national emergency in child and adolescents mental health care. In a joint statement, they urged all policymakers to make necessary and needed changes to support children’s access to mental health care and services.

The declaration emphasized how the pandemic has taken a serious toll on children’s mental health as young people continue to face physical isolation, ongoing uncertainty, fear and grief. In addition, it also stressed that even before the pandemic, mental health challenges facing children were of great concern, and COVID-19 has only exacerbated them. Moreover, the report accentuated how the impact of the pandemic on many young people who lost loved ones, which disproportionately impacted children of color. Additionally, the declaration made a point of the shocking increase of self-injury and suicidal cases seen in children’s hospitals across the country as well as the rise in Emergency Room visits. (1).

This is a declaration of what we already knew all along. It is a phenomena we see in all the 52 states and not only in the state of Missouri. Only Boone County has sufficient supply of practicing Child and Adolescent psychiatrists. Five additional counties in Missouri, Henry, Polk, Vernon, Marion, and Adair County, are considered High Shortage areas. The rest of Missouri counties are considered severe shortage areas (2).

We support the declaration and it is proposals including the following:
Urging policymakers to take several actions, such as
- Increasing federal funding to ensure all families can access mental health services
- Improving access to telemedicine
- Supporting effective models of school-based mental health care
- Accelerating integration of mental health care in primary care pediatrics
- Strengthening efforts to reduce the risk of suicide in children and adolescents
- Addressing workforce challenges and shortages so that children can access mental health services no matter where they live.

The second important development in the field of child and adolescent mental health also was announced by the Department of Education, the same day of October, 2021.

The Biden-Harris Administration announced the release of a resource through the Department of Education that provides schools and mental health providers with recommendations addressing youth mental health. This is a very welcomed resource that will help those working with children and adolescents provide them with better mental health services. The over 100 page document is divided into several sections. The first section addressed challenges faced when dealing with this population such as the raising mental health needs and disparities among children and student groups; perceived stigma as well as barrier to accessing services even when available; and ineffective implementation of practices. The second section includes recommendations, such as prioritize wellness for each and every child, student, educator and provider; enhance mental health literacy and

(Continued on page 11)
Recent Developments in Child Psychiatry
Balkozar Adam, MD and Garima Singh, MD
Burrell Behavioral Health

reduce stigma and other barriers; also establishing a continuum of evidence-Based prevention practices. The third section included a comprehensive list of references. And the last section incorporated different areas that those working with students may find helpful in their daily practice. (3). As a Missouri psychiatrist, we encourage you to review this document and find what could help you provide the best care to Missouri children.

A third important event which took place in October was the 68th annual meeting for the AACAP. The virtual annual meeting started on 10/18/21 and ended on 10/30/21. AACAP’s Annual Meeting program provided a variety of programming in different formats. Whether you’re looking for hands-on learning, discussing case-based specifics with Master Clinicians, or watching films together, this meeting provided Child and Adolescent psychiatrists with the best continuing medical education in the format that benefits them the most. Many of Missouri’s child and adolescent psychiatrists were able to attend, learn and teach others. (4). There were over 4000 attendees of the annual meeting, and almost 1300 of them were trainees. It is hoped that exposing trainees to child psychiatry early on may increase their interest in the filled and help address the current emergency in child and adolescent mental health care.

The preliminary plans of the AACAP to deal with the national crisis is summarized in this simple mnemonic AEIOU which stands for:

A: Array of services
E: Evidence-based treatments
I: Integrated services with schools, pediatricians, juvenile justice system...
O: Organized efforts to address workforce shortage
U: Universal access to services, which addresses diversity, equity and inclusion issues

Different Missouri universities and mental health organizations are working on addressing the current crisis. Burrell Behavioral Health Services (BBHS) is doing its best to meet the mental health needs of children, adolescents and their families. It is dedicated to provide easy access and comprehensive care to each and every person in the community. The organization greatly value and celebrate diversity and inclusion among our patients, workforce and communities. BBHS collaborate with multiple community partners including families, school, colleges, legal system, healthcare systems, nonprofits and other networks to provide appropriate and quality care for each situation.

We are sure your organization is also working to meet the challenges faced by children and their families and we value collaboration between the various Missouri mental health organizations in an attempt to address the current crisis in children mental health care. Together, we can make a difference in children’s lives.

References:
Drug overdose deaths reached six figures in one year and represents a 29% increase in overdose deaths from the prior year.

Synthetic opioids (that mimic the effects of natural opioids like heroin but are far more potent), primarily fentanyl, were responsible for 64% of the total deaths, a rise of nearly 50% from the year before, according to the CDC’s National Center for Health Statistics. Psychostimulants, such as methamphetamine, were responsible for 28% of the total deaths.

APA, responding to this news, renewed its call for the following actions:

- Improved access to mental health and substance use services through early identification, utilizing evidence-based models that integrate behavioral health treatment into primary care services.
- Effective substance use disorder treatment for all patients, through the development of science-based policies that are based on a thorough review and discussion with Congress, federal policymakers, and experts in the field of addiction treatment.

White House Response

The White House Office of Drug Control Policy also yesterday issued a model law states may adopt to expand access to the emergency opioid agonist naloxone, which can reverse opioid overdoses. At present, naloxone access is largely dependent on where one lives, according to Rahul Gupta, M.D., director of National Drug Control Policy. “This model law provides states with a framework to make naloxone accessible to those who need it—an evidence-based solution that, according to research, would have a significant effect on reducing opioid-related overdose deaths,” Gupta said in a media release.

The model law aims to be a template for state legislatures. It would require health insurers to cover naloxone, encourage citizens to obtain it, protect individuals from unjust prosecution for administering it, and increase access in educational and correctional settings.

Last month, the Department of Health and Human Services released an overview of the Biden administration’s plan to combat drug overdoses. It includes measures designed to remove barriers to prescribing medication for opioid use disorder; reduce stigma; and provide new funding for prevention, evidence-based treatment and recovery support, and harm reduction. President Biden’s proposed fiscal year 2022 budget for drug-related programs and initiatives totals $11.2 billion, a 54% increase over this year’s budget.

For related information, see the Psychiatric News article “Drug Overdoses Surge Due to Pandemic, Early Reports Show.”
Free Early Psychosis Clinic for 13-25 Year Olds
Director: Dr. Daniel Mamah

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.

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COVID-19 Vaccine Benefits and Risks: Patients’ Perspectives
Sultana Jahan, MD, University of Missouri-Columbia
Ellen O’Neill, Undergraduate Student, University of Missouri-Columbia
Megan Loehr, MD, University of Missouri Columbia

Background
Researchers are confident herd immunity obtained by mass vaccination of the public is necessary to end the COVID-19 pandemic that has resulted in more than 5 million deaths worldwide (John Hopkins University, 2021)(5); however, this plan of action is challenged by vaccine hesitancy. Prolific exchange of information over the internet has presented a challenge in managing the COVID-19 pandemic. While rapid access to late-breaking news allows education to be provided to the public in a timely manner, an excess of information causes confusion. The term “infodemic,” which was in use before the COVID-19 pandemic, has become increasingly relevant as a flood of unreliable information has followed each uncertain step in understanding the virus and the vaccines against it.

During some public health crises, media coverage may be a significant, measurable factor in infection control because of its influence on human behavior (1). For example, media-driven education may have helped to control the spread of severe acute respiratory syndrome (SARS) in 2002 and 2004 as a decrease was observed in person-to-person contact (2).

However, media messages about COVID-19 have often shown inconsistency and contradiction. As each phase of scientific understanding has unfolded in real time, a variety of conclusions has swiftly followed. Individuals who come to distrust authorities on public health may reject or actively impede measures to control infection.

A survey of 1325 Finnish adults found that among 3 factors-conspiracy beliefs, distrust in information sources, and endorsement of complementary and alternative medicine- distrust in information sources was the most consistent predictor of a negative response to non-pharmaceutical interventions for infection control (3).

Another survey of 1,000 U.S. adults showed that willingness to be vaccinated against COVID-19 was most significantly affected by the predicted effectiveness of the vaccine (more than the likelihood of side effects or serious adverse reactions) (4).

With this survey, we aim to gain insight into what specific conclusions our participants have drawn about the COVID-19 vaccine.

Objective
To compare beliefs about COVID-19 vaccines, their advantages and disadvantages, and the information sources that shape those beliefs between participants who chose to receive the vaccine and those who did not

Methods
A proposal was approved by the University of Missouri-Columbia Internal Review Board to conduct this study. Our questionnaire was administered to the families of patients receiving care at the University of Missouri Child and Adolescent Psychiatry Clinic. One hundred participants were randomly selected. The person who ultimately decided to participate was either the patient or a family member accompanying a minor patient. No identifiable information was collected from study participants. The survey’s first question asked whether or not the study participant had received the COVID-19 vaccine. That was followed by free response questions prompting responses about what advantages and disadvantages they thought of receiving the COVID-19 vaccine. The next survey question asked from where or from whom they received their information regarding the vaccine. The final study question asked participants about the ways to improve people’s understanding of the vaccine. These free response format allowed for multiple answer responses and enabled participants to fill out all five survey questions or leave some blank.

(Continued on page 15)
Results
57% of the 100 study participants reported they were fully vaccinated against COVID-19 (Fig-1), as compared to Missouri’s vaccination rate of 50.3% and the United States’ rate of 58.7% (Ritchie et al., 2021) (6).

When asked about the advantages of vaccination, participants who chose to receive the vaccine most often perceived that the shot would decrease the chances of COVID-19 infection and spread (39%) and/or mitigate symptom severity if infection did occur (23%).

Those who had not received the vaccine most often responded that they did not know the advantages or did not think there were any (47%) (Fig-2).
When asked about the disadvantages of getting the COVID-19 vaccine, those who had already received it responded most frequently that they did not know of any disadvantages (47%) or that they may have short-term side effects (28%). Participants who had not received the vaccine most often responded that they did not think enough research had been done (35%), that they did not know about the disadvantages (30%), or that long-term adverse effects may occur (28%).

Stigma was listed as a potential disadvantage by vaccinated participants (5%) but not mentioned by unvaccinated participants (Fig-3).

Those who had received the vaccine most frequently listed health care professionals as one of their sources for information about COVID-19 (49%). Those who had not been vaccinated most frequently responded that internet articles were a source of COVID-19 information for them (40%) (Fig-4).

More vaccinated than unvaccinated participants named health care professionals, CDC/FDA/WHO, or pharmacies as a source of information. More unvaccinated than vaccinated individuals reported receiving information from internet articles or social media or were not sure of their information source (Fig-4).

About half of the participants (51%) answered that they thought it was possible to improve the public’s understanding of COVID-19 vaccines (Fig-5). To achieve better understanding, the greatest number of participants felt it was necessary to focus on education, minimize unreliable information, and publish more research. The smallest number of participants perceived a need for politicians and celebrities to weigh in (Fig-6).

**Discussion**

For this questionnaire, participants answered each question in free response form except the first question. Having participants respond in their own words allowed us to authentically capture their beliefs about COVID-19 vaccines and avoid influencing them by suggestion (which would likely have occurred had we used multiple choice options). At the same time, the use of free response was one of our study’s limitations. Non-identical answers were grouped together based on common themes. Other limitations of this study were small sample size, recruitment of participants from a specific population (child and adolescent psychiatry clinic).

Similarly to the results published by Kaplan and Milstein (4), our results suggested that perception of the vaccine’s effectiveness strongly affects willingness to receive it. 39% (Fig-2) of the vaccinated participants were confident enough that the vaccine would prevent infection to list this as an advantage. Those who had not been vaccinated frequently responded that they did not know of any advantages to taking the vaccine and/or that more research was needed. It could not be determined from our results whether vaccine effectiveness or long-term adverse effects were more influential. While 28% of the unvaccinated participants listed long-term effects as a disadvantage, 35% were concerned about limited research. In their responses, our participants referred to a need for research both on how well the vaccine works and what effects it may have long-term (Fig-3).

(Continued on page 17)
Our results suggested that information accessed online during the COVID-19 “infodemic” may decrease vaccine acceptance. The percentage of unvaccinated participants who obtained information from online articles and social media was 40% and 19%, respectively, compared to 16% and 12% of vaccinated participants (Fig-4).

The strong influence of education by health care professionals is reflected in our results. Health professionals were the most frequently mentioned source of information among those who had received the vaccine. Unfortunately, many people with limited access to health care may not have a relationship with a trusted professional.

While many people consult the internet for health advice, those who do not have a primary care provider may rely on internet-based sources almost exclusively.

Based on our findings, we suggest that licensed health care professionals use the internet as an educational tool. Although an article or video cannot take the place of an active provider-patient relationship, a professional who is unaffiliated with any particular news outlet may earn trust by presenting evidence-based information online.

**Conclusion**

Vaccinated individuals frequently perceived that the vaccine would prevent COVID-19 infection and spread and/or decrease illness severity. Unvaccinated individuals were often uncertain of the vaccine’s benefit and concerned that research was too limited. Frequent use of internet articles and social media by those who had not been vaccinated supports the role of the COVID-19 “infodemic” in vaccine hesitancy. Our results support the idea that trust in a health care professional may increase willingness to accept a vaccine. When most of a population uses the internet but fewer access regular health care, it may be helpful for licensed health professionals to provide education over the internet.

**References**


The Missouri Psychiatric Physicians Association strongly supports the dedicated, crucial work of Missouri’s city, county and state public health officials as they continue to promote safety and provide guidance to their fellow citizens during the ongoing coronavirus pandemic. Because of the novel and highly contagious nature of this virus their job already had been a difficult one. Recent episodes of harassment and threats directed at them from some members of the public have made their tasks more difficult and stressful. The rampant spread of misinformation has added to the difficulty facing public health officials and agencies as they try to communicate their recommendations. All this has an adverse effect on the mental health of these officials as well as on that of the public at large whom these agencies are charged with protecting.

Reluctance to wear masks or receive a vaccine are understandable but dialogue about these issues should be respectful and aimed at discerning actions which are based on the best science available. Peaceful protest is a constitutional right but threats, harassment and violence are not and should not be tolerated. We support our public health officials as they try to do their best to ensure that their policy decisions are based on the latest and most reliable scientific data. We also support their efforts to communicate their recommendations to government officials and the public in a way that maximizes public safety.

**The news release in reference to MPPA Supporting Public Health Officials was sent to public health administrators around the state, plus Kansas City, St. Louis, Springfield, Columbia and Jefferson City newspapers.**
People who frequently use cannabis and/or those with cannabis use disorder are more likely to report having been diagnosed with a psychotic disorder than those with no past-year cannabis use, according to a report in *AJP in Advance*. The study also found evidence to suggest psychotic disorders in the adult U.S. population rose from 2001-2002 to 2012-2013.

“Our finding that the prevalence of past-year self-reported psychosis increased significantly between 2001-2002 and 2012-2013 is the first reported change in prevalence of self-reported psychotic disorders based on large-scale, nationally representative samples of U.S. adults,” wrote Ofir Livne, M.D., of the Columbia University Mailman School of Public Health and colleagues.

The findings were based on data collected from more than 79,000 people during two waves of NIAAA’s National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), conducted 10 years apart. Livne and colleagues specifically focused on self-reports of psychotic disorders by survey respondents with varying levels of cannabis use: any nonmedical use, frequent nonmedical use, daily/near-daily nonmedical use, or a diagnosis of *DSM-IV* cannabis use disorder. Nonmedical use was defined as use without a prescription or other than prescribed. (The NESARC did not include a question about medical use of cannabis, precluding examination of this question in NESARC data.) Respondents were classified as having a self-reported psychotic disorder if they had been told by a medical professional that they had schizophrenia or psychotic illness or episode.

In the 2001-2002 survey, 178 of 43,093 respondents had a self-reported psychotic disorder. In the 2012-2013 survey, 337 of 36,309 respondents had a psychotic disorder.

Participants with cannabis use disorder reported in the 2001-2002 survey had a higher rate of self-reported psychotic disorders than nonusers (2.55% compared with 0.27%); in the 2012-2013 survey the difference was even greater (3.38% compared with 0.68%).

In the 2012-2013 survey (but not in the 2001-2002 survey) people who frequently used nonmedical cannabis were more likely to have a psychotic disorder than nonusers (2.79% compared with 0.68%).

“The increasing perception of cannabis as a harmless substance may deter the general public as well as health care providers from recognizing that nonmedical cannabis use may play a role in exacerbating the risk for psychotic disorders,” the researchers wrote. “[I]mproving public knowledge and educating providers about this risk may serve a useful function.”

For related information, see the *Psychiatric News* article “Daily and High-Potency Use of Cannabis Linked to Psychosis.”
More than 8% of older veterans have subthreshold posttraumatic stress disorder (clinically significant PTSD symptoms below the threshold for a diagnosis), a study in the American Journal of Geriatric Psychiatry suggests.

Jennifer Moye, Ph.D., of the VA New England Geriatric Research Education and Clinical Center and colleagues analyzed data from 3,001 U.S. veterans aged 60 years or older who participated in the National Health and Resilience in Veterans Study between November 2019 and March 2020. The veterans were assessed using the PTSD Checklist for DSM-5, the Life Events Checklist for DSM-5 (for trauma exposure), and other measures. The researchers collected demographic information from the participants (including age, gender, race/ethnicity, and education), as well as their history of trauma exposures; suicidal behaviors; psychiatric and substance use disorders; and mental, cognitive, and physical functioning.

Overall, 8.5% of veterans screened positive for subthreshold PTSD, and 1.7% screened positive for full PTSD. Furthermore, 92.7% of all veterans in the study reported exposure to one or more potentially traumatic events, and among those, 9.6% screened positive for subthreshold PTSD and 1.9% screened positive for full PTSD. The prevalence of both subthreshold and full PTSD was higher in women and those who used the VA as their main source of health care. Veterans with subthreshold PTSD were equally as likely as those with full PTSD to have psychiatric, cognitive, and physical comorbidities, including a history of suicide attempts and current suicidal ideation.

“Given that older veterans aged 55 to 74 are at the highest risk for dying by suicide, better recognition of both subthreshold and full PTSD may be an important component of suicide prevention efforts,” Moye and colleagues wrote.

“Subthreshold PTSD is associated with a comparable clinical and functional burden as full PTSD, thus underscoring the importance of assessing, monitoring, and treating both of these manifestations of PTSD symptoms in clinical settings,” the researchers concluded.
William M. Irvin, Sr., MD
William M. Irvin, Sr., MD, 93, passed away Sunday, September 26, 2021.

Beloved husband of sixty-five years of the late Jeanne Marsailes Irvin (d. March 26th, 2021); loving father of William (Emily) M. Irvin, Jr., M.D., Therese (Jim) Hagemeister, Melissa Irvin, Mary Beth (Erik) Hynes, Megan (Rich) Witzel, and Tom Irvin; adoring grandfather of Peter and Alice Irvin, Tess and Claire Hagemeister, Connor and Maggie Hynes, Richie, Billy, and Jimmy Witzel; dear brother of Marianne (Victor) Carnahan and the late Eugene (Rose) Irvin; dear uncle of 13 nieces and nephews. A devoted family man and lifelong optimist, he generously mentored many and encouraged all.

Dr. Irvin specialized in the practice of psychiatry for nearly sixty years, two of these occurring in service in the United States Air Force. After completion of residency in 1961, he treasured his time working with the patients, doctors and nurses at SSM St. Mary’s and Mercy Hospital St. Louis. He will be missed on the wards and in the office, as well as on the links and at the track.

Natarajan ‘Bob’ Laks, MD
Natarajan ‘Bob’ Laks, MD, 84, passed away Wednesday, October 13, 2021. He was born in Chennai, India and was a physician specializing in Psychiatry.

He is the beloved husband of Meenakshi Laks (nee Chellappa); dear father of Yamini Laks and husband Chris Georges; loving grandfather of Sunvi, Relle, and Anthos Laks-Georges; He was preceded in death by his son Deepak Kumar Laks.

Dr. Layla Ziaee
Dr. Layla Ziaee, 47, beloved daughter of Maryam and the late Dr. Mahmoud Ziaee passed away September 1, 2021 surrounded by her loving family.

Layla is survived by her husband, Gerald Cassaude and her cherished son, Cyrus. Layla also leaves behind brothers Dr. Ali (Emily) Ziaee and Babak (Renata) Ziaee and her many cousins, nieces and nephews.

Layla graduated from St. Louis University Summa Cum Laude, where she also received her medical degree and completed her psychiatry residency. She was a dedicated psychiatrist who devoted her time to her patients and to her country as a counter terrorism consultant.

Layla loved traveling and spending time with her many friends and family but above all relished her time with Cyrus. She could always be found cheering him on in the swimming pool or quietly listening to him play guitar. Her time with Cyrus, especially during her final weeks, brought her comfort and peace.
# APA BENEFITS

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*Benefits may vary for Resident-Fellow and International members. Visit psychiatry.org/join*
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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People who develop major depression following a COVID-19 infection appear to respond to treatment with selective serotonin reuptake inhibitors (SSRIs) within four weeks, according to a small study reported in *European Neuropsychopharmacology*.

“After COVID-19, depression was reported in 40% of patients at one-, three-, and six-months’ follow-up,” wrote Mario Gennaro Mazza, M.D., of Vita-Salute San Raffaele University in Milan, Italy, and colleagues. “The host immune response to SARS-CoV-2 infection and the related severe systemic inflammation seems to be the main mechanism contributing to the development of post-COVID depression.”

The study included 60 adults (average age: 55 years) who developed a major depressive episode within six months following recovery from COVID-19 and were starting a new SSRI treatment; 26 were treated with sertraline, 18 with citalopram, 10 with paroxetine, four with fluvoxamine, and two with fluoxetine. The researchers evaluated the patients using the Hamilton Depression Rating Scale (HDRS) at the beginning of the study and after four weeks of SSRI treatment.

After four weeks, average HDRS among the patients dropped from 23.37 to 6.71, with similar improvements seen in men and women as well as people with or without a history of psychiatric illness. Fifty-five of the 60 patients (92%) achieved a clinical response to antidepressant treatment, defined as ≥50% reduction in HDRS score. For comparison, studies in the general population have shown that depressed patients tend to respond to an antidepressant about 40% to 60% of the time, the authors wrote.

“SSRI treatment could contribute to the rapid antidepressant response by directly targeting the neuroinflammation triggered by SARS-CoV-2,” they wrote.

While the authors acknowledged the limitations of the study (including the lack of a control group and the small sample size), they suggested that the findings point to the importance of routinely screening COVID-19 survivors for depression so they can be promptly treated.
What is the MO Psychiatric Physicians PAC?
MoPPPAC is an organization that accepts volunteer contributions to help strengthen the Missouri Psychiatric Physicians Association’s (MPPA) participation in elective processes at state and local levels.

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

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

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

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

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

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

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

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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
January 11, 2022
March 15, 2022
April 2, 2022
June 7, 2022
August 16, 2022
September 23, 2022
November 15, 2022

Spring Meeting
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