The year 2016 is moving along at a quick speed. In just a few weeks the Missouri Psychiatric Association holds its Annual Meeting - Saturday March 19th in Saint Louis. As in past years, MPA’s Annual Meeting with the Membership also provides the opportunity for earning CME credits, touching base with local colleagues and networking with other psychiatrists from around the state. This year the meeting will be held in Saint Louis at the Renaissance Hotel. One also has the opportunity to attend seminars offered by the Missouri State Medical Association during their Annual Meeting which is held the same weekend at the same venue.

Approximately four years ago, the American Psychiatric Association mandated that all psychiatric associations within each state merge into one state organization. Thus, Eastern Missouri Psychiatric Society, Central Missouri Psychiatric Society and Western Missouri Psychiatric Society merged into one organization, The Missouri Psychiatric Association (MPA). This merger has left us with many challenges. One of the more difficult challenges has been that of trying to keep members from all parts of Missouri involved in MPA’s Executive Council. The Executive Council ‘meets’ via teleconference call several times year and is composed of the officers of MPA along with the chairs of MPA’s Committees: Child Psychiatry, Disaster Psychiatry, Early Career Psychiatry, Ethics, Legislative Affairs (which includes state and national legislative affairs along with legislative activity in the APA and AMA), Political Action Committee, Continuing Education Committee, MPA Newsletter, Public Affairs, and others. Currently we are looking for members who would be interested in joining any of these committees. And we are interested in hearing anyone’s suggestion about forming additional committees that may be of more interest today. For instance, a committee interested in the psychiatric care available for US Veterans; or a committee involved in Addiction Psychiatry and the impact of opioids widely available in both rural and urban Missouri. Or perhaps you may be interested in a committee proposing changes in the “Maintenance of Certification” requirements -- Did you know that the American Board of Internal Medicine has suspended all requirements for MOC at least through 2018? I am interested in exploring suspending requirements for MOC for Psychiatry while we investigate how best to keep psychiatrists up to date with important developments in all aspects of psychiatry. I am also interested in establishing a committee to explore ways to stimulate interest in medical students in considering psychiatry as a career. Please contact any of the officers of MPA if you are interested in becoming more involved or simply email MPA at sandyboeckman@gmail.com.

The American Psychiatric Association Annual Meeting is being held in Altanta this year May 14th through May 18th. And please save the date of October 8th when MPA will be holding the Annual Fall Conference in Columbia Missouri.
Missouri Psychiatry

Missouri Psychiatric Association
http://missouri.psych.org

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2015 Fall Assembly Update
Missy Iqbal, MD, FAPA, FASAM

This past fall your Missouri representatives, Jim Fleming and I, attended the Fall meeting of the APA National Assembly in Washington DC. It was a busy weekend and we attended many meetings and work groups. The Assembly works hard to advocate for our colleagues, profession and patients. One of the ways in which this advocacy takes place is through the presentation of and voting on a variety of action papers.

The concept of an action paper may be unfamiliar to some APA members. The following is from the APA website. “An action paper is the product of an idea. Assembly members, representing and informed by their constituency, the members of their district branch, actively formulate these ideas into actionable tasks that the Assembly can review, debate, and vote on. The development process for an action paper may involve determining what activities or policies regarding the idea are currently being undertaken at APA or have been in the past. As the idea is developed, the action paper is honed and parsed into a subject, intent, problem, alternatives, recommendation, and implementation. These sections outline the details being brought forth by the author(s). Once an action paper is submitted to the Rules Committee, it may be assigned to a Reference Committee or Area Council. The Reference Committee hears testimony about the paper and discusses it, potentially making changes. The paper is then brought to the floor of the Assembly at which time the Assembly may make additional changes. The Assembly then votes on the action paper. If the action paper is approved, it is then typically referred to the Joint Reference Committee. The Joint Reference Committee may then refer it to the Board of Trustees for consideration or to the appropriate component for additional information and work or for implementation.”

There were a number of action papers presented at the 2015 Fall Assembly. The following is a description of the action papers that were approved.

Access to Care Provided by the Department of Veterans Affairs
ASMNOV1512.A

Synopsis: The action paper asks that the APA support any and all clinical activities that can improve the mental health care and treatment of veterans.

Description: BE IT RESOLVED: That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans. That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans. That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA.

Status: Approved

Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer
ASMNOV1512.H

Synopsis: The action paper asks that the APA Ethics Committee review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law. The Assembly voted to refer this action paper to the Council on Healthcare Systems and Financing.

(Continued on page 3)
Description: BE IT RESOLVED: That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting. The Ethics Committee review will specifically address at least the following questions: 1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law? 2) If an insurance company policy or the review standards that guide a psychiatrist reviewer’s decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer? 3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law?

Status: Approved with motion to refer to develop a toolkit for psychiatrists in managed care to handle situations that they may be placed in that could compromise parity.

APA Support for NIMH Funding of Clinical Research
ASMNOV1512.G

Synopsis: The action paper asks that the APA produce a white paper determining the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus.

Description: BE IT RESOLVED: That the APA shall: 1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA’s 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget. 2. The APA will advocate the implementation of the recommendations of the White Paper.

Status: Approved

Ad Hoc Workgroup to Explore the Feasibility of Developing An Electronic Clinical Decision Support Product
ASMNOV1512.E

Synopsis: The action paper asks that the APA form an ad hoc work group to evaluate the feasibility of developing an electronic clinical decision support product.

Description: BE IT RESOLVED: That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the “CDS Product Workgroup”) for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA’s series of Practice Guidelines, in addition to that within other appropriate APA products; and That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.

Status: Approved

Payer Coverage for Prescriptions from Nonparticipating Prescribers
ASMNOV1512.F

Synopsis: The action paper asks that the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid.

Description: BE IT RESOLVED: That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid. 

Status: Approved

2015 Fall Assembly Update continued
Position Statement similar to that of AMA’s supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.

Status: Approved

Prior Authorization
ASMNOV1512.D

Synopsis: The action paper asks that the Assembly Procedural Code be rewritten to make the election of Assembly officers based on a majority vote.

Status: Approved

Utility of Specific Code of Ethics for Elders
ASMNOV1512.E

Synopsis: The action paper asks that the APA seeks to collaborate with other medical societies, including the American Geriatric Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner.

Description: BE IT RESOLVED: That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner.

Status: Approved

Making Access to Treatment for Erectile Disorder Available Under Medicare
ASMNOV1512.P

Synopsis: The action paper asks that the APA in collaboration with other medical specialty societies to advocate for those with illness which may result in

Status: Approved

Equality in Permanent Licensure Policy
ASMNOV1512.K

Synopsis: The action paper asks that the APA adopt a policy supporting equality in the number of years ACGME-accredited training required for IMGs and US medical grads for the purposes of obtaining permanent medical licensure.

Description: BE IT RESOLVED: That the APA adopts a policy supporting equality in the number of years ACGME-accredited training required for IMGs and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support

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be sent to the various state medical boards. That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.

Status: Approved

Partial Hospital Training in Psychiatric Residency
ASMNOV1512.L

Synopsis: The action paper asks that the APA recommend to the RRC of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care.

Description: BE IT RESOLVED: That the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.

Status: Approved

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Status: Approved

Systems to Coordinate Psychiatric Inpatient Bed Availability
ASMNOV1512.O

Synopsis: The action paper asks that the APA review existing models and programs of online registered psychiatric bed availability.

Description: BE IT RESOLVED: That the APA’s Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.

Status: Approved

There were other action papers that were either not approved or were withdrawn from the agenda. If you have any questions about the assembly or are inspired with an idea for a future action paper, Jim and I hope you will contact us.

Calendar of Events

Continuing Medical Education Workshops
March 18-20, 2016
Joint Annual Conference
Missouri State Medical Association’s
158th Annual Convention
Renaissance St. Louis Airport Hotel
St. Louis, Missouri

Executive Council Meetings
Conference Calls Scheduled at 7:00 pm
April 13, 2016
June 8, 2016
Managing Psychiatrist Shortages
Syed Arshad Husain, MD

The Affordable Care Act has added millions to the pool of insured Americans seeking medical attention. It is expected that in the next 10 years, 15 million Americans will become eligible for Medicare and 32 million younger Americans will become insured.

Current graduation and training rates indicate that over the next 15 years, there will be a shortage of approximately 150,000 physicians. Affected by this shortage, 20% will be the rural and inner-city locations that are already underserved. The greatest demand will be for Primary Care Physicians. It is estimated that there will be a need of 45,000 additional PCPs by 2020 (CNN, 2 October, 2013).

The government is exploring various ways to help with this physician shortage before a crisis erupts. Many states have developed funding to increase the number of medical schools enrollees. However, the federal government has not removed the Medicare funding cap that was established in 1997, thus limiting funds for residencies (Marquez L. AAMC, 22 September, 2014).

One other fact that the Medical field is facing is the “Aging Out” of the physicians. Over half of the nation’s physicians are over the age of 50. Over 75 percent of psychiatrists in practice are 50 year or older (Merritt Hawkins, Healthcare Industry Trends: 7 May, 2014).

On the other hand mental illness affects one in seventeen adults and one in ten children. Research shows that fifty percent of all lifetime psychiatric cases begin in adolescence.

There have been many suggestions to assist with the physician shortage.

- Increase the role of Nurse Practitioners and Physician Assistants where they are more able to specialize in specific fields and receive collaboration from a physician.
- Change in laws to expand non-physician prescribing medication. Several states are looking at the possibility of psychologists receiving additional training to be able to prescribe medications under the supervision of a psychiatrist.
- Medical homes usage could potentially decrease the demand for physicians by 25% by allowing a mix of medical providers, nurse practitioners, and physician assistants to deliver medical care rather than relying solely on a physician.

Psychiatrist Shortage
According to an estimate there are approximately 46,000 psychiatrists in the United States. Of these, 32% are international medical graduates. By 2020, the demands for psychiatric services will increase approximately by 19%. A decline in an interest of the medical students to pursue psychiatry as their career choice, along with the aging out of a significant number of psychiatrists, will pose a serious challenge to the mental health delivery system.

According to national surveys, 55% of the counties in the United States do not have a practicing psychiatrist and there are 3,900 geographical areas across the country that are considered mental-health shortage areas because of the lack of psychiatrists and limited mental health resources available. In order to keep up with the demand, 2,800 more psychiatrists are needed in the U.S.

Psychiatrist Shortage in Missouri
The federal government has designated 104 of 114 Missouri counties as mental health shortage areas due to the lack of psychiatrists and mental health resources available. There are no licensed psychiatrists in 72 of the 114 counties. Missouri psychiatrists are faced with issues involving insurance reimbursements. Because of this, a majority of psychiatrists do not accept Medicaid, and many of the psychiatrists in Missouri are electing to not accept any form of health insurance because of the low reimbursement and the mounting paperwork in order to receive a reimbursement.

According to St. Louis Today, the average wait time to get an appointment with a psychiatrist is from 10-30 days. This can be detrimental to a person with a severe mental health issues. In addition, there are only 1,174 psychiatric beds in the state of Missouri, forcing many residents to go to another state for hospitalization. (St. Louis Today, 18 January, 2014)

Child and Adolescent Psychiatrist Shortage in USA
It is anticipated that by 2020, there will be a 100% nationwide increase in the need for psychiatric services for children and adolescents. Currently there are 8,300 practicing child and adolescent psychiatrists in the USA falling far short of estimated required number of 13,000 to meet the psychiatric needs of the younger population. It is reported that ¼ of U.S. children have a diagnosable psychiatric disorders, but only 20% ever receive evaluation and treatment. A significant number of these children receive psychiatric help from primary care physicians.

Child and Adolescent Psychiatrist Shortage in Missouri
According to the Missouri Coalition of Community Mental Health Centers, in Missouri, the high school drop-out rate for students with mental illness is 50%. Nine percent of

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adolescents between the ages of 12-17 suffered from at least one psychiatric episode in the previous year. Impulse control disorder accounts for 37% of these episodes, while mood disorders make up 26% and anxiety disorders account for 14%. In Missouri, it’s even more difficult for the children and adolescents to receive treatment from a psychiatrist. The average wait time in the St. Louis area is 6 months, which is more than 300 times the national average. (Missouri Coalition of Community Mental Health Centers, 2014)

Solutions for Physician Shortage
Missouri’s use for Health Home will allow the collaboration between PCPs and mental health professionals, including psychiatrists, to better serve the residents of Missouri. Additionally, the AMA has created a new policy, and they are encouraging the government, to increase the number of residency slots available to medical students so there will be more specialty doctors. The AMA is also encouraging state governments to create incentives for those doctors that are willing to provide care in underserved areas with the use of loan forgiveness contracts. (Jakubek, K., AMA outlines ways to address Physician Shortage, 12 June, 2014. Accelerating change in medical education, 23 September, 2014)

Our Solution
In view of the shortage of mental health services in rural Missouri, Royal Oaks Hospital developed Project TERMH (Training Enhancement in Rural Mental Health) to find innovative ways to fill this shortage. It had four initiative including training primary care physicians, nurse practitioners, and physician assistants in psychiatry and child psychiatry. The other initiatives included training additional psychologists, supporting training graduate level of nurses in mental health and supporting the psychiatric residency training programs.

A survey was conducted to explore the extent of psychiatric services already being provided by the primary care physicians located in the 13 most underserved counties in southwest Missouri. Fifty-two PCPs were surveyed, of this, 23 were physicians and 29 were nurse practitioners. According to this survey, each PCP was seeing on the average of 36 patients of all ages every week that required purely mental health services. These included children adolescents and adults. Among the diagnostic categories included were Anxiety Disorders (92.3%), Bipolar Disorders (84.3%), Major Depressive Disorders (84.5%), ADHD (77.4%), Substance Abuse Disorder (73.8%), PTSD (67.7%), Schizophrenia (45.5%) and ODD/Conduct Disorder (40.8%).

Most PCPs surveyed provided medication follow-up (85.9%), individual and family therapies (24% individual, 7.9% family). Anti Depressants (SSRIs) were the most prescribed psychotropic medication (83%) followed by atypical antipsychotic (55%), anxiolytic medications (52.7%) and mood stabilizers (44.8%).

On the average a PCP was referring 7 patients every month to a psychiatrist for higher level of treatment because of treatment failure or suicidal risk. They also refer them out if there was a diagnostic question or the patient was on too many medications. The PCPs also reported that approximately 40% of their general medical patients had some mental health issues.

Funding Support
The U.S. Department of Labor provided the funding for project TERMH by awarding a three-year grant of $2.7 million with the matching funds of up to 8 million dollars.

Training PCPs in Psychiatry
The PCPs were offered 84 hours of didactics and practicum in psychiatry, child psychiatry, and psychopharmacology. The training curriculum was very comprehensive and included all psychiatric conditions in adults, children and adolescents listed in DSM-IV and their psychopharmacological treatment.

Outcome Study
The outcome study included a pre and post training test. The test consisted of 110 multiple choice questions covering all of the topics included in the curriculum and was administered to each participant. A control group of fourth and fifth year psychiatric residents were also given the same test. The mean pre-test scores obtained by the PCPs was 45.14%; the same questionnaire was administered to each PCP upon completion of the course. The post test average was 63.88%. The control group’s average was 76.4%.

Integrated Mental Health Team
Upon completion of the training, all participants were invited to join the “Integrated Mental Health Team” that allowed the PCPs the following benefits:
- 24/7 consultation hotline
- Immediate access to a psychiatrist
- Medication guidance
- Inpatient hospitalization – when needed
- More extensive out-patient options

Non Accredited Fellowship in Psychiatry and Child Psychiatry (NAP)
The U.S. Department of Labor awarded a second grant to support the “Non-Accredited Fellowship in Psychiatry and Child Psychiatry” because of the success of Project TERMH. This fellowship was an expansion of Project TERMH to provide 120 hours of training, with 56 hours of didactics and 64 hours

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Managing Psychiatrist Shortages continued

of practicum in an inpatient setting. The training was made available to general practitioners, nurse practitioners, family physicians, and pediatricians. A child psychiatry track was offered to general psychiatrists and pediatricians.

The practicum for the NAP was offered at the Royal Oaks Hospital. The practicum training was designed after the ACGME model that includes psych evaluations, interview techniques, treatment planning and outpatient management. Close supervision was provided to each trainee in all facets of practicum.

Conclusion

Training primary care physicians in psychiatry and child psychiatry is a viable practical solution to combat the psychiatrist shortage. As our survey demonstrated, primary care physicians are already providing psychiatric services to a considerable number of their clientele because they show up at their clinics. Most of them felt uncomfortable for being in that situation because a lack of training but did not have an immediate alternative because an acute psychiatrist shortage. Most were very receptive to the idea of non accredited training psychiatry and child psychiatry. Our outcome study showed that after the training under project TERMH, the PCPs knowledge in psychiatry increased significantly and so did their comfort level at treating psychiatric patients. The Integrated Mental Health Team offered an immediate consultative opportunity to the PCPs. The Project TERMH model is cost effective and can be implemented in various psychiatrist shortage areas in the nation.

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Dr. Arturo Taca, Jr., St. Louis Psychiatrist, Elected Midwest Chapter President of American Society of Addiction Medicine

Dr. Arturo C. Taca, Jr., Diplomate of ABPN / ABAM, a St. Louis-based psychiatrist, and founder / medical director of INSynergy, was recently elected President of ASAM (American Society of Addiction Medicine) Midwest Chapter for a 3-year term.

ASAM has 39 state and regional chapters throughout the United States that involve members in local activities, education and state advocacy efforts.

"Addiction is a real public health issue. I'm honored to be asked to by our members to help lead and serve our region to educate the public and treatment providers about how we can make a difference," said Taca.

Dr. Taca is a Diplomate of the American Board of Addiction Medicine and the American Board of Psychiatry and Neurology. He completed medical school from the University of the East and medical internship and psychiatry residency at St. Louis University. He founded INSynergy, an outpatient substance abuse program based in Creve Coeur, in 2011.

Evan Schwarz (Secretary) and Christina Davila (Treasurer and President Elect). Dr. Schwarz practices Emergency Medicine and specializes in medical toxicology at Washington University. Dr. Davila is a psychiatrist from Kansas and Medical Director of Awakenings Treatment Program in Kansas City.

Founded in 1954, ASAM is a professional society representing over 3,600 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

Founded in 2011, INSynergy also addresses the psychological and psychiatric issues that lead to addictive behaviors such as ADHD, anxiety, bipolar disorder, and depression. INSynergy Treatment Center is the premier alcohol and drug rehabilitation facility in St. Louis, Mo. Patients at INSynergy are treated using a modern-day approach combining medical pharmaceutical therapy with counseling. To learn more, please visit www.insynergystl.com or call (314) 649-STOP (7867).
Obama Calls for Tighter Background Checks, More MH Funding to Cut Gun Deaths

President Barack Obama this morning announced several executive actions intended to reduce gun violence in the United States. The steps included tightening requirements for background checks for gun purchasing while upgrading the background system, better enforcement of existing gun laws, more research on gun safety technology, and an added focus on domestic violence.

Obama also called for an additional $500 million to increase access to mental health treatment, noting that the majority of gun deaths were suicides.

“Gun violence is a public health problem and needs to be addressed as such,” said APA President Renée Binder, M.D., in a statement. “We welcome the announcement from President Obama to make needed investments in mental health and curb the epidemic of gun violence in our country.”

The administration issued a final rule today governing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to permit certain hospitals and state agencies to report individuals under specific circumstances to the National Instant Criminal Background Check System (NICS).

In a letter to members of APA’s Board of Trustees and Assembly, APA CEO and Medical Director Saul Levin, M.D., M.P.A., said, “It is APA’s sense that the final HIPAA/NICS rule released today is well balanced and addresses our previously articulated major concern regarding the need to preserve privacy, incentivize treatment, and prevent any federal law or regulation that ... would require or permit psychiatrists to report their patients directly to NICS or any other federal database.”

For more in Psychiatric News about reducing gun violence, see “Gun Violence Reduction Possible With Combined, Varied Actions.” Also see the new book Gun Violence and Mental Illness from American Psychiatric Association Publishing edited by Liza H. Gold, M.D., and Robert I. Simon, M.D.

Reprinted from the Psychiatric News Alert

APA Foundation Executive Director Paul Burke to Retire

The American Psychiatric Association Foundation has announced the retirement of Foundation Executive Director Paul Burke this summer. Burke has been with the APA Foundation, the philanthropic and public educational arm of the APA, since 2007 and will retire July 1, 2016.

Under Burke’s leadership the Foundation has advanced public understanding of mental illness through a combination of educational programs, grants, awards and numerous partnerships. Foundation initiatives have included programs in military mental health, depression education, workplace mental health, and the Typical or Troubled? school-based mental health educational program. Burke is currently helping lead a major collaborative effort to help end the criminalization of people with mental illness, which will culminate in a national summit on the topic in April that’s cosponsored by the National Association of Counties and the Council of State Governments.

“We are grateful for Paul’s many years of dedicated service to increasing public awareness and improving mental health care,” said APA Foundation Board Chairman Saul Levin, M.D., M.P.A. “We are pleased Paul will remain with the Foundation for the next several months to continue the important work of the Foundation and to ensure a smooth transition.”

Prior to joining the Foundation, Burke served as the President and CEO of the Childhood Cancer Foundation (CureSearch), as the national director of marketing and communications for United Cerebral Palsy, and in public service positions in the federal government. He serves on the national boards of the Brain & Behavior Research Foundation and of America’s Charities.
Some of you may have seen the graphic illustrations used for everyone from elementary schoolers to bewildered adults explaining “How a Bill Becomes a Law”. If not, you may find a quick internet search using this phrase yields a worthwhile civics lesson in both the state and federal legislative process. Likewise, I hope this article will give Missouri psychiatrists a better idea of the functioning of the APA Assembly, the equivalent of Congress or the state legislature, for our 37,000 member national organization. In particular I hope to illustrate the path of how an Action Paper (AP), one of the primary activities of the Assembly, eventually leads to an actual action. Dr Iqbal’s article in this issue of the newsletter references this same process in a paragraph from the APA website. I hope a description of my personal experience of writing, advocating for and trying to track progress of an AP will bring this process to life. More importantly, I hope some of you will be inspired to consider both proposing ideas for future Action Papers and or even running for Assembly Representative someday soon.

Reviewing, debating and voting on APs and Position Statements consume the majority of time during Assembly meetings which are held every November in Washington, D.C. and every spring just prior to the APA Annual Meeting in the same location as that meeting. So here is the story of two APs, the first which was my idea and second, a much shorter story, which arose out of an Assembly Work Group I serve on involving “Access to Care” (work groups, by the way, are relatively new entity started by the immediate past Speaker of the Assembly intended to keep Assembly Reps more active between the main meetings).

An AP usually begins in the mind of an Assembly Representative, though it could be written or proposed by any APA member who also may serve as a co-author. My first venture into the AP arena, started with an issue I had been concerned about since elementary school when I chose “pollution” as a topic for a science essay. The topic turned out to be gargantuan, and I eventually “narrowed it down” to the still exceedingly broad topic of air pollution. Much later, as physician and literally a “card carrying environmentalist” (I am life member of Sierra Club), I became increasingly concerned about the impact of environmental toxins on human health and behavior. At the same time, I noted almost no attention whatsoever to this issue from either organized or academic psychiatry. (1)

This changed noticeably in the fall of 2014, when the APA online version of Psychiatric News published some news alerts linking exposure to environmental toxins in utero or early childhood to later development of ADHD (2). This time period also coincided with my first Assembly meeting where I had a chance to meet some of our amazing colleagues in the Assembly who not only provided mentoring but some of these individuals also became co-authors for the paper. One of my first lessons about the AP process was that choosing co-authors whom are well known in the Assembly or in the APA helps with eventual acceptance of the paper.

Another important lesson learned was that the APA staff were—and are—consistently available and always willing to help Assembly members with the process of filing and following the progress of APs. Online resources are certainly helpful and necessary (3) to consult but being able to talk with someone directly is irreplaceable especially for the rather arcane process of coming up with predicted costs to the APA for the execution of the AP. I first spoke with several long term Assembly members and got conflicting opinions about proper wording of the AP as well as appropriate actions requested, which APA entities to carry out those actions, etc. (e.g. was it a Task Force, a Work Group or something else?). Eventually I was referred to a senior APA staff member who was able to give me some definitive answers.

APs have two main sections:
1. The “WHEREAS” section where the author lays out arguments to justify the second section.
2. The “BE IT RESOLVED” section which specifies what action the APA is requested to take.

If the paper passes a majority vote in the Assembly, the WHEREAS section disappears in subsequent deliberation by the other APA bodies and only the second section, which is the ‘action step’ remains. This BE IT RESOLVED section needs to be succinct but curiously, I was advised to not be too specific about what would be done when and which component of the APA would do what, the reason being that if the proposed action was not how the relevant component usually functions it would be “shot down” on procedural grounds by someone opposed to the paper.

My AP, which was entitled: “Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior” had a relatively long WHEREAS section with 15 separate parts addressing decades of research as well as prior actions by other professional medical organizations and relevant regulatory and legislative issues. It was for me a “labor of love” which

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would have been worth the effort even if it hadn’t passed. But being the competitive person I am I was determined to be sure I did all I could to have it pass so did extensive research and included 11 references. This would be a low number for a typical scientific paper, but I was told by one of my co-authors, Dr Elias Sarkis — a child psychiatrist with extensive experience in the Assembly—that the paper I drafted had more references than any AP he had previously seen. (4)

After submitting an AP the next step is to defend and explain the paper at the Assembly meeting before the Reference Committee to which it is assigned. These committees are made up of Assembly Reps from each of the geographical areas as well as members representing special groups including resident-fellows, minority/underrepresented psychiatrists, and representatives from allied organizations. A normal amount of anxiety about the process was increased by my also serving on another Reference Committee and while I thought I had worked out an arrangement to leave my committee in time to answer questions about my AP, I ended up missing the beginning of the discussion on my paper because that the committee reviewing my paper skipped ahead of the planned schedule! Fortunately, my main co-author Elias Sarkis was well prepared and had already started to answer questions by the time I entered the room. The committee ended up supporting our AP with some changes in the BE IT RESOLVED section one of which we were disappointed in because it removed the requirement that the APA would establish a Work Group “comprised of researchers and clinicians knowledgeable in the area of the neurodevelopmental and behavioral effects of environmental toxins”. But thanks to Parliamentary Procedure which is followed during Assembly meetings, when the AP was discussed in the general session, someone offered an amendment which added this provision back into the required actions. Several Assembly rose to voice their support for the paper and no one opposed the paper. The amended paper passed easily and—as far I could tell— unanimously, which I found gratifying after all that work!

Well it would be nice if that was the end of the story but passing an Assembly represents only about the half-way point in the journey of an Action Paper and I quickly learned that one has to be vigilant to be follow the subsequent path through the process. In years past, authors would sometimes learn that the AP which they so diligently worked to get passed seem to fade away into apparent bureaucratic oblivion, leading one astute Assembly member (Daniel Anzia, our Speaker Elect) to develop an online way to track progress of APs which he dubbed “What Happened to My Action Paper?” And at the November 2015 Assembly meeting which occurred over Halloween (complete with creative costumes) one enterprising member, Dr Joe Napoli, dressed up like an undertaker to advertise his “business”: Action Paper Resurrection Service

The next step for the vast majority of APs is a referral to the “JRC” (Joint Reference Committee) which consists of Assembly officers the APA Medical Director and the President-Elect as well as a member of the Board of Trustees. The JRC then refers to the paper to one or more of 13 Councils and/or other entities established by the Board of Trustees. The JRC meets every July and January and in the case of my AP, at the July meeting the JRC recommended it be sent to the Council on Children, Adolescents and Their Families, the Council on Medical Education and Life Long Learning (CMELL) and the APA Division of Education. At the time of submission of this article it appears that the JRC has directed that the Council on Children [etc.] be the lead council and that they “should constitute a workgroup of advisors on this topic to advise the Division of Education”.

After the AP on environmental toxins passed at the May Assembly last spring, I decided to take a nice long break from filing any more APs and just see the first one through. However during a conference call for the Assembly Work Group on Access to Care, I made a suggestion that we encourage the APA to engage in a concerted effort to advocate for Medicaid expansion under the Affordable Care Act in those states which had not done this (Missouri: Hello!). The Chair of the Work Group, Dr Joe Mawhinney, said in response: “We should do an Action Paper on that”. I reluctantly said that perhaps I could help out with this but was very busy, he said basically the same thing and, well, I (rather than “we”) ended up writing the AP! As it turned out, this paper was much easier to do: the topic was straightforward, did not require an extensive literature search and I had the benefit of experience as well as advice from Joe on which Councils to send it to for input (which is now a more formal part of the process). Still, I was nervous having to present another paper and about possible opposition from members who thought the issue was too politically controversial (even though both the APA and the AMA support Medicaid expansion). So it was with significant relief to learn from Joe (over breakfast the day before the main Assembly session last November) that the AP was placed on the “Consent Calendar” by the Assembly Rules Committee which means that it not debated and automatically passes unless any Assembly member requests to remove from the Consent Calendar. Joe had explained that the committee “liked the paper” and as it is their prerogative to place any action on the Consent Calendar, they did so. At the opening session of the Assembly, no one asked for it to be removed, so—presto!—it passed. Whew! This was infinitely more

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**Journey of an Action Paper continued**

effortless than the first paper but given the other steps involved in the “journey” we will have wait and see to what extent and when it actually gets implemented.

At this point, I have no plans to embark on writing any more Action Papers. But, who knows? Perhaps someone reading this article will inspire me or my fellow MPA Assembly Representative Dr Missy Iqbal to write one. The action paper deadline for the next Assembly meeting is March 24, 2016(5).

1. The issue of environmental toxins and neurodevelopment has become very prominent in recent weeks due to the reports of high lead levels in the drinking water and in the blood of children in Flint, Michigan. What makes the story so disturbing is that lead is very well known for decades to be very toxic,

2. “ADHD Linked to Expectant Moms’ Smog Exposure”
   http://www.nlm.nih.gov/medlineplus/news/fullstory_149296.html (this report also appeared online in APA Psychiatric News Alerts in Nov 2014 but is no longer available there)

3. Entering “Action Paper” in the Search window of the APA website (www.psych.org) leads to numerous helpful links

4. A copy of the original Action Paper is available upon request from Dr Fleming who may contacted at: jflemingmd@yahoo.com

5. Meanwhile, our colleague, Area 4 Rep Dr Bob Batterson has written an important AP dealing with the Performance in Practice aspect of Maintenance of Certification which could also be used for the roughly 25% of psychiatrists who are not Board Certified allowing them as well as others to qualify for increased reimbursement from the Center for Medicare and Medicaid (CMS).

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APA Praises Subcommittee Passage of Helping Families in Mental Health Crisis Act

Late last night, the House Energy and Commerce Health Subcommittee passed HR 2646, the Helping Families in Mental Health Crisis Act of 2015, by an 18-12 vote. The Act, introduced by Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas), will now move on to the full Committee for consideration. The bill has 161 other co-sponsors from both parties. The American Psychiatric Association (APA) has joined with many leading mental health organizations to urge Congress to pass bipartisan legislation reforming the mental health system. APA has endorsed both HR 2646 and similar legislation introduced in the Senate.

APA President Renée Binder, M.D., issued a statement today in response to last night’s subcommittee vote:

We are very pleased by Wednesday night’s passage of HR 2646 by the House Energy and Commerce Health Subcommittee. This is a major milestone in the push for comprehensive mental health reform. This bill goes a long way in addressing the shortcomings of our nation’s broken mental health system. We will continue to work with our partners and with members on both sides of the aisle to pass this legislation in the House. We encourage the full committee to act on this bill soon.

APA Welcomes President’s Call for Investments in Mental Health, Efforts to Reduce Gun Violence

Today the American Psychiatric Association issued the following statement from its president, Renee Binder, M.D., in reaction to President Obama’s announcement today on gun violence and mental health:

“We welcome the announcement from President Obama to make needed investments in mental health and curb the epidemic of gun violence in our country. Gun violence is a public health problem and needs to be addressed as such. We support the president’s efforts to expand background checks, propose policies that respect physician-patient confidentiality, and increase funding for mental health services by $500 million. We will work with Congress to make that funding proposal a reality, as we also work with allies in Congress who are championing comprehensive mental health reform.”
NHC is pleased to partner with AllyAlign Health to start a Medicare Advantage I-SNP in the State of Missouri. The Plan, which begins January 2017, is limited to Medicare patients who are long-term residents in a NHC nursing facility.

**What is an I-SNP?**
The term I-SNP stands for Institutional Special Needs Plan and, by definition, is very small as it targets a limited number of patients.

**Why is NHC developing an I-SNP?**
Put simply, it is the best thing for our patients. Unfortunately, the traditional Medicare payment structure often presents an obstacle to appropriate proactive care for long-term care residents. Through the I-SNP model, CMS empowers NHC Advantage to modify the traditional benefits to meet the complex needs of this frail and underserved patient population.

The I-SNP strategy is in line with the quality and coordinated care NHC Advantage seeks to provide for all our patients and allows NHC to further enhance the clinical integration and services offered to patients and our clinical partners. Using nurse practitioners based in the nursing facility to provide care coordination, the Plan is able to proactively direct appropriate care to network providers to address emerging health issues. This approach helps prevent acute episodes while minimizing administrative burden on our provider partners.

**Why is NHC reaching out to me as a Provider?**
NHC identified the providers who currently serve our patients as the top priority for inclusion in the provider network with NHC Advantage. Our key goal is to maintain these pivotal relationships to ensure NHC Advantage patients may continue to seek services from their local providers.

As an I-SNP, NHC needs to meet full Medicare Advantage network adequacy within the counties that NHC operates skilled nursing facilities (SNF). Per CMS’ requirements, AllyAlign reviews the number and location of providers needed based on the location of Medicare beneficiaries in each county, and not solely on the location of the actual NHC SNF.

**What will the Membership of NHC Advantage look like?**
Membership, given the targeted (and eligible) population, will likely be in the range of 1,250 to 1500 members in the year beginning January 2017.

**What is the medical composition of the Membership?**
Some of the most common diagnoses for long-term care residents include hypertension, ischemic heart disease, hyperlipidemia, heart failure, diabetes, and COPD.

**How will providers be reimbursed by the I-SNP?**
Reimbursement is intended to be no less than Medicare, and payments will follow Medicare guidelines.

**What contract is needed with the I-SNP?**
NHC Advantage is offering a provider-friendly contract. The contract is definitely far less complicated than any of the large payers, and agreement on final language and terms should be a relatively easy process.

**What timeframe is NHC Advantage working for building out a provider network?**
The Plan needs to have provider agreements in place by January 31, 2016 in order to meet CMS’ deadlines for submission. CMS accepts agreements counted towards the network as that which is fully executed with NHC Advantage by both parties.

**About NHC**
At National HealthCare Corporation, NHC, care is our business. Care that respects the individual. Care that promotes recovery, well-being and independence. Care that seeks to meet all standards of quality.
Missouri Psychiatry

This monthly newsletter is prepared by APA’s Communications Team as a benefit for our District Branches and State Associations. Feel free to share the articles below in your own newsletter. If you have any questions, please contact James Carty at jcarty@psych.org or 703-907-8693.

Want to keep up with APA in between newsletters? Connect with us on Facebook, Twitter (@APAPsychiatric) and LinkedIn for the latest news and updates.

What’s New at the APA
- On Dec. 11th, APA applauded the senate passage of the “Comprehensive Justice and Mental Health Act,” introduced by Senators Al Franken (D-Minn) and John Cornyn (R-Texas). The bill includes provisions that support APA’s mission of reducing the number of people with serious mental illness in our nation’s jails.
- On Dec. 14th, APA President Renee Binder participated in a congressional briefing on the Medicaid IMD Exclusion. Dr. Binder led a panel that included former APA President Steve Sharfstein, Joe Parks, Missouri HealthNet director, and Mark Covall, President and CEO of NAPHS.
- The NIH received $32.1 billion in funding for medical research in the year-end budget deal, fully funding Precision Medicine and BRAIN initiatives, and providing a major boost for Alzheimer’s and cancer research. APA is a steadfast supporter of NIH and funding for medical research.
- APA Members are encouraged to urge their member of Congress to protect patient safety in mental health treatment by opposing the Medicare Mental Health Access Act (H.R. 4277). The bill would define psychologists as “physicians” under Medicare, a designation that does not equate to the medical education residency training undergone by Medical Doctors. Encourage your Member of Congress to oppose the bill.

Mark Your Calendar
- National Stalking Awareness Month (January)
- National Winter Sports TBI Awareness Month (January)
- APA Election Voting Opens Jan. 4

Briefs For Your Newsletter

Voting for APA Elections to Open January 4
The final slate of candidates has been set, and the voting for the most visible leadership positions at the APA will commence on Jan. 4th. Voting will remain open until the deadline on Feb. 1 at 11:59 p.m. ET. For more information on the candidates and voting process, please visit APA’s Elections page.

APA Annual Meeting 2016 Registration Now Open
Early Bird registration rates for APA Annual Meeting 2016 are available for members and non-members until Feb. 4th. Register today and save!

Legal Information and Consultation Available to APA Members
As one of your member benefits, APA has an agreement with Anne Marie "Nancy" Wheeler, J.D., to offer confidential triage consultation on practice-related issues to APA members at a preferred rate. She will also provide names of local counsel when your issue requires representation or an opinion based on your state’s law. All plan options include a quarterly e-newsletter that covers legal issues related to the practice of psychiatry and includes an FAQ section. (This plan is not available to members residing or practicing in North Carolina.)

Apply to Be a Fellow of the APA
Take your psychiatric career to the next level and become a fellow of APA. Fellow status is an honor that reflects your dedication to the work of APA and signifies your allegiance to the psychiatric profession. It’s easy to apply. Download and complete the application for fellowship before Sept. 1 and be recognized by your colleagues as a member of this select group at the 2017 annual meeting.

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January 7, 2016 — On January 4th, President Obama released a series of executive actions to reduce gun violence, including a final rule from the Department of Health and Human Services. This final rule amends HIPAA’s Privacy Rule to “remove unnecessary legal barriers preventing States from reporting relevant information about people prohibited from possessing a gun for specific mental health reasons.”

BACKGROUND
The federal Gun Control Act of 1968 has categories of people prohibited from gun ownership, including any individual “who has been adjudicated a mental defective or who has been committed to a mental institution.” Commitment under this law refers to involuntary commitment and excludes voluntary admission or admission for observation. (Note that there are pending regulations to modify the term “mental defective.”)

The Brady Handgun Violence Prevention Act of 1993 established the National Instant Criminal Background Check System (NICS), and required those purchasing guns from federally licensed firearms dealers to first pass a background check. Run by the FBI, gun sellers must run prospective buyers through this system to see if the buyer is disqualified from owning a gun. Participation in NICS is voluntary; states are not required to provide names of individuals prohibited from gun ownership due to mental health issues.

In 2008, Congress passed the NICS Improvement Amendments Act. Among other things, this law created financial incentives to improve reporting to the NICS those individuals prohibited from gun ownership due to mental health issues. However, states were still not reporting, due in large part to privacy concerns such as HIPAA. Under the Privacy Rule, releases of patient information for governmental purposes and law enforcement can only be made if “required [not just allowed] by law.” At my last count, only 23 states “require” reporting to NICS.

In 2013, President Obama signed 23 executive orders addressing gun violence, including HHS’ amendment to the Privacy Rule to increase NICS reporting. Three years later, that amendment was published in today’s Federal Register.

WHAT IS THE NEW LAW?
HIPAA’s Privacy Rule § 164.512 “Uses and disclosures for which an authorization or opportunity to agree or object is not required” is amended to add a new paragraph (k)(7) which says:

(7) National Instant Criminal Background Check System. A covered entity may use or disclose protected health information for purposes of reporting to the National Instant Criminal Background Check System the identity of an individual who is prohibited from possessing a firearm under 18 U.S.C. 922(g)(4) [the mental health prohibitions] provided the covered entity:

(i) Is a State agency or other entity that is, or contains an entity that is:

(A) An entity designated by the State to report, or which collects information for purposes of reporting, on behalf of the State, to the National Instant Criminal Background Check System; or

(B) A court, board, commission, or other lawful authority that makes the commitment or adjudication that causes an individual to become subject to 18 U.S.C. 922(g)(4); and

(ii) Discloses the information only to:

(A) The National Instant Criminal Background Check System; or

(B) An entity designated by the State to report, or which collects information for purposes of reporting, on behalf of the State, to the National Instant Criminal Background Check System; and

(iii)(A) Discloses only the limited demographic and certain other information needed for purposes of reporting to the National Instant Criminal Background Check System; and

(C) Does not disclose diagnostic or clinical information for such purposes.

THINGS TO KEEP IN MIND:
• There is no new reporting requirement created under this amendment.

The amendment explicitly permits the pre-existing reports to be made without violating HIPAA.

• Not every psychiatrist who involuntarily commits an individual will have to make a report to NICS.

NICS reporting is done by the State, and typically by the mental health facility rather than by an individual physician.

Some states prohibit such reporting.

(Continued on page 17)
**HIPAA and NICS continued**

- Not every individual with a mental health diagnosis is affected by this law.

From HHS’ comments: “...we emphasize...that a mental health diagnosis does not, in itself, make an individual subject to the Federal mental health prohibitor, which requires an involuntary commitment or adjudication that the individual poses a danger to self or others or lacks the mental capacity to contract or manage his other own affairs....the Federal mental health prohibitor, which applies only where an individual has been involuntarily committed or otherwise has received a relevant adjudication from a court, board, commission, or other lawful authority...”

- The covered entities making the report are few.

Some states have entities other than covered entities responsible for the reporting

* For example, California law requires mental health facilities to report involuntary commitments to the state DOJ; the state DOJ then makes the report to NICS

From HHS’ comments:

* “…limiting the permission to those covered entities that also perform an adjudicatory or data repository function.”

* “This final rule applies only to covered entities that function as repositories of information relevant to the Federal mental health prohibitor on behalf of a State or that are responsible for ordering the involuntary commitments or other adjudications that make an individual subject to the Federal mental health prohibitor....Our understanding is that, for the most part, formal adjudications and repository functions of this nature are conducted by entities, such as court systems or law enforcement agencies, that are not covered by HIPAA.”

- This is only federal law – state law could prohibit such disclosures.

From HHS’ comments: “…because the Privacy Rule, as modified by this final rule, only permits (but does not require) the disclosure for NICS reporting, State laws that prohibit such disclosures are not contrary to the Privacy Rule, and covered entities in States with such laws remain subject to any applicable prohibitions against disclosures under State law.”

**January 8, 2016** – In my last post, I commented on one of President Obama’s gun control actions – amending HIPAA’s Privacy Rule to explicitly permit covered entities to release names of those involuntarily committed to NCIS.

In this post, I want to address two more concerns about the President’s gun control initiatives:

1. NOTHING in the executive actions requires – or even allows – mental health professionals to discuss their concerns about patients with law enforcement. I realize that many news reports, including those from very credible sources, are saying this, but it is not true. For a great analysis of how this false information likely came about, see Dr. Ford Vox’s article for CNN.

2. There is a new entity that the President is hoping to have report individuals disqualified from gun ownership due to federal mental health prohibitors. That entity is the Social Security Administration (SSA).

My thoughts? Not only does this raise privacy issues, but I don’t believe that a SSA disability determination includes the risk of gun ownership. For an excellent analysis, see Dr. Liza Gold’s comments in this news report.

For more information about the mental health prohibitions on gun ownership, including any individual “who has been adjudicated a mental defective or who has been [involuntarily] committed to a mental institution.” A “mental defective” [there are proposed regulations to amend this term] is defined to include an individual lacking the mental capacity to manage his own affairs.

According to the White House: “The Social Security Administration (SSA) will begin the rulemaking process to ensure that appropriate information in its records is reported to NICS. The reporting that SSA, in consultation with the Department of Justice, is expected to require will cover appropriate records of the approximately 75,000 people each year who have a documented mental health issue, receive disability benefits, and are unable to manage those benefits because of their mental impairment, or who have been found by a state or federal court to be legally incompetent. The rulemaking will also provide a mechanism for people to seek relief from the federal prohibition on possessing a firearm for reasons related to mental health.”

For more information about the mental health prohibitions on gun ownership, and information on restoration of gun rights, I can highly recommend a chapter I co-authored, along with Dr. Liza Gold, in Gun Violence and Mental Illness (APPI, 2015).
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Top Three HIPAA Lessons Learned in 2015

Justin Pope, J.D., Associate Risk Manager
Professional Risk Management Services, Inc. (PRMS)

1. Encrypt!
Admittedly, this lesson should have been learned quite some time ago. In 2014, one-third of Office of Civil Rights’ (OCR) resolution agreements were related to the improper disclosure of protected health information (PHI) due to the theft of an electronic portable device. In 2015, half of OCR’s case resolution agreements involved the theft of portable devices. While the inability to safeguard devices in these cases is alarming, even more troubling is the fact that investigated covered entities failed to encrypt their portable devices.

The U.S. Department of Health and Human Services defines encryption as “a method of converting an original message of regular text into encoded text.” This past year, St. Elizabeth’s Medical Center (SEMC), Cancer Care Group (CCG), and Lahey Clinical Hospital each incurred the wrath of OCR after having unencrypted laptops stolen, agreeing to pay millions in resolution settlements. These breaches could have been avoided by encrypting laptops and making PHI indecipherable to thieves. In recent years, OCR has been fairly vocal about the need encrypt portable devices housing sensitive PHI. Under HIPAA’s encryption safe harbor, the loss of encrypted portable devices is not deemed to be a breach. We hope more physicians take advantage of this safe harbor by encrypting in 2016.

2. A “thorough and accurate” risk assessment is a great start.
In 2015 case resolution agreements, OCR consistently noted that investigated covered entities failed to do “thorough and accurate” risk assessments. The Security Rule requires covered entities to engage in a scrupulous analysis of potential threats and vulnerabilities and implement policies and procedures accordingly.

For those investigated entities that did make such an assessment, OCR most frequently criticized the scope of the assessment and/or the failure to effectively implement policies that addressed the risks.

Have you determined what type of PHI you store and the manner in which you store it? Do you know who has access to your PHI? These are two questions that would likely need to be addressed in a thorough risk assessment. In November, Triple-S Management Corporation learned this lesson the hard way when they were forced to settle with OCR for $3.5 million. After ending its investigation, OCR found that, among other violations, Triple-S did not conduct an adequate risk assessment and consequently failed to revoke database access rights for two former employees who accessed member names, diagnostic codes, and treatment codes while working for a competitor.


3. Technology can help and hurt.
Advances in technology have made new software platforms and systems available to practices, streamlining clinical care and enhancing workplace efficiency. However, before using any platform that manages PHI, it is important to understand the way in which the platform stores and protects that data. Discussing the platform with your IT department or IT consultant will be essential because you will need to understand how it works in order to properly assess for threats and vulnerabilities.

Keep in mind that certain platforms, systems, or applications may not have been intended to store PHI, and, as a result, may not meet HIPAA’s security standards. In the previously mentioned case resolution agreement involving SEMC, OCR also found that certain SEMC employees wrongfully used an “internet-based document sharing application” to store the PHI of approximately 500 individuals. Covered entities shouldn’t assume that any platform is HIPAA compliant. If you are going to use a platform that stores or accesses PHI, the maker of the platform should be able to provide an assurance that the platform is indeed HIPAA compliant and should also be willing to sign a business associate agreement. You might be surprised to find that some widely used platforms may not be HIPAA compliant.

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Four Outstanding Mental Health Programs to be Honored at IPS: The Mental Health Services Conference

The American Psychiatric Association today will recognize four outstanding mental health programs with Psychiatric Services Achievement Awards at the 2015 IPS: The Mental Health Services Conference. The top award winners are the Missouri Community Mental Health Center Health Home Program and the Sexual Behaviours Clinic in Ottawa, Canada.

The awards recognize innovative programs offering services to people with mental illnesses or disabilities that can serve as models for other programs. They will be presented at the Opening Session of the conference at the Sheraton New York Times Square on Oct. 8, noon – 1:30 p.m. Several of the award winners will discuss their programs at a special session from 2 p.m. – 5 p.m. Brief descriptions of the award-winning programs are provided below and detailed descriptions are presented in the October issue of Psychiatric Services.

Sexual Behaviours Clinic, Ottawa, Ontario
Gold Achievement Award – Academically/Institutionally Sponsored Program
In recognition of its commitment to improving community safety by providing treatment to a highly marginalized clinical population, the Sexual Behaviours Clinic (SBC) was selected to receive APA’s 2015 Gold Achievement Award in the category of academically or institutionally sponsored programs. Through a combination of medications and psychotherapy, SBC’s pioneering treatment program for sex offenders has achieved remarkable success, lowering recidivism rates to near zero. Treatment is provided by a multidisciplinary team. To help ex-offenders avoid falling back into old patterns, the SBC has developed partnerships with community organizations.

Missouri Community Mental Health Center Health Home Program, Jefferson City, MO
Gold Achievement Award – Community-Based Program
In recognition of its leadership in establishing “health homes” to provide integrated care to its clients and demonstrating dramatic improvement in health outcomes and reduced costs of care, Missouri’s Community Mental Health Center (CMHC) Health Home Program was selected to receive APA’s Gold Achievement Award for community-based programs. Missouri’s Department of Mental Health collaborated with the state’s Medicaid system (MO HealthNet) and community mental health system to establish “health homes” throughout the state’s 29 CMHCs. This allows Medicaid enrollees to receive mental health care and primary care for targeted medical conditions. Clients receive annual screening, social and functional skills training, and treatment planning. After the first year, the program resulted in $31 million in Medicaid savings and significantly improved health outcomes.

Mental Health Association of East Tennessee, Knoxville, TN
Silver Achievement Award
In recognition of its integrated outreach programs that provide prevention and early intervention for thousands of students annually, the Mental Health Association of East Tennessee (MHAET) was selected to receive APA’s 2015 Silver Achievement Award. For 15 years, MHAET has worked in schools to help ensure prevention, early recognition, and treatment of mental health problems. The programs reach both students and teachers: Mental Health 101 for middle and high school students and training for teachers, including Typical or Troubled?, a program of the American Psychiatric Association Foundation. In the 2014–2015 school year, these programs had a direct impact on nearly 24,000 students in 83 schools in eastern Tennessee.

Bronze Achievement Award
In recognition of its innovative approach to large-scale dissemination of collaborative care for low-income seniors, SUSTAIN (Supporting Seniors receiving Treatment And Intervention) was selected to receive APA’s 2015 Bronze Achievement Award. SUSTAIN, a private-public partnership of the Pennsylvania Department of Aging and the University of Pennsylvania’s Department of Psychiatry, identifies elders at risk of poor health outcomes, including nursing home admission, and supports them and their primary care prescribers in managing their mental health care. Since 2010, SUSTAIN staff have engaged more than 4,500 patients and family caregivers in a range of behavioral health services.

Certificates of Achievement
This year two additional programs are being recognized with Certificates of Significant Achievement:

- CHARG Resource Center Heartland Clinic, Denver, Colo.

The winning programs were selected by the Psychiatric Services Achievement Awards Committee, chaired by Christina J. Arredondo, M.D., and the award program is supported by the APA.

The American Psychiatric Association is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention, and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org.
New Evidence for Air Pollution as Autism Risk

An interaction between genes conferring risk for autism and the prenatal environment may be occurring near the freeways and heavily traveled streets of Los Angeles, according to Beate Ritz, M.D., Ph.D., a professor of epidemiology at the University of California, Los Angeles.

Studies of the effects of air pollution have typically tracked growth, lung function, or mortality in developing children but less often on fetuses, said Ritz on Sunday at the annual meeting of the American Association for the Advancement of Science in Washington, D.C.

So Ritz and her colleagues used data from 200 air monitors emplaced across Los Angeles according to a land use regression model they developed. This model was based on approximately 300 measurements of outdoor air pollution taken during 2006-2007 in locations across Los Angeles County. The researchers linked that information with 7,603 cases of autism among children born in Los Angeles from 1995 to 2006 and diagnosed with autism between 1998 and 2009 as recorded by the California Department of Developmental Services. The researchers compared each child in this cohort with 10 children who were born during the same period but did not have autism.

The researchers found an increased risk of autism of 9 percent for higher interquartile rates of ozone, 8 percent for particles 2.5 [mu]m or smaller, and 9 percent for nitric oxide and nitrogen dioxide exposure. Research by others has suggested that prenatal exposure to these pollutants may have adverse neuromotor or neurobehavioral effects. Ritz also observed higher rates among children of mothers with less than a high school education, a pattern opposite to that seen in clinics, where children of better educated parents present more frequently.

Although pollution levels have declined in Los Angeles in recent decades, the study suggests that heavily polluted cities like Beijing should be concerned about the connection with autism, Ritz concluded.

For more in Psychiatric News about air pollution and autism risk, see “Autism Linked to Air Pollution In Preschool Children.”

Reprinted from Psychiatric News

Mark Your Calendar

Joint Annual Conference with the
Missouri State Medical Association 158th Annual Convention

“Psychiatric Advocacy”
Renaissance St. Louis Airport Hotel, St. Louis MO
Saturday, March 19, 2016

~ AGENDA ~

8:00 - 9:00 am  MPA Executive Council Meeting
9:00 - 9:30 am  General Membership Meeting
9:30 - 11:30 am “Advocacy Training: The Importance of Grassroots Advocacy on the State and Federal Levels” Speaker: Pamela Thorburn, MPSA, APA
11:30 - 12:30 pm “Ways to Eliminate the Psychosocial Causes of Community Disruption and Marginalization - An Update” Speaker: Dr. Roy C. Wilson, Resilience Coalition
12:30 - 1:00 pm Buffet Luncheon
1:00 - 3:00 pm “Seizing the Day: A Trans-Generational Approach to Higher-Impact Prevention of Psychiatric Conditions of Childhood” Speaker: John N. Constantino, MD, Washington University School of Medicine
Missouri Psychiatry

“Road Map to Power”

I am pleased to announce the release of Dr. Arshad Husain’s newest book, *Road Map to Power* (MSI Press), that he co-authored with his educator son, Darius Husain, Executive Director of *Face to Face Academy*. *Road Map to Power* is a direct response to a society that, despite climbing out of one of the most crippling Recessions in its history, still operates under a general malaise and cloud of pessimism. The book breaks down the root causes for these feelings of loss of control in one’s life and the lack of hope for the future. In the end, Road Map to Power provides a new, inwardly focused path forward that promotes dignity, satisfaction, and happiness. Part of Road Map to Power’s strong research foundation includes many topics and themes relevant to those in the Medical and Mental Health field.

Themes include:
- Building Resiliency in Youth
- Effects of Media exposure on Youth (especially vulnerable youth)
- Attachment Theory and the Importance of a Secure Attachment
- Real Self, Ideal Self, and Self Schema
- Bullying
- Trauma and PTSD
- Striving for a values based life through a Straight Path

Dr. Husain is humbled by the overwhelming positive support Road Map to Power has received since its release just a few weeks ago. Road Map to Power was named an “Amazon Hot New Book” and has earned critical acclaim from multiple sources. Here is a link to a few of the “5 Star” reviews: https://readersfavorite.com/book-review/road-map-to-power

Because no personal accolades could be possible without direct guidance of the Creator and in the spirit of Road Map to Power’s central message, “be more than Humane, be a Humanitarian,” *all author’s proceeds from book purchases will go directly to the International Medical and Educational Trust (IMET)*. IMET’s non-profit initiatives include it’s work with children exposed to unspeakable acts of trauma, a hospital and clinic for the underprivileged in Karachi, Pakistan, and a vastly growing school for those who otherwise would lack any access to education (also in Pakistan). To learn more about IMET’s mission visit click on the following link: http://imet.us/

To purchase your copy of *Road Map to Power* both in Paperback and Kindle please visit:
http://www.amazon.com/Road-Power-Syed-Arshad-Husain/dp/1942891040/ref=sr_1_1?ie=UTF8&qid=1443459363&sr=8-1&keywords=Road+Map+to+Power

To learn more about Road Map to Power and its authors please log on to:
www.roadmaptopower.com

Sincerely,
Allison Thurman

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I would like to take this opportunity to congratulate Dr. Husain on his book, “Road Map to Power.” The thoughtful and captivating work offers hope for a life of true freedom. In his book, he dissects the meaning of power and success and challenges the reader to undertake a journey filled with generosity and service of others. The stories he shares impart practical wisdom for improving the reader’s life. The book reflects on Dr. Husain’s personal experiences and his more than 40 years of work that has taken him all over the world. By the time you finished this book, it will challenge how you choose to spend your time and ultimately your life.

- Dr. Balkozar Adam
You and the American Psychiatric Association—A Career-long Partnership

KNOW THE FACTS ABOUT APA MEMBERSHIP

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For more information, call 703.907.7300 or email membership@psych.org.
Until recently, hoarding was considered an adult disorder, but emerging research has shown that hoarding behavior can start in childhood. In fact, it is not uncommon for children younger than 6 to hoard things. Pediatric hoarding is chronic, progressive and a poor prognostic factor. Children who hoard have reduced social functioning, quality of life and insight.

Children with hoarding disorder often do not present to clinic complaining of this behavior. Instead, many times they present with Attention Deficit Hyperactivity Disorder, Obsessive Compulsive Disorder or even Autism Spectrum. Historically, hoarding was considered to be a symptom or subtype of OCD.

While pediatric hoarding is not a current DSM diagnosis, DSM-5 in 2013 recognized hoarding as a diagnosis for adults (1). In addition, there are several indicators that hoarding exists in children and adolescents, separate from OCD. Research shows that many patients with hoarding disorder did not actually present with concurrent OCD (2). Hoarding symptoms may result from deficits in information processing, beliefs about and attachments to possessions, emotional distress and avoidance behaviors (3).

The DSM-5 criteria include: a persistent difficulty in discarding or parting with possessions, regardless of their actual value; perceived need to save items and distress associated with discarding them; and an accumulation of possessions that clutter living areas and compromises their intended use.

Because hoarding is such a new diagnosis, clinicians often fail to ask specific questions. For example, “Do you find it difficult to throw away items you no longer need or use? Do you have a strong urge to save unneeded items? Do you keep things despite of lack of storage space? Do you feel distress throwing items away?”

It is important to note that excessive acquisition of items, be they purchased or free, is not a criterion for hoarding disorder. Clinicians must differentiate between adverse hoarding symptoms and developmentally appropriate child behavior of acquiring and collecting things. Also, while some kids have both hoarding disorder and OCD, hoarding can be present in absence of OCD in children and adolescents (4). If hoarding disorder is present in childhood, it is more likely to persist into adulthood. While hoarding can start before age 6, the average age is 11-20 years old (5).

Hoarding looks different in children compared to adults. Children can hoard a variety of items, including candy wrappers, empty soda cans, wrapping paper, old magazines, broken toys and school papers and pens. Unlike adults, children have less control over their environment. That also means that while adults can fill up an entire house, children are typically limited to their bedroom. Parents also can offer control and organization. They can refuse to pay for items and de-clutter. Of course, that’s only possible if the parents do not have hoarding disorder. Research shows that hoarding runs in families and that genetics play a role, along with environment.

Estimates put hoarding in the adult community between 2 and 6 percent. The impact is harmful. One study found that adults with hoarding disorder reported an average of 7 days a month of work impairment (more than patients with anxiety or depression). They also reported utilizing mental health services five times as often, with chronic and severe medical problems (6). The community also is at risk, as there is increased chance of fire and sanitation problems (7).

There are a number of assessment tools to help clinicians, chief of which for children is the Children’s Saving Inventory (CSI) (8). It is imperative to study this topic further and gain additional data on hoarding-specific treatment modalities. Current treatment studies in pediatric patients with hoarding symptoms are lacking. Pharmacotherapy with serotonergic antidepressants and cognitive-behavioral therapy involving exposure and response prevention are effective in reducing OCD symptoms (9). However, they are generally not effective with patients with hoarding problems (10). A case study found that treating hoarding disorder in childhood with behavioral modification and psychoeducation was effective (11). If clinicians are able to diagnose and treat hoarding disorder before adulthood, there is a chance to avoid the many negative outcomes and reduce the risk of depression, alcohol use disorder, injury and even death.

References

(Continued on page 25)
The Stepping Up Initiative

Renee Binder, MD, APA President
Saul Levin, MD, MPA, APA Foundation Chair
Fred Osher, MD, Director of Health Systems & Services Policy, CSG Justice Center

A partnership of The American Psychiatric Association Foundation, the Council of State Government Justice Center & National Association of Counties

As you may already be aware, in response to the tragedy of huge numbers of persons with serious mental illnesses in the criminal justice system, the American Psychiatric Association Foundation (APAF), the Council of State Governments Justice Center (CSG Justice Center), and the National Association of Counties (NACo) are spearheading an unprecedented national effort to help counties reduce the number of individuals cycling through our jails: the Stepping Up Initiative (www.stepuptogether.org). Stepping Up unites county leaders, state and local policymakers, criminal justice and behavioral health professionals, people with mental illnesses, and other stakeholders in a single goal: to safely reduce the number of people with mental illnesses in the nation’s jails. A National Summit will take place in Washington, D.C., in April 17-19, 2016. We are writing to encourage psychiatrists at the local level to participate in the Stepping Up initiative.

Ways to Become Involved
Visit the Stepping Up website for updated information on the initiative. (This page in particular will show which counties have already passed supportive resolutions: https://stepuptogether.org/what-you-can-do.) Then consider deeper involvement by identifying the psychiatrists within your District Branch with expertise and passion on this topic. Meet with county leaders to advance the planning process. And help your community put forward the strongest possible application to attend the summit so that a team from your state can come to D.C. in April. Psychiatric involvement is one of the criteria for these competitive applications. If a county in your state is selected for the Summit, we hope one of your DB’s members in that county will be a part of the team.

If you need to contact your local officials, go to http://explorer.naco.org/, click on “County Search” and type in the desired county. This will give you a contact phone number for the County Board of Commissioners/Supervisors. The person who answers the phone can direct you to the best person to talk with about getting involved. If you encounter difficulties, let the APA Foundation staff know.

This is a significant moment in time where everyone acknowledges that jail is the wrong spot for people with mental illnesses that do not pose a risk to public safety. The Summit is a serious new investment in raising attention and marshaling support for change. Together we can turn this moment into a movement that promotes recovery among our most disabled citizens and helps make our communities safer. If you have questions about how to get involved, please write to APA Foundation Executive Director Paul Burke at pburke@psych.org.

Hoarding: Not Only An Adult Disorder continued

January 15, 2016

Dr. Jo-Ellyn M. Ryall
Missouri Psychiatric Association
722 E Capitol Ave
Jefferson City, MO 65101

Dear Dr. Ryall,

On behalf of NAMI St. Louis, I thank you for your generous $500.00 donation for our 2016 NAMI Walk.

The theme of our Walk on May 28, 2016, is “NAMI Walks for the Mind of America.” Research and the improvements in diagnosis and treatment that follow hold promise for a better quality of life for those suffering from mental illness. The Walk raises awareness of mental illness and the challenges a diagnosis brings both to the person affected and their family. By educating others in this way, we help reduce stigma, which in turn also helps bring about a better treatment outcome.

The funds raised through our Walk are used for the free programs and services that NAMI St. Louis provides to the St. Louis community. Again, many thanks for making our work possible. I am certain that you join with me and all of our NAMI families, psychiatrists and mental health providers in looking forward to the day when mental illness is thought of and treated like any physical illness.

If someone ever confides to you that a friend or close relative has been diagnosed with a mental illness, I hope you’ll tell them about NAMI St. Louis and help spread the word about the free programs and services we offer. Our website is: www.namistl.org, and our HELP Line number is: 314-962-4670. We are here to help you and those you care about!

This letter substantiates that you received no goods or services as a result of your donation. Therefore it qualifies in full amount as a charitable contribution for tax purposes.

Sincerely,

Darwyn E. Walker
Executive Director
Media Benefits for MPA Members

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

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

2. **Reduced newsletter ad rates.** MPA members may place any size ad in *Missouri Psychiatry*, MPA’s quarterly newsletter, for 50% off the regular rate. *Missouri Psychiatry* reaches nearly 500 MPA members and associated healthcare professionals in the state and appears online at the MPA 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. *Missouri 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 *Missouri Psychiatry*, Missouri Psychiatric Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to donmoise@hotmail.com. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

We strive to offer content in *Missouri 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, *Missouri Psychiatry*, 722 E. Capitol Avenue, Jefferson City, MO 65101, or sandyboeckman@gmail.com.

Submit items specific to your local office to:

Central Missouri Regional Office: Hina Syed at hinsayedcmps@yahoo.com; Eastern Missouri Regional Office: Paul Simon at Ps13_99@yahoo.com; Western Missouri Regional Office: Dr. Bob Batterson at bbatterson@cmh.com

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