President’s Message

By Susan Minchin, MD

“It was the best of times. It was the worst of times......”

This is a unique time for psychiatrists. There is much promise and hope to be gained from the explosion of information about the brain. The development of new technology has increased the ways the brain and mental illness can be studied, volumes of research published each year reveal more and more information about the brain and mental illness; pharmaceutical companies are devoting more research funds to increasing development in the neuroscience pipeline and, now, more attention is finally being given to the connection between the brain and all other organ systems in the body. The world of medical research is looking at the entire body as a complex system of communication and interaction between your head and your toes and everything in between. It is exciting to see treatment options that include manipulating chemical signaling and electrical signaling in the brain to achieve better outcomes for our patients.

However, we have so many difficult challenges facing the field of psychiatry. Challenges that demand time and attention from mental health professionals NOW: inadequate funding for mental health care, the public image of the mentally ill; the criminalization of persons with mental illness; the need for public education regarding the benefits and risks of legalizing marijuana; mass homicides attributed to persons with mental illness; access to psychiatric care; physician assisted suicide; the growing presence of physician burnout; the wide discrepancy in the quality of care delivered by licensed mental health professionals; restrictions on inpatient and outpatient treatment for patients experiencing exacerbations of severe illness; the discrimination persons with psychiatric illness face when seen by other medical specialties; the advances of personalized medical treatments based on genotypes while managed care continues to push its “one size fits all” treatment plans ...... I could go on and on.

Two of our toughest challenges are that of decreasing the stigma attached to mental illness and improving access to mental health care. As mental health providers we still must fight.... along with those who suffer from mental illness and those that watch their loved ones struggle with mental illness... fight the constant presence of s-t-i-m-a. Stigma that causes people to avoid getting help until a crisis develops, stigma that keeps family from getting help for loved ones and instead adapt to their loved one’s “eccentricities”, stigma that causes best friends to keep secrets from each other about the health of their family members, stigma that keeps the mentally ill as outsiders to any other group in society. Consider this – it may be very difficult for a person with mental illness to be accepted even by members of their own church. They may well be afraid of you after they learn that you suffer from mental illness and are, in fact, disabled by the illness.

Our other biggest challenge is providing mental health care to those who seek it. Access is extremely limited. If mental health care is available, one may need to wait three to six months to be evaluated as a new patient in either a private practice or a public clinic. This is the irony – the world of organized mental health providers know how hard it is for someone to finally decide to get treatment, yet the availability of mental health providers, especially in rural areas is critically limited. If one is ‘lucky’ to find a practice or clinic taking new patients, the time until the next available appointment can easily be three or more months away.

Addressing just these two challenges of access to care and erasing stigma is overwhelming – even for organized groups of psychiatrists, groups of other mental health professionals, and patient advocacy groups. But it is extremely important that we begin to work together to find solutions to these challenges. This is what I would like to see the Missouri Psychiatric Association and its membership devote time and creative energy to over the next few years.

In the next few weeks all members of the Missouri Psychiatric Association will be receiving a survey via email about what you would like to see the Missouri Psychiatric Association do for you. Are you interested in more opportunities for CMEs? Are you interested in meeting your colleagues across the state to discuss job opportunities? Are you interested in interacting with the APA and/or the AMA as we address current issues? Are you interested in creating pressure in the political arena to increase funding for mental health care? We will also be looking for ideas on how to increase member participation in both regional conferences and national meetings.

I do have one request of all of the members of the Missouri Psychiatric Association – and I would like you to consider requesting this of your own colleagues – I would like all of us to make a point to communicate the intellectual and emotional fulfillment that you feel in your chosen career. I believe if you can communicate to others how fulfilling your practice is to you, you can spark interest in your colleagues and friends for the field of behavioral health. If you can show others how rewarding a career in mental health can be, perhaps we can recruit health professionals of all types to join us in the field of mental health care. We must increase the number of health professionals interested in practicing in the mental health field in order to begin to fill this void of providers. This is the only way we can adequately care for all those in need of treatment. I have been practicing psychiatry in Saint Louis for over twenty years, and as I see it, there will never be enough mental health professionals – even in the city of Saint Louis.

Susan
2016 Distinguished Service Award Nominations

Nominations for the Distinguished Service Award (DSA) are now being accepted. Please submit nominations to ctobita@psych.org by October 31.

The Distinguished Service Award was established in 1964 by the Board of Trustees to honor an APA Distinguished Fellow, Fellow, General Member, nonmember, or organization who has contributed exceptional meritorious service to the field of psychiatry.

Nominations should include the full name and contact information for the nominee as well as a 150 word statement and CV describing the nominee's contributions to psychiatry.

2015 Distinguished Service Award Recipients

- Jack W. Bonner, MD
- Joseph T. English, MD
- Dilip V. Jeste, MD
- Wayne J. Katon, MD
- Helen Mayberg, MD
- Academy of Psychosomatic Medicine

2014 Distinguished Service Award Recipients

- Carl Bell, MD
- David Fassler, MD
- Ivan Goldberg, MD
- Laura Roberts, MD
- Joel Yager, MD
- The Jed Foundation

2013 Distinguished Service Award Recipients

- Ronald M. Burd, MD
- David J Kupfer, MD
- The John A. Hartford Foundation

Help Support NAMI and MPA!

PRMS, the manager of The Psychiatrists’ Program, has an referral initiative that can benefit NAMI St. Louis. PRMS will make a donation of $25 to NAMI on behalf of the Missouri Psychiatric Association (MPA) for every MO referral received from one of its insured psychiatrists who are members of MPA. Please consider participating if you have colleagues who might want to purchase medical professional liability coverage. To register your referral and get credit for NAMI/MPA, contact Victoria Chevalier, Assistant Vice President, Underwriting, at (703) 907-3804 or (800) 245-3333 or chevalier@prms.com.
**Missouri Legislative Agenda for 2016**

James Fleming, MD, MPA Legislative Chair

APA Assembly Representative

(Please note the following article represents the views of Dr. Fleming and do not necessarily represent an official view of the MPA or APA except where stated on specific issues. Thanks to MPA Lobbyist Mo McCullough for information on relevant legislative bills)

The following is a summary of two major issues impacting on the mental health of Missourians and in my view should be legislative priorities in the 2016 Missouri legislative session. The two issues overlap and are also connected with other trends in Missouri in recent years which many, myself included find very troubling.

**A. MEDICAID EXPANSION/REFORM**

Expansion of Medicaid in Missouri should be a top legislative priority in 2016. This would help the state meet the health needs of many citizens who now have to remain ill or even die due to lack of medical care. Missouri would receive approximately $900,000 from the federal government under the Affordable Care Act (ACA), which represents approximately an additional 25% of the amount we receive now to administer this program. Legislators and citizens in our state should be made aware that Medicaid expansion is supported not only by the Missouri State Medical Society, the APA and the Missouri Psychiatric Association but also by a large coalition consisting of other professional associations and healthcare organizations, as well as veterans and law enforcement groups, faith-based and others.

In order to pass Medicaid expansion it will be vital to work with these groups to help pass this necessary measure and we need to do a better job at explaining to both legislators and voters the benefits of passing this legislation as well as the consequences of continuing to block it.

The legislative leadership (which happens to be currently Republican) has given various reasons why they have resisted Medicaid expansion, most commonly stating that they don’t trust the federal government to not later require states to contribute a much greater share to cover the costs of the program in the years ahead. If there had been any examples of this in the past, I have not heard them cited. Because of the importance of this issue to one of the most vulnerable segments of the population we are called to serve, I asked about this at a special meeting of Legislative Chairs at the Area 4 meeting in Chicago last March. Jeff Regan, a staff member working in the APA Government Affairs office (and former U.S. Congressional staffer) could not think of any examples of this occurring when the question was posed to him. Some legislators in Missouri have also said the amount promised by the federal government would not cover the cost of the expansion. Those favoring expansion of Medicaid flatly refute this citing other budget figures. The argument also ignores several key facts which would be common sense to any business person:

1. The amount of funding from the federal government would represent a major influx of capital which would stimulate the economy of local communities and save some rural communities from financial collapse, depending as many do on their health care systems as primary sources of employment and economic activity.

2. Funding to hospitals for uncompensated care (of uninsured patients) was eliminated under the ACA, putting great financial strain on hospitals in states which have refused to expand Medicaid.

3. Much, if not most of the mental health care of seriously mentally ill persons in Missouri, takes place in our prisons and jails. Recent studies have shown that throughout the US more mentally ill patients reside in prisons and jails than in hospitals. While, much of this trend has to do with closing of mental health facilities, one has to wonder how many seriously mentally ill individuals end up incarcerated due to lack of insurance coverage leading to lack of care, regular medication usages, etc. Correctional facilities are not equipped to adequately treat this population and because of their illness, these individuals often end up in administrative segregation (commonly known as “solitary confinement”). Because of their difficulty adjusting to the stark conditions which include sensory and social deprivation, they frequently become even more disruptive leading to a vicious cycle resulting prolonged isolation and further deterioration. In addition to being very costly to house these individuals in this setting, it is clearly inhumane and not worthy of a country which prides itself on human rights and freedom.

*These situations also can lead to federal lawsuits contending violation of the 8th Amendment which prohibits cruel and unusual punishment, further burdening the Department of Corrections and raising costs. (See B below for more on this issue).*
there are problems with the system such as poor provider reimbursement compared to that of private insurance and Medicare which leads to low participation rates. Expansion alone will exacerbate the problems Medicaid recipients experience in finding a provider but approving the funding for higher provider reimbursement is likely to be difficult in the current budgetary climate. One way to offset lack of provider participation is to expand loan repayment programs for medical/osteopathic students and physician extenders (nurse practitioners and physician assistants) who work in health systems with high Medicaid populations. Another possible reform to Medicaid would be re-examine the formulary for medications which is available to Medicaid recipients. Pharmaceutical companies have successfully lobbied for and obtained coverage for the newest and therefore most costly medications Medicaid formularies. While an overly restrictive formally would not be in the interest of patients or their providers who are trying to provide treatment, a review process similar to Medicare or some responsible, private insurers could save the state significant funds. In recent years, some Republican legislators have submitted bills to reform Medicaid and expand Medicaid. We need to continue working in a bipartisan fashion to pass expansion but also need to confront the refusal to expand the program which has dominated the discussion since the establishment of the ACA. Some of our most vulnerable patients need more and stronger advocacy.

(*APA President Renee Binder, a forensic psychiatrist has spoken about these concerns and is planning a public event with judges, psychiatrists, and government leaders next spring in Washington, D.C to highlight the need for reform in this area. She has also helped start the "Stepping Up Initiative" intended to reduce the number of mentally ill people in jails and prisons by diverting minor offenders into treatment vs incarceration---see her column in the June 17, 2015 Psychiatric News Stepping Up to Address Our Nation’s Shame: Psychiatric News: Vol 50, No 14).

B. CRIMINAL JUSTICE AND CORRECTIONS

Even though the US constitutes only about 5% of the world’s population, 25% of those in prisons or jails worldwide are housed in our country and Missouri is no exception to this costly, wasteful, ineffective phenomenon. Long prison sentences for non-violent offenders and inflexible sentencing guidelines which restrict the decision-making abilities of judges to limit sentences have led to this intolerable and non-sustainable situation. Further exacerbating the problem is widespread intimidation of suspects by prosecutors who threaten excessively long and inappropriate prison terms which would never be approved in a jury trial. Defendants thus threatened, routinely accept plea bargain offers resulting in shorter, but still excessive and unnecessarily long prison terms. Problems associated with the mass incarceration of mentally ill individuals are addressed above.

Funding for educational and vocational training for offenders in Missouri prisons has fallen to an abysmal level such that offenders who could benefit from these programs do not have access to them and are simply warehoused along with repeat or truly dangerous criminals at a cost of approximately $25,000 per year ($35,000 or more yearly for those in administrative segregation).

In August 2014, the shooting death of Michael Brown, an unarmed African American male by a white police officer in Ferguson, Missouri set off protests and then rioting there, which triggered a massive military-type response by police and subsequent rioting. Subsequently, a federal review of the policing began, not only in Ferguson but in African American communities around the US. In March of this year, a Department of Justice investigation released a 102 page report outlining a pattern of racial profiling in Ferguson which, according to a St Louis Dispatch article (http://www.stltoday.com/news/local/crime-and-courts/doj-finds-ferguson-targeted-african-americans-used-courts-mainly-to/article_d561d303-1fe5-56b7-b4ca-3a5cc9a75c82.html) revealed an "out-of-control police department whose officers target African-Americans, stop and search people without reasonable suspicion, arrest people without probable cause, abuse their authority to quash protests, routinely ignore civil rights and use excessive force by unnecessarily using dogs, batons and Tasers." The report also described “a city government that uses its police and courts as an ATM, tolerating a culture of police brutality while pressuring the police chief and court officials to increase traffic enforcement and fees without regard to public safety.” This kind of strong condemnation of normally respected organizations may be difficult for many citizens to hear about, but should provide those of us who are “psychologically minded” with a better understanding of the factors leading to massive community unrest.

What happened in Ferguson in August was repeated in similar fashion elsewhere around the country, as national news reported

(Continued on page 5)
Missouri Legislative Agenda continued

more unarmed black men dying at the hands of police in New York, Baltimore and elsewhere and protests and further unrest erupted in these cities and others. In response to these events the Missouri legislature put forth several bills and did pass a bill to reform the state’s municipal court system which included restrictions on the percentage of income a municipality can collect from traffic fines or court fees, something which the DOJ report cited as a rampant problem in Ferguson. Because of a partisan fight in the Missouri Senate at the end of the legislative session over the “right to work” bill, several other measures died including one which would have updated a state law regarding police use of deadly force, and another to encourage the use of police body cameras.

The anniversary of Michael Brown’s death in Ferguson should provide a solemn reminder to state lawmakers that the conditions that led to tragedy and unrest in our state and which was repeated around the country, still desperately cry out for a solution. They should redouble their efforts in the next session to address ongoing problems and risks in community-police relations. **Having police routinely wear body cameras, for examples can protect both police and citizens and is supported by both police departments and community activists.** We also need major reform of our criminal justice system especially as it relates to the seriously mentally ill. An expansion of mental health and drug courts would be an important start as well as oversight of the use of administrative segregation for inmates identified as mentally ill.

**OTHER LEGISLATIVE ISSUES RELATED TO MENTAL HEALTH**

Bills on other issues relevant to mental health are likely to be brought up again, such as a prescription drug monitoring program intended to decrease inappropriate prescribing and diversion of controlled substances. A bill involving this probably would have passed were it not for the deadlock which occurred at the end of the session in 2015 due to a partisan fight over the “Right to Work” bill. Missouri is the ONLY state which does not have such a program and it needs to pass one.

I’d like to close with some thoughts on recent, disturbing trends in Missouri, Kansas and elsewhere to reduce government benefits to the poor and unemployed, a phenomenon which one Missouri state legislator referred to as “an all out war on the poor.” For example, in the last session, the Missouri legislature over-rode a veto by the governor of a bill which shortens the time poor families can receive TANF benefits (Temporary Assistance for Needy Families). The Department of Social Services estimates that 9,500 Missourians would lose benefits in the first year including 6,400 children. The governor referred to the bill as “mean spirited” and vetoed it because he believed it would punish children for the shortcomings of their parents. The leadership said there are other programs which will make up for the decreased support these families will experience but others, including myself, are skeptical. While not a mental health issue per se, it should be common sense that if poor families have difficulty obtaining food, clothing, shelter, transportation, etc. that this will have an adverse impact on the mental and physical health of entire family in the short term and will add to the risk of traumatization of children in the long term. It also not difficult to see how these effects can worsen crime and unrest in communities like Ferguson. Further, a study from Maine quoted by the Kansas City Star after the legislative override of the veto this spring, showed that similar cuts of benefits led to even greater dependency of poor families, and did not—as proponents of the measure in Missouri stated—help these families “escape the trap of poverty”. In my view its high time mental health professionals and others who see the impact of these speak out against these misguided cuts in services and support to our most vulnerable of citizens.

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**LOOKING FORWARD TO THE 2016 LEGISLATIVE SESSION**

Two thing will influence both the direction and the outcome of 2016. First due to the resignations of some key members of the general assembly, there will be new leadership in both the House and the Senate. The Republicans will still have firm control but the priorities will certainly be different. Secondly, 2016 is a huge election year on both a statewide and national level and this will affect the entire legislative process.

Once again right-to-work, Medicaid transformation, gun control, education, racial discrimination, and prescription drug monitoring will be on the forefront along with many other important issues. If nothing else, 2016 in Jefferson City promises to be an interesting and exciting year.

Mo McCullough
Enacted Legislation

HB 709, 8/28/2015, Rep. Don Gosen
Nurses: Scope of Practice &
Payment Level Parity
Changes the laws regarding entities
regulated by the Department of
Insurance, Financial Institutions and
Professional Registration.

SB 58, 8/28/2015, Sen. Bob Dixon
Licensed Marriage and Family
Therapist (LMFT)
SS/SB 58 - This act repeals a number
of committees that have dissolved or
expired as required by their
authorizing statutes. The defunct
committees are the Advisory
Committee on Tobacco Securitization
(section 8.597); Joint Committee on
Corrections (21.400 to 21.465); Joint
Committee on Capital Improvements
and Leases Oversight (21.530 to
21.537); Joint Committee on
Missouri’s Energy Future (21.830);
Joint Committee on the Missouri
Criminal Code review of sexual
offender registry (21.835); Joint
Committee on Solid Waste
Management District Operations
(21.850); Joint Committee on
Missouri’s Promise (21.920);
Missouri Investment Trust and its
board (30.953 to 30.971); Joint
Subcommittee on Recovery
Accountability and Transparency
(33.850); Committee on State-
operated Wireless Communications
Systems (37.250); Joint Committee on
Real Property Tax Increment
Allocation Redevelopment (99.863);
... (Please see bill detail).

SB 107, 8/28/2015, Sen. David Sater
Nurses: Scope of Practice &
Payment Level Parity
SCS/SB 107 - This act provides that
certain professional boards and
commissions, as specified in the act,
which license professions may issue
oral or written opinions addressing
topics relating to the qualifications,
functions, or duties of any profession
licensed by such board or
commission. The opinions are for
educational purposes, are not binding
on the licensee, and cannot be used as
the basis for discipline against a
licensee. A board or commission shall
not address topics relating to the
qualifications, functions, or duties of
any profession licensed by a different
board or commission. This provision
is similar to HCS/HB 422 (2015) and
HCS/SS/SB 58 (2015), and identical
to provisions contained in SCS/HCS/
HB 709 (2015), HCS/SB 392 (2015),
HCS/SS/SB 457 (2015), and HCS/
SCS/SB 146 (2015). The act also
modifies provisions of law relating to
the licensing of speech-language
pathologist... (Please see bill detail).

SB 145, 8/28/2015, Sen. David
Pearce
Mental/Behavioral Health
Insurance/ Mental Health Parity;
Psychiatrist
SS/SCS/SB 145 - This act requires
health benefit plans delivered, issued
for delivery, continued or renewed on
or after January 1, 2017, in
accordance with current law
requirements for coverage of mental
health disorders, to provide coverage
for the diagnosis and treatment of
eating disorders. The act further
requires that the provided coverage
include a broad array of specialist
services as proscribed as necessary
by the patient's treatment team.
Coverage under this act is limited to
medically necessary treatment and
the treatment plan must include all
elements necessary for a health
benefit plan to pay claims. Under the
act medical necessity determinations
and care management for the
treatment of eating disorders shall
consider the overall medical and
mental health needs of the individual
with the eating disorder and shall not
be based solely on weight. Coverage
may be subject to other... (Please see
bill detail).

Jack Lester Croughan, MD
December 6, 1942 - August 10, 2015
Beloved husband of Patricia Flance Croughan; dear father and father-in-law of Sarah (B.J.)
Thompson, Anthony (Courtney Leyva) Pepe, Rebecca (Michael) Pedone, Rachel (Bryce Zucker) Pepe
and Leah (Tomer Ben Haim) Croughan; dear brother and brother-in-law of Caitlin Croughan, Tim
(Sue) Croughan, the late Shelly (Earl) Booth, Mary Croughan and Matthew (Kathy) Croughan; dear
grandfather of Sydney, Hailey and Peter Thompson, Carter Leyva, Isabella, Michael and Emma
Pedone and Vivienne Zucker; our dear brother-in-law, uncle, cousin and friend. Dr. Croughan was a
beloved psychiatrist in St. Louis for more than 40 years and served as medical director of Chestnut
Health System. Dr. Croughan, in partnership with the Missouri State Medical Society, created the Missouri Physicians Health Program. He also served on the Board of the National Council of Alcoholism and Drug Abuse.
We first saw San Quentin State Prison well before our bus arrived at the prison. At a distance, it’s unmistakable and distinctive, mixing architectural styles with some dating back to the 1850s. Fifteen minutes later, our bus arrived at the main gate. The members of APA’s Board of Trustees were likely not fully prepared for what they would see once we crossed onto the grounds.

In June, I arranged for the Board of Trustees to tour San Quentin in northern California. It was a powerful, moving, and formative experience, and I’m thankful to Dr. Paul Burton, the chief psychiatrist, and to the California Department of Corrections and Rehabilitation for giving us that access. Our visit was important because, if one wants to understand firsthand the toll mental illness is taking on our country, one just needs to peer beyond the bars of our nation’s jails and prisons. It’s also important to have a detailed and nuanced understanding of the situation.

Our tour was a no-holds-barred look at San Quentin State Prison. For three hours, we were shown various aspects of prison life.

The first part of our tour took us to the execution chamber, where over 200 men have died. We also saw California’s “Condemned Row”—the largest in the nation. And we saw the grounds’ oldest and obsolete cells, located in what can only be called a dungeon. The cell doors have been removed so that these cells will never be used again.

The most recent major addition to the grounds came in January 2010: a 50-bed hospital that offers inmates the medical, dental, and mental health care they need. It was as formidable as the other buildings we saw. But the inside felt much, much different.

We specifically saw the psychiatric facilities, which are highly used by the inmates. In many ways they are state of the art. As you’d expect, sharp angles in the halls and cells, down to the door hinges and door handles, were filed smooth to prevent inmates from using them to aid in a suicide attempt. Many cells provided a sanctuary for inmates, nearly always curled up on a plain bed with a blanket covering them head to toe.

But the rooms that captivated our group were the group therapy rooms. Separate enclosures or “modules” formed a semi-circle for people who are at once both dangerous and needing and deserving of help. We briefly observed one group. Those participating highly praised the care they were getting. One patient’s body language told us when he had enough of our interruption; in a visceral way, it was clear he valued his treatment.

The four psychiatrists with whom we interacted were obviously compassionate and concerned about each of their patients. At each stop, it was abundantly clear that the care provided by the staff psychiatrists was superb and professional. Even if incarceration itself is likely a detriment to many individuals’ mental health, the physician-patient interactions we witnessed gave us hope.

**Tragic Scenario Plays Out Across the U.S.**

Nationally, the numbers are staggering. Each year, roughly 2 million adults with serious mental illness such as schizophrenia, bipolar disorder, and major depression are admitted to our jails, and many of these also suffer from drug and alcohol use problems.

Jails and prisons have become the front lines of treatment for mental illness. The data indicate that San Quentin is an anomaly in the quality of care that’s available in such a setting. This is likely due to its proximity to a highly desirable metropolitan area and its affiliation with the University of California, San Francisco, Department of Psychiatry.

According to a 2010 study by the Treatment Advocacy Center and the National Sheriff’s Association, there was one psychiatric bed for every 300 Americans in 1955. By 2005, that rate dropped to one psychiatric bed for every 3,000 Americans. Over time mental illness has been criminalized, and our jails and prisons take up the slack, despite being seriously ill-equipped to do so. Our jails and prisons have turned into warehouses for those with mental illness; the number of people with mental illness in jails is three to six times higher than that of the general public.

This is why APA and the American Psychiatric Association Foundation have joined forces with the National Association of Counties and the Council of State Governments Justice Center in the “Stepping Up” Initiative. The initiative seeks to reduce the number of people with mental illness in our prisons and jails by promoting the use of mental health courts and diverting minor offenders who have mental illness to treatment resources rather than incarceration. Stepping Up is a great start, but we will and must do more.

This is a problem that is truly national in its scope: In 44 states, the largest institutions housing people with severe psychiatric illness are prisons or jails. The costs are high and increasingly are understood to be unsustainable. Worse still, the toll on patients and on our communities is unacceptable.

(Continued on page 8)
New Medicaid Requirements for Ordering, Prescribing or Referring Providers
July 15, 2015

The Affordable Care Act (ACA) now requires all ordering, prescribing or referring physicians to be enrolled in the state Medicaid program (42 CFR 455.410). Traditionally, most providers have enrolled in a state’s Medicaid program to furnish cover services to Medicaid recipients and to submit claims for these services. Now, the ACA requires physicians to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid.

This new enrollment requirement does not mean providers must see Medicaid patients or be listed as a Medicaid provider for patient assignments or referrals. Rather, the ACA requires providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries come from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. This new requirement is only applicable to physicians who order, prescribe or refer items or services for Medicaid beneficiaries. Physicians who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately.

Finally, it is important that providers understand the consequences of not enrolling in Medicaid. If you are a physician that does not enroll in Medicaid then, other physicians, practitioners and facilities who actually render services to Medicaid beneficiaries based on your order, prescription or referral will not be paid for such items and services.

In summary, if you are an ordering, prescribing or referring provider of items or services for Medicaid beneficiaries you:
• must enroll in the state’s Medicaid program
• are not obligated to see Medicaid patients
• are not required to be listed as a Medicaid provider
• are not required to annually renew enrollment
• can continue to see Medicaid patients without billing the Medicaid program.

Failure to enroll will result in your orders, prescriptions and referral for Medicaid patients not being accepted or paid.

If you have any questions, please contact Maureen M. Bailey at 703-907-7399 or mbailey@psych.org.

Stepping Up continued

This is why I’m announcing that APA, as part of my work as your president, will step up and do more in this arena. One thing we will do is raise awareness, with policymakers, opinion leaders, news media, and partners. We will hold a major national event on this issue in the coming months, and I urge you to join us as we focus on care, not incarceration, in every case where it is appropriate.

Fyodor Dostoyevsky once said, “The degree of civilization in a society can be judged by entering its prisons.”

We must reduce the use of our jails and prisons as warehouses for Americans with mental illness, partly to help our patients, but also because of what this tragedy says about the kind of nation we are. This is an effort for our patients, for our profession, and for our nation.

She has also helped start the “Stepping Up Initiative” intended to reduce the number of mentally ill people in jails and prisons by diverting minor offenders into treatment vs incarceration—see her column in the June 17, 2015 Psychiatric News  Stepping Up to Address Our Nation’s Shame: Psychiatric News: Vol 50, No 14

Office Space Available in Clayton Missouri
Administrative Staff also available if desired

Contact the office of Susan Minchin MD for more details
314-367-3050
“Her depression is getting worse and the soonest we can get is for a psychiatrist in 6 weeks.” These are the words spoken by the mother of a 13 year old girl who was brought to the emergency room at Missouri University Psychiatric Center (MUPC). She hoped that a psychiatrist there could evaluate her daughter and begin treatment for depression. The issue of the lack of access to child psychiatrist is evident across the United States. One of the contributors is the shortage of child and adolescent psychiatrists. The American Academy of Child and Adolescent Psychiatry (AACAP), has assessed the workforce and estimate the number of child psychiatrists needed is up to 30,000 and currently there are about 8,000 in the US.

In Boone County, a new program was created in order to provide immediate access to children and adolescents, The MU Bridge Program: School-Based Psychiatry, which began serving children in the schools in Boone County in March 2015. But the idea of such a program and the planning began much earlier. In 2011, while walking on the inpatient child unit at MUPC, one of the nurses (Carole Schutz) mentioned to Dr. Laine Young-Walker that, “what Columbia needs is to take psychiatrists to the schools.” That initial comment was the impetus to begin meeting with the Columbia Public Schools and to have discussions of the possibility of such a program. There were a series of planning meetings for 6-9 months. In the fall of 2012, a plan to initiate school-based services was to be implemented. But, funding challenges caused the program to be abandoned. One year later, in 2013, Mrs. Schutz and Dr. Young-Walker approached the schools a second time and proposed a pilot. The program would be implemented, at no cost, for several months. During that time, outcomes would be measured to determine effectiveness of the program. Everyone was in agreement, and from February to May, 2014 the pilot program for school-based psychiatry occurred in the Columbia Public Schools. The initial data showed a reduction in psychiatric symptoms, improvement in classroom functioning, and high satisfaction with the parents and teachers.

Near the time that the pilot was ending, the Boone County Children’s Services Board issued a Request for Proposal (RFP), for agencies who provide services to children and adolescents in Boone County. The monies to support the funded projects was from the Children’s Mental Health tax that was passed in Boone County in 2012. With the success of the pilot school-based psychiatry program, an application was submitted and funding was approved to start the MU Bridge Program: School-Based Psychiatry. This time, school-based services were not only for Columbia but for all of Boone County.

MU Bridge Program: School-Based Psychiatry fills the gap for many children in need of psychiatric assessment and treatment by a child psychiatrist. Children in the program receive an initial psychiatric evaluation and two to three follow-up appointments at no cost to the parent/guardian. All of the treatment occurs in the schools. After the initial evaluation, if it is determined that a child does not need medication, he or she will be referred to other in-school or outpatient behavioral health programs. If medications are started, discussions with the parent/guardian occur; at the first visit, about continued care in the community. A community provider is selected and a plan for the nurse case manager to make that appointment is established. The Bridge Program allows the child to begin treatment while waiting to be seen by a community provider. The Child Psychiatrist and a psychiatric nurse case manager work as team members with school counselors and other school staff for the benefit of every child in the program. The role of the nurse case manager is critical to the program’s success. They are the liaison between the school and the patient/parent. Referrals to the Bridge Program are made by the school counselors and the counselors provide valuable information on the child’s functioning in school. The nurse case managers make the initial contact with parents, schedule appointments and follow-up with parents after the child is seen. They provide support/education to the parents and ensure that follow-up with community providers occurs as the children transition out of the Bridge Program. If a child does not have insurance, they will assist in completion of the MO Health Net application when the child is eligible.

In the initial 3 ½ months of the program, from mid-March 2014 to the end of June 2014, 73 children were seen. The criteria for accessing the program are simple. There needs to be a concern by the parent/guardian or school that a child is having mental health symptoms and has not been able to access outpatient psychiatric services. The MU Bridge Program makes psychiatric treatment more accessible and provides timely appointments. It brings psychiatry into schools to help reduce crises. Children with emotional/behavioral problems will be able to get back on track faster, so that they can learn, socialize, and feel better.

**Bridging the Gap: School-Based Psychiatry**

Laine Young-Walker, MD
**APA Applauds Senator Murphy and Cassidy for Introducing Comprehensive Mental Health Reform Legislation**

ARLINGTON, Va. Aug. 4, 2015 – The American Psychiatric Association (APA) released the following statement from APA CEO and Medical Director Saul Levin, M.D., M.P.A., regarding bipartisan comprehensive mental health reform legislation introduced today by U.S. Sens. Chris Murphy (D-Conn.) and Bill Cassidy, M.D., (R-La.).

“We look forward to the House and Senate delivering comprehensive mental health reform this year, especially on behalf of patients and families living with serious mental illness.”

Levin said the APA supports legislation in the House and Senate that will help patients and families gain access to vital mental health services. These bills include significant provisions that will strengthen enforcement of mental health parity and establish a national strategy to address the national mental health workforce shortage.

Levin pointed out that the APA is pleased to see many of the important provisions in the bill previously introduced in the House by Reps. Tim Murphy (R-Pa.) and Eddie Bernice Johnson (D-Texas), the Helping Families in Mental Health Crisis Act, are included in this proposed Senate legislation.

“The nation’s mental health system needs reform and investment, and we applaud Senators Murphy and Cassidy for this comprehensive reform initiative,” Levin said. “We will work with legislators on both sides of the aisle to accomplish mental health reform.”

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**APA Receives Transforming Clinical Initiative Award**

Collaborative network will join federal government and other partners in supporting large-scale health care transformation among clinician practices

Arlington, Va., Sept. 29, 2015 – The American Psychiatric Association (APA) is one of 39 health care collaborative networks selected to participate in the Transforming Clinical Practice Initiative, announced today by Health and Human Services Secretary Sylvia M. Burwell. APA will receive up to $2.9 million over four years to train a network of practicing psychiatrists throughout the United States in the clinical and leadership skills needed to support primary care practices that are implementing integrated behavioral health programs.

“Supporting doctors and other health care professionals change the way they work is critical to improving quality and spending our health care dollars more wisely,” said Secretary Burwell. “These awards will give patients more of the information they need to make informed decisions about their care and give clinicians access to information and support to improve care coordination and quality outcomes.”

As a Support and Alignment Network, APA will train 3,500 psychiatrists to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health and reduced cost. The network will provide leadership training and teach clinical skills related to evidence-based integrated care consultation. These trainings will help participating clinicians meet the initiative’s phases of transformation and associated milestones, clinical and operational results.

“Research shows that integrating behavioral health care into primary care settings improves patient outcomes and reduces health care spending,” said APA President Renee Binder, MD. “This grant will allow APA to expand the number of psychiatrists who are trained to provide evidence-based integrated mental health care to people throughout the United States.”

These awards are part of a comprehensive strategy advanced by the Affordable Care Act that enables new levels of coordination, continuity, and integration of care, while transitioning volume-driven systems to value-based, patient-centered, health care services. It builds upon successful models and programs such as the Hospital Value-Based Purchasing Organization Program, Partnership for Patients with Hospital Engagement Networks, and Accountable Care Organizations.

For more information on the Transforming Clinical Practice Initiative, please visit: http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
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Federal law is clear that insurers can no longer discriminate against patients with mental illness, including substance use. Yet many people are unaware of what constitutes a violation under federal law (Mental Health Parity and Addiction Equity Act and the Affordable Care Act). Patients who know their rights are better equipped to protect their rights.

That’s why the American Psychiatric Association created a tool to help enforce the parity law and end discrimination: a poster titled, “Fair Insurance Coverage: It’s the Law.” The poster has been recently updated and a new Spanish-language version is now available. The poster clearly and simply explains the law and the steps to take when a violation is suspected.

APA hopes its members and partners join the effort to protect mental health patients and ensure that all insurers comply with the law.

Go to www.psychiatry.org/parity, print out both versions of the poster and post them in physicians’ offices, clinics and break rooms at workplaces. Share the link as well.
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**Missouri Psychiatry**

**Psychiatrist Group Warns DOJ Insurance Merger Could Hurt Care**

The American Psychiatric Association warned U.S. antitrust regulators this month that two proposed health insurance deals could worsen access to mental health care services, adding to public opposition from several prominent doctor groups.

Anthem Inc would become the largest U.S. health insurer through a proposed $47 billion acquisition of Cigna Corp, announced in late July. Earlier that month, Aetna Inc said it would buy the Humana Inc to make it the largest provider of Medicare plans for older people.

The American Medical Association, the American Hospital Association and the American Academy of Family Physicians have already appealed to regulators to look at the possible impact on competition.

Antitrust concerns have kept investors and other experts skeptical about the likelihood the deals will make it past the U.S. Department of Justice antitrust reviews now underway.

There is also political opposition. Earlier this week, Democrats and Republicans grilled Anthem and Aetna during a Senate hearing on the effects of insurer consolidation.

The group of 36,000 physicians specializing in psychiatry released on Thursday a letter dated Sept. 9 that states that insurers had a history of denying mental health benefits and that their networks of psychiatrists were inadequate and likely to worsen.

Aetna and Anthem were not immediately available for comment.

The letter was also sent to state insurance commissioners and state Attorneys General, and urged regulators to consider these networks and insurers' historical patterns of providing access to care in their reviews.

"After a thorough investigation of existing practices, we are confident the relevant authorities will be convinced that the merged entities would be a threat not only to consumer choice and pricing, but also to consumer mental health and well-being," the letter said.

(Reporting by Caroline Humer; Editing by Alan Crosby)

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**New REMS for Clozapine**

Professional Risk Management Services, Inc. (PRMS)

We want to make certain that you are aware of a recent Safety Announcement from the FDA announcing the modification of monitoring for neutropenia associated with clozapine and the approval of a new shared REMS (risk evaluation and mitigation strategy) program for clozapine.

Beginning October 12, 2015, clozapine will be available only through the Clozapine REMS Program which replaces the six existing registries maintained by individual manufacturers. Patients who are already being treated with clozapine will be automatically transferred to the Clozapine REMS Program. Prescribers and pharmacies will be required to be certified in the REMS Program under a transition schedule beginning October 12.

Per the FDA's communique, they have “clarified and enhanced the prescribing information for clozapine that explains how to monitor patients for neutropenia and manage clozapine treatment.” Prescribers will now have greater latitude to make “individualized treatment decisions if they determine that the risk of psychiatric illness is greater than the risk of recurrent severe neutropenia, especially in patients for whom clozapine may be the antipsychotic of last resort.”

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Real-World, Multifaceted Treatment for First-Episode Psychosis Improves Multiple Patient Outcomes

Arlington, Va., Oct. 20, 2015 – A new treatment program for young patients in their first episode of psychosis called NAVIGATE has reported significant advantages in symptom ratings, participation in school or work and quality of life. The effects are especially pronounced for patients whose illness had lasted less than 74 weeks prior to first treatment.

NAVIGATE has four components: personalized medication management, family psychoeducation, resilience-focused individual therapy, and supported education and employment. This team-based, multicomponent treatment program is designed to be implemented in routine mental health treatment settings and was shown to be superior to standard treatment.

The study was funded by the National Institute of Mental Health (NIMH), and the report was released online today in The American Journal of Psychiatry (AJP) at AJP in Advance.

The study’s lead author, John M. Kane, M.D., stated: “The NAVIGATE program was designed for real-world conditions, so it can be implemented in many U.S. community clinics. Comprehensive treatment for first-episode psychosis is already available in some other countries. The finding that NAVIGATE was especially important for patients who received treatment early in their illness underscores the need for interventions that are tailored to new patients, to keep them from developing chronic illness.”

The NAVIGATE program was developed as part of the Early Treatment Program of RAISE (Recovery After an Initial Schizophrenia Episode), an initiative of the NIMH.

Thomas R. Insel, M.D., the head of NIMH, emphasizes the value of adapting and optimizing currently known, evidence-based practices. “While there is every reason to seek new and better treatments for schizophrenia, RAISE reminds us that we can achieve better outcomes by adapting the medical and psychosocial treatments we have today.”

The National Alliance on Mental Illness (NAMI) plans to use this program and study findings in support of a major campaign to promote broader adoption of coordinated specialty care services for first-episode psychosis across the states. NAMI has arranged a Congressional briefing today, where John Kane and Lisa Dixon will present RAISE comparative effectiveness and implementation results to members and staff.

What’s New at the APA

⇒ Twenty-three mental health organizations co-signed a letter urging fashion designer Kenneth Cole to remove a stigmatizing billboard in New York City.
⇒ On Sept. 21, arguments were heard in APA’s pending lawsuit against Anthem, Inc. The case, being heard in the US Court of Appeals, Second Circuit, concerns parity for mental health care.
⇒ On Sept. 29, APA received an award to participate in the Transforming Clinical Practice Initiative. APA will receive up to $2.9 million over four years to train a network of practicing psychiatrists throughout the U.S. in clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs.

ICD-10 Coding Transition Now in Effect
Effective Oct. 1, all HIPAA-covered entities must now use ICD-10 codes. The new codes are listed in the DSM-5, along with the ICD-9 coding. More information about the switch to ICD-10, including a brief tutorial video, is available on the APA website.

APA Responds to Kenneth Cole Billboard
Mental health organizations and advocates joined together in September to ask fashion design Kenneth Cole to replace a billboard that stigmatized people with mental illness. As part of a #givestigmaheathboot social media campaign, APA delivered a letter co-signed by 22 other groups that urged Cole to take down his billboard immediately. You can see the billboard in question, and read the letter on the APA website.

Dr. Adeyinka Akinsulure-Smith to Deliver Keynote Speech at IPS: The Mental Health Services Conference
Adeyinka Akinsulure-Smith, Ph.D., an associate professor in the Department of Psychology at City College of the City University of New York (CUNY) and at the Graduate Center, CUNY, will deliver the keynote address at IPS: The Mental Health Services Conference on Oct. 8. Dr. Akinsulure-Smith’s speech will focus on the impact that the trauma of war and forced migration can have on the mental health of children and their families. You can read APA President Renee Binder’s blog post announcing her as keynote speaker on the APA website.

APA Sends Letter to DOJ Voicing Concerns on Insurance Mergers
APA has sent a letter to the Department of Justice’s Antitrust Division voicing concerns about potential mergers between Anthem, Inc. and Cigna, as well as Aetna and Humana. If approved, the mergers would consolidate four of the nation’s five largest insurers into two companies. A recent blog post by APA President Renee Binder, M.D., and CEO and Medical Director Saul Levin, M.D., breaks down the ways in which these mergers will have a negative impact on patients.
APA members stay up-to-date on all the latest research and advances in the field through:

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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, 3466 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 hinasyedcmps@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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Mark Your Calendar

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

Renaissance St. Louis Airport Hotel
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Calendar of Events

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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
October 14, 2015
November 18, 2015