Greetings to all MPA members!

During this year the APA has focused on increasing membership through providing incentives for residents who join (the 100% club) and offering a reduction in dues for organizations who have psychiatrists join as a group. While there is excitement about increasing the membership, it is important that members engage actively in psychiatric advocacy.

Our current President, Maria Oquendo’s priorities as APA president:

- Secure a key role for psychiatrists as health care reform is implemented while ensuring high quality care for all, particularly persons with the most severe mental illnesses
- Pursue equitable reimbursement and true parity for psychiatric care
- Secure robust federal funding for education and research, coordinating efforts with advocacy groups
- Strengthen collaboration with psychiatric subspecialties and primary care
- Pursue active communication with all members

We stand at a time for great potential in Missouri and in the nation as the elections draw near. Political conversations dominate many interactions. Some are in strong support of either candidate and discussions can become very heated and contentious. The MPA is not taking a stand for one candidate over another. Still, as an advocate for mental health it is important for each of us to remember psychiatric advocacy and to remain in line with the APA priorities.

As we grow our organization, your active involvement is critical to success. We encourage participation in the MPA and future contributions to the Newsletter. We are excited to enhance psychiatric knowledge in our fall and spring programs and look forward to seeing you.
Missouri Psychiatric Association

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MPA Fall Conference
“Intractable Adult Depression, Care for High Risk Children, Treatment of Preschool ADHD”
Area IV Summer Meeting Report
August 2016

GENERAL
- The Kansas Psychiatric Society (KPS) and MPA members in the KC area are working on developing yearly joint meetings.
- The MPA has met with NAMI-MO to establish a mutually beneficial partnership. We hope this will help our providers, patients as well as aid in legislative efforts.
- Our new president, Laine Young-Walker MD, has had an impressive start and she has filled all vacant or non-active positions on our executive council.

LEGISLATION
In spite of the election year, the MPA doesn’t anticipate any major changes in the makeup of the majority or minority parties in the General Assembly. A few issues that we are monitoring include:
- **Meaningful Medicaid Expansion:** Still not popular with the majority party.
- **PDMP:** This failed in the last session continuing Missouri’s reign as the only state without a monitoring system. Physician members of the General Assembly are still in opposition.
- **APRN Scope of Practice Expansion:** The Missouri State Medical Association remains firmly opposed to this as are physicians who are currently in the Missouri General Assembly. Jim Fleming hopes to find some middle ground on this issue and will meet with the MSMA’s lobbyist and chief counsel about this issue in the fall.

- **Religious Freedom/LGBT:** Will be contested and the direction this might take is unknown at this time.
- **Psychologist Prescribing Bills:** Have been dormant the last few years in MO but growing across the country. We will monitor as these could come roaring back in 2017 in Missouri.
- **Tele-health:** A continuing effort to make access to healthcare, including mental health, easier especially in underserved areas.
- **Gun Violence/Firearms Ownership:** Broad topic with important mental health issues involved. Majority party pro 2nd amendment.
- **Medical Marijuana:** There is growing interest in this topic nationally. The MPA is sponsoring a CME program on this topic in St. Louis in early 2017.
- **CBD Oil Expanded Usage:** Attempts to expand list of legally approved conditions.
- **Industrial Hemp:** Attempt to legalize the cultivation and processing of industrial hemp.

CME
The MPA is sponsoring a fall CME program entitled: “Intractable Adult Depression, Care for High Risk Children, Treatment of Preschool ADHD.” It will be held at the Stony Creek Inn, in Columbia, MO on Saturday, October 8, 2016

Dear Members,
Would you like to contribute to the quarterly newsletter? Contact us if you would like to write about one of the topics listed below -- or another psychiatry-related topic of your choice. Topics include:

- Ethics in Psychiatry
- Child Psychiatry
- New Treatments
- Opioid Epidemic
- Legislative Issues
- Training Issues
- Telepsychiatry
- Substance Abuse
- Gun Violence

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A Psychiatric Manifesto

Henry A. Nasrallah, MD

Psychiatry is one of the most rapidly evolving medical specialties. Its scientific foundation is neuroscience, which is growing at the most explosive pace in science. Yet the public and even other medical specialists still envision psychiatrists sitting behind a couch scribbling Freudian jargon on a yellow pad. For that reason, I propose the following “manifesto” that promulgates the basic tenets of psychiatry. I invite the members of the MPA to comment on them and to suggest additions or deletions:

- Psychiatry is a medical specialty that focuses on brain disorders of behavior, thought, mood, cognition, perception and conation that are either primary, or secondary to general medical conditions or substance use.

- Psychiatric disorders are the product of complex interactions of genes and environmental factors, from the fetal stage throughout life.

- Psychiatric disorders are quite common, ranging from 25% to 50% of the population in various studies, and vary in severity from very mild to extremely severe and disabling.

- The complete assessment of psychiatric disorders almost always requires corroboration by a third party.

- A psychiatrist must be a fully trained physician who can integrate biologic, psychological, and social antecedents, make an accurate diagnosis, and administer pharmacologic/somatic and psychotherapeutic treatments to repair both brain and mind.

- As with all medical disciplines, the best outcome in psychiatry is full remission and recovery and the worst is mortality from suicide, homicide, self-neglect, comorbid medical illness, or iatrogenic causes.

- Social/vocational disability may be associated with some psychiatric disorders but most are not disabling. In addition, disability can remit but the public mental health system penalizes recovery by withdrawing health care coverage.

- Psychiatric diagnoses have far more reliability than validity at this time. This discrepancy will be resolved as specific pathophysiology of psychiatric disorders are elucidated.

- Severe psychiatric disorders with the potential for harm to self or others often require treatment against the will of the patient, whose insight into the illness and urgent need to receive treatment is seriously impaired. In contrast to their initial anger and resistance, involuntarily treated patients often are grateful after treatment.

- Current pharmacologic treatments of psychiatric disorders are based predominantly on serendipity rather than evidence-based neuro-biologic mechanisms. However, the surge of genetic and neuroscience advances promises to lead to breakthroughs that will reshape treatment of psychiatric disorders.

- Although drug or neurostimulation treatments for psychiatric disorders are heavily regulated by the FDA and have specific indications based on large, placebo-controlled trials, psychosocial treatments are not. Extending regulatory approvals to psychotherapy may reduce the use of psychotherapeutic modalities not based on evidence.

- The public mental health system is broken and dysfunctional. Seriously mentally ill individuals are stigmatized and impoverished, lack primary medical care, die decades earlier than the life expectancy of the general population, often abuse alcohol and illicit drugs, and are incarcerated in such huge numbers that jails and prisons have become the new psychiatric “institutions.”

- The medical model is as appropriate for psychiatric disorders as it is for cancer and heart disease. However, political influences and the preponderance of nonphysicians in the mental health care system have shifted psychiatric treatment into a predominantly social model. This can be a disservice to psychiatric patients who do not receive any medical workup or treatment before diagnosis.

- Psychiatry has more detractors and self-appointed critics than any other medical specialty. This is the product of a malignant mix of ignorance and self-interest, especially by cults who offer their own scientifically untested “solutions” to mental illness (at a price, of course).

- The future of psychiatry is bright because it is intimately linked to neuroscience discoveries, which ultimately will delineate specific brain pathways underlying psychiatric nosology and treatment.

I invite MPA members to comment or to suggest additions or modifications to this manifesto.
An Opinion Piece

Ethics, Advocacy and Presidential Mental Health

James L. Fleming, MD

The unprecedented intensity and extremes of the 2016 race for President of the United States present some major challenges as well as opportunities for the profession of psychiatry as we continue to advocate for our profession and our patients. In this article, I present observations and conclusions which many of us may prefer to ignore due to concerns about controversy or crossing ethical boundaries, but which I believe we avoid at our peril.

At the end of August, Assembly members received an email from APA Medical Director Saul Levin, MD lauding Hillary Clinton’s mental health agenda and plan. Similar information was posted on the APA website and was also sent to member subscribers of Psychiatric News Alert. Dr. Levin also stated that the APA would continue bipartisan outreach to the Presidential candidates. At press time for this newsletter we had not received any updates from the APA, so presumably, the other major contender for President, Donald Trump, has not yet released a mental health agenda. His campaign website has only a few sentences on mental health reform with few specifics.

If we only had this issue on which to base a decision, it would be clear which candidate organized psychiatry should support. The APA doesn’t endorse candidates for any office but praise for Clinton’s plan in the context of lack of a plan by her main rival, while not an "endorsement" per se, would seem to have the same effect.

There are, however, other important issues at play in this election cycle which have a bearing on psychiatry. First, character or “temperament” issues, as well as “fitness for duty” concerns, have been repeatedly raised in recent months, particularly about Mr. Trump. This was illustrated in the September 2nd issue (1) of our association newspaper, Psychiatric News which focused mainly on comments about Donald Trump by members of the media. But the article mainly served as a warning about the ethical problems associated with psychiatrists commenting publicly on the mental condition of political candidates. The article reviewed the unfortunate story of the “Goldwater Rule” from 1964 when about half of the psychiatrists who responded to a poll by Fact magazine concluded that Senator Barry Goldwater was unfit to serve as president. Goldwater later successfully sued the magazine for libel and—due to a public backlash—9 years later, the APA revised its ethical guidelines (2. Also see A below for the full text of the Goldwater Rule). Also around the end of August, APA President Maria Oquendo released a statement about the issue which appeared on the APA website for several weeks and which concluded: “breaking the Goldwater Rule is irresponsible, potentially stigmatizing and definitely unethical”.

For the most part, the Psychiatric News article provided support for this conclusion but also gave space for an alternative viewpoint: e.g. that rigid application of the rule “denies an individual psychiatrist’s responsibility to speak up about political leader’s behavior that strongly suggests psychopathology”. This was expressed by authors of an article in the June issue of the Journal of the American Academy of Psychiatry and the Law (3). The authors, Jerome Kroll, MD and Claire Pouncey, MD, Ph.D., further state: “Psychiatrists, as behavioral health specialists, have an obligation to help the community to understand public behaviors that do not match social standards and expectations”.

While the authors caution against reckless or self-promotional third party assessments, they challenge basic assumptions about the Goldwater Rule and contend that the Goldwater Rule was an excessive organizational response to what was clearly an inflammatory and embarrassing moment for American psychiatry. They state: “psychiatrists have an obligation to protect the privacy of psychiatric patients, but not the public perceptions of the psychiatric profession”.

They also mention other sections of the code (e.g. 2, Section 7.2) which taken to together encourage psychiatrists “to engage in rather than refrain from commentary when public figures seem to pose a risk to community safety”. Finally—and remarkably—the authors state that the rule itself is unethical if “it suppresses public discussion of potentially dangerous public figures”.

Given these considerations, we should now consider whether any of the candidates fall into the categories of being “potentially dangerous” or “posing a risk to community safety”. So far, few psychiatrists have dared to venture in this contentious discussion. Dinah Miller,

(Continued on page 7)
An Opinion Piece continued

MD who writes the Shrink Rap column in Clinical Psychiatry News, while making the point that the opinions of psychiatrists about political figures “shouldn’t matter”—because in this digital age everyone has ample “data” available to make a judgement about presidential fitness—but then proceeds to list a number of Mr. Trump’s behaviors which have been very offensive to many: “we’ve now seen him countless times in debates and rallies. We know how he treats his running mates, journalist Megyn Kelly, a news reporter with a disability, and the parents of a fallen soldier. We’ve watched him assure the nation during a primary debate that his genitals are big enough. Every individual is free to decide if Mr. Trump’s widely viewed patterns of behavior represent much-needed spunk and change... or if his words and behaviors represent cruelty, impulsivity, poor judgment, and a pattern of actions that some might not feel is dignified enough for our country’s leader” (4).

Prudence Gourgeuchon, MD, a psychoanalytist, and Assembly colleague from Area 4, strongly disagrees with the notion that psychiatrists having “nothing to add” to the public discussion in this regard and has been direct and outspoken, pointing out in an internet interview (5) “bullying” behaviors exhibited by Trump. The interview cuts to several video clips of Trump from the campaign to support these assertions. Like Kroll and Pouncey, she encourages colleagues to embrace their role as educators in the service of public health: “We can talk about the use of language and its effects. We can talk about what contributes to the overall mental health of a community. What increases trust and wellbeing, what increases mistrust and paranoia” (6).

I agree but would argue that mental health professionals are not the most important of professions when it comes to deciding whether or not a public figure—in this case, the potential highest office holder in the nation—poses a threat to the country. A letter from 50 senior national security leaders, published by the New York Times in August (7) uses language often used in correctional or forensic psychiatric settings but with much higher stakes than anything we, as psychiatrists ever deal with. The letter states that Mr. Trump: “lacks the character, values and experience” to be president...He is unable or unwilling to separate truth from falsehood...He does not encourage conflicting views. He lacks self-control and acts impetuously. He cannot tolerate personal criticism. He has alarmed our closest allies with his erratic behavior. All of these are dangerous qualities in an individual who aspires to be president and commander in chief, with command of the U.S. nuclear arsenal.”

Now, during intense political contests, one might expect intense criticism of candidates, even strongly negative assessments such as this one, however, this argument is rendered impotent when one realizes that all of the signatories to the letter had served in Republican administrations, several at the highest levels and remain members of Mr. Trump’s own party. While some of them were critical of Hillary Clinton as well, the letter was meant as a stark warning to the country about Donald Trump and they all vowed to not vote for him. This, in my view is serious, it is unprecedented and clearly not partisan in the usual sense of ”Democrat vs Republican”.

There is one more aspect to this campaign season which should be of serious concerns to psychiatrists and to the APA. Many individuals and organizations have expressed grave concerns about Mr. Trump’s repeated statements and discriminatory tone toward racial and religious minorities, his encouragement of violence and other behaviors noted above. The APA has made a great effort to expand diversity and provides women, minorities, and other underrepresented groups expanded opportunities for representation within and outside of our organization. It would be difficult for anyone to conclude that Mr. Trump’s campaign is representative of the kind of values that the APA has been trying to promote.

Obviously, we are all free to support the candidate of our choice but I suggest readers think carefully about the implications of the subsection of the APA code of ethics which states:

"A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.” (2, Section 1.2). What are boundaries or limits of being “a party to” discriminatory policies? You decide. And by all means, vote your conscience in November.

NOTE: Any opinions expressed in this article are solely those of the author and do not represent the views or policies of the APA or the MPA.

(Continued on page 9)
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An Opinion Piece continued

FOOTNOTE:
Section 7.3 of the Principles of Medical Ethics states in its entirety is as follows: "On occasion, psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."

REFERENCES


2. APA “Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry” (https://psychiatry.org/about-apa/read-apa-organization-documents-and-policies)


6. Personal communication


Addendum from the MPA President: Laine Young-Walker M.D.
Thank You, Dr. Fleming, for a provocative article that raises a number of points that are sure to be examined in the future. I encourage members to respond and add their viewpoints on this issue.
Given the evolving research on marijuana and mental illnesses—and the potential impacts of the shifting landscape of marijuana-related policy and legislation in the United States—psychiatrists must remain informed about how marijuana use affects mental health.

Perhaps most importantly, although occasional (that is, neither regular nor heavy) marijuana use may be of little consequence to healthy adults, use among adolescents is a serious concern. Adolescents who regularly use marijuana are at greater risk of amotivation, reduced academic performance, lower educational attainment, and potentially even school dropout. Marijuana use in adolescents also can have negative effects on IQ and increase the risk of cannabis dependence and other drug use.

There are at least three issues that further substantiate the concern about adolescent marijuana use.

- Marijuana use in the United States, particularly among adolescents, appears to be increasing, not decreasing. There is some evidence that perceptions of risk of using are decreasing, which likely serves as a key driver of increasing use and is potentially related to ongoing legalization initiatives.
- Marijuana used by adolescents today is very different from the marijuana that their parents or grandparents may have used. Indeed, in the age of engineered cultivation, the delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) content (and thus the ratio of THC to CBD) of Cannabis sativa strains are being fine-tuned; diverse strains and products are being marketed based on this content and its presumed effects.
- Growing research on the endocannabinoid system (which, in general terms, regulates neurotransmitter systems) shows that this internal cannabinoid system plays crucial roles in brain development and maturation (for example, neurogenesis, axon elongation, neural differentiation and migration, glia formation, and synaptic pruning), especially during adolescence and early adulthood. Perturbing this system with exogenous cannabinoids could have both immediate and long-term effects.

Studies also show that marijuana use has complex connections with a number of psychiatric illnesses, including mood and anxiety disorders, other substance use disorders, and particularly psychotic disorders. Growing evidence strongly suggests that marijuana use (especially heavier use in adolescence) is an independent risk factor for, or a component cause of, schizophrenia and other psychotic disorders. There is also convincing evidence that marijuana use before the onset of any psychotic symptoms hastens the onset of psychosis among those who do develop a psychotic disorder, and marijuana use during the early course of psychotic disorders is associated with a number of poorer outcomes.

From a policy perspective, psychiatrists should be familiar with the evolving movement around decriminalization (that is, reducing or removing criminal penalties) of marijuana possession and use, and even legalization (that is, removing criminal penalties and establishing a system of taxation and regulation of production, processing, and distribution) of both medical marijuana and recreational marijuana. Many more state legislatures will be addressing these issues, and we should be following the story and contributing to the political discourse and debate in a balanced, objective, and research-informed fashion.

Aside from decriminalization and legalization of recreational marijuana, about half of the states (and the list will undoubtedly grow) have already passed medical marijuana legislation. Psychiatrists and other physicians will increasingly be approached by patients with questions about medical marijuana, if not direct requests for qualification letters.

Some people who use marijuana (especially in adolescence) will develop addiction. More research is needed to determine the factors that predispose to and protect from addiction in the context of initial or escalating drug intake. Perhaps of greatest importance for psychiatrists is the evaluation and management of cannabis use disorder; specifically, the typical withdrawal symptoms that can occur, and the best-supported psychosocial (and potentially emerging

*What You Should Know About Marijuana Use in the United States*

*Michael T. Compton, MD, MPH*

Published online: May 18, 2016
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(Continued on page 11)
pharmacological) approaches to treatment. Although prevention efforts are typically carried out in school-, family-, and community-based venues, psychiatrists may play a role in communicating the short- and long-term risks associated with cannabis use.

Another topic that psychiatrists should remain informed about is synthetic cannabinoids. Although these synthetic chemicals bear little resemblance to marijuana, many who use these potent and potentially very dangerous chemicals consider them to be somehow comparable to marijuana derived from the Cannabis sativa plant. A growing body of case literature and observational studies indicates that synthetic cannabinoid ingestion can bring about prominent and sometimes very serious acute psychiatric and medical manifestations. We have much to learn about the evaluation, management, and prevention of synthetic cannabinoid use.

As we look to the future, health professionals should be prepared for changes in laws pertaining to legalization, driving under the influence, drug-free workplace policies, and medical marijuana programs. Health professionals should also stay tuned for information on potential therapeutic uses of CBD for several health conditions, possibly including psychotic disorders.

Michael T. Compton, M.D., M.P.H., is chair of the Department of Psychiatry at Lenox Hill Hospital in New York and a professor of psychiatry at Hofstra Northwell School of Medicine. Compton is the editor of Marijuana and Mental Health from American Psychiatric Association Publishing.

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Missouri Psychiatric Association
“The Endocannabinoid System and Marijuana Abuse”
Chase Park Plaza, St. Louis, MO
Thursday, January 26, 2017

Jointly provided by the American Psychiatric Association and the Missouri Psychiatric Association

Agenda

5:30 - 6:00 pm  Registration and Reception
5:30 - 9:00 pm  Exhibits (Exhibits will be provided)
6:00 - 7:00 pm  Dinner
7:00 - 9:00 pm  “The Endocannabinoid System and Marijuana Abuse”
    Speaker: Donald Bohnenkamp, MD, Assistant Professor of Psychiatry, Washington University School of Medicine in St. Louis
9:00 pm  Thank You & Wrap-Up

OBJECTIVES
1. Participants will become more knowledgeable about the endocannabinoid system.
2. Participants will better understand how THC effects this system.
3. Participants will learn about cannabis use disorder and how to treat it and its detrimental side effects.
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**APA Applauds Congressional Passage of the Comprehensive Addiction and Recovery Act**

On July 14, 2016 the American Psychiatric Association (APA) praised the Senate’s overwhelming vote yesterday in support of comprehensive legislation addressing the national opioid crisis. The Comprehensive Addiction and Recovery Act, S.524, was overwhelmingly approved by the House last week. The measure now goes to President Obama for his anticipated approval.

“We are encouraged by the bipartisan support for this legislation—it encompasses many critical first steps toward fighting the nationwide opioid use epidemic,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “But we cannot stop here. These programs must be fully funded to be effective. APA looks forward to continuing to work with Congress to curb this epidemic.”

Nearly 2.5 million people in the U.S. have a substance use disorder involving heroin or prescription pain relievers, and more than 29,000 overdose deaths in 2014 were related to heroin or prescription pain relievers.

The Comprehensive Addition and Recovery Act includes a range of measures to address the growing addiction problem, among them:

- Provides grants to expand access to life-saving opioid overdose reversal drugs (such as naloxone) and to expand access to addiction treatment services, including evidence-based medication-assisted treatment.
- Provides grants to community organizations to develop and enhance recovery services and build connections with other recovery support systems.
- Provides grants to states to carry out comprehensive opioid abuse response, including education, treatment, and recovery efforts, prescription drug monitoring programs, and efforts to prevent overdose deaths.

**Daniel Gillison Named New Executive Director of the APA Foundation**

The American Psychiatric Association Foundation (APAF) announced today that Daniel Gillison will assume the role of Executive Director beginning Monday, June 27.

Gillison joins the APAF, the philanthropic and public education arm of the APA, from the National Association of Counties (NACo) where he was the National Director of County Solutions and Innovation. In his role, he led corporate and philanthropic fundraising efforts and directed the educational programming of the NACo Research Foundation. During Gillison’s time at NACo, corporate support more than doubled and the NACo Foundation substantially expanded its educational offerings in mental health and criminal justice. He has previously held positions at Sprint, XO Communications, and Wesley Brown & Bartle.

“Daniel Gillison brings a wealth of experience in raising corporate support and securing foundation funding to the American Psychiatric Association Foundation. His significant strategic planning experience will be useful in guiding the APAF as it raises public awareness of mental illness,” said APAF Board Chairman Saul Levin, M.D., M.P.A.

Gillison replaces APAF Executive Director Paul Burke, who is retiring July 1 after more than nine years of service.
**Human Trafficking: What Psychiatrists Need to Know**

**Balkozar Adam, MD**

When a recent patient described the fear and anguish that she felt after being a victim of human trafficking, I knew she was not alone.

News outlets continue to report on the shocking cases of human trafficking all across the United States. In June 2016, news broke of a sex scandal involving the alleged human trafficking of one underage girl, 28 police officers, five police departments and four police chiefs (1). The Chicago Tribune reported in 2014 that a young woman, a juvenile ward of the state who had been placed at a residential facility, was offered to truckers for $20 (2).

As psychiatrists, we must be prepared to treat our patients who have been trafficked. Although the issue has started to draw attention recently, it is not a new subject. In 2000, Congress first defined human sex trafficking (3). Many youths don’t display any outward signs of being trafficked, making it difficult to identify adolescents who have been victims. That makes it all the more critical for psychiatrists to know the psychological, social, environmental and physical signs of this form of modern-day slavery (4).

Some indicators may include being cut off from family, friends and community; dramatic changes in behavior; no longer attending school; answers appear coached or rehearsed; patient appears tired, disoriented, fearful or timid; no stable living situation. (5) Traffickers use various techniques to control their victims and to keep them enslaved. This may include isolation from the public and from family, confiscation and control of identification documents, threats of violence or of shaming their victims (6).

More needs to be done to increase awareness of human trafficking among psychiatrists. We need to know how to recognize signs of human trafficking and the best course of treatment for the victims. We have to be cognizant of the physical, sexual and emotional consequences of human trafficking on adolescents. Some of the psychological effects of human trafficking may include anxiety, depression, suicide, aggression, guilt, shame, substance abuse and Post Traumatic Stress Disorder (7). Although there is still much to be done to identify specific therapeutic treatment for this population, research shows that cognitive behavioral therapy and trauma-focused therapy has been effective (8).

As with other forms of sexual abuse, we must remember our reporting obligations and remain well-informed as to available resources and appropriate referral options. Our jobs as clinicians are made more challenging because human trafficking statistics tend to be underreported due to the secretive nature of the problem. It’s important to note that human trafficking can be domestic or international. For international human trafficking, the promise of a better life, the language barrier and the fear of deportation or criminal prosecution often keeps victims from seeking help.

At home in the U.S., we need to pay particular attention to adolescents who have a higher risk of being trafficked, including youths with a history of abuse or neglect, child welfare involvement, mental health problems or substance abuse issues, LGBTQ youths, adolescents who have run away or who live in poverty. A key component of treatment is understanding that adolescents who are being trafficked are victims. They are not to blame. They are not criminals. They cannot consent. As psychiatrists, we can play a significant role in identifying, intervening and advocating for the victims of human trafficking.

References:
6. www.acf.hhs.gov/programs/endtrafficking/
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.

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Advertisement Information

For advertisement information, please contact Sandy Boeckman by email at sandyboeckman@gmail.com.
Calendar of Events

Executive Council Meetings
Conference Calls Scheduled at 7:00 pm
November 16, 2016

Educational Workshops
“The Endocannabinoid System and Marijuana Abuse”
Thursday, January 26, 2016

MPA/MSMA 159th Annual Convention
March 31-April 2, 2017
Sheraton Kansas City Hotel at Crown Center
Kansas City, MO