The Annual Mental Health Check-up: A Key to Prevention
Psychiatry and Public Health

There are 200 types of tissue in the human body. Yet, 50% of the 22,000 genes in our chromosomes are dedicated to developing the brain and its tissue and the other 199 tissues get the other 50%. The brain, which generates a mind and its advanced mental functions, is clearly the supreme organ in humans!

So that raises an important question: why is the annual physical exam a long-standing sacred ritual and yet, an annual mental health check-up is not? Such an annual checkup can identify behavioral, mood, thought, cognitive and addictive disorders as early as possible so that prevention or intervention can be implemented. Most serious psychiatric disorders begin in childhood and adolescence, and early detection can be far more clinically effective and cost-effective compared to treating an acute psychotic, manic, depressive or anxiety episode.

Mental health is critically important in our lives. Even if a person is physically in top shape does not have a healthy mind, he or she can become functionally and socially dysfunctional with a poor quality of life. NIMH-funded epidemiological studies have shown that psychiatric brain disorders are highly prevalent with estimates of 25% or more of the population experiencing a psychiatric illness over a life-time (1). The estimated costs of mental illness and addictions are estimated to exceed $400 billion annually. Thus, early detection and treatment can be associated with enormous financial savings for society, releasing resources for various social programs or medical research.

And let’s not forget that mental illness of the brain can be as deadly or disabling as any physical illness of the body. The death toll of psychiatric disorders is very substantial with tens of thousands of deaths annually from suicide and homicide, which inflict enormous direct and indirect costs to society, including hospitalization, medications, outpatient care, laboratory tests, forensic costs, absenteeism at work and disability payments. The annual mental health check-up can be done at a relatively modest cost because primary care is significantly cheaper than tertiary or quaternary health care. It can also spare those affected and their family’s immeasurable anguish and suffering. As we know, family burden of mental illness is rarely factored into the costs of mental illness despite its serious impact.

In addition to the genetically caused psychopathology, every day stress due to unforeseen adverse life events is inescapable and is often a common trigger for mental disorders, and it spares no one including families, workers, mental health professionals, company executives and national leaders. The annual...
**President’s Message**

mental health check-up can identify the emotional, behavioral, addictive and cognitive repercussions of stress and can facilitate cost-effective interventions such as stress-management techniques, counseling and nonpharmacological methods like yoga or exercise. This would also reduce the reliance on medications or having to manage side-effects.

With age, the brain becomes susceptible to various medical disorders, many of which can be detected early with an annual mental health check-up, leading to early intervention. For example, dementia experts have reported that persons who develop Alzheimer’s disease often manifest psychiatric symptoms 10-20 years before cognitive deterioration, including anxiety, depression, personality changes, paranoid thinking or irritability. An annual mental health check-up can identify such changes much earlier than the diagnosis of dementia, enabling the implementation of innovative preventative measures and pre-emptive interventions.

Another valuable benefit from an annual mental health check-up is that it can be instrumental in detecting the psychiatric symptoms secondary to general medical conditions, or their treatments (iatrogenesis), lending to early treatments of such secondary psychiatric disorders.

Finally, everyone agrees that a healthy mind is indispensable for wellness and the pursuit of happiness, even in the presence of an illness in the body. The value of the annual mental health check-up is summarized in the well-known aphorism: An ounce of prevention is better than a pound of care. Let’s not just agree with that saying: Let’s collectively act on it , and make it a routine health insurance benefit for children, adolescents, adults and seniors.

Henry A. Nasrallah, MD
President MPPA

References:
APA Applauds CHIP Reauthorization, Providing Continued Access to Health Care for Millions of Low-Income Children and Youth

The American Psychiatric Association (APA) applauds bipartisan congressional passage of legislation extending the Children’s Health Insurance Program (CHIP), protecting children’s health coverage and providing access to needed health and mental health services for nearly nine million children and adolescents from low-income families.

As part of a short-term government funding bill, Congress has passed a measure extending funding for CHIP for six years, through Fiscal Year 2023. The bill also extends funding for the Childhood Obesity Demonstration Project and the Pediatric Quality Measures Program and extends specified outreach and enrollment grants.

“Early access to quality evidence-based mental health services and treatment is critical for children and adolescents facing mental health challenges,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A. “Extension of the CHIP program will provide access to mental health care services for low-income children and youth who otherwise might not have access to care.

“We are also glad to see that members of both parties came together and voted for this important measure,” Levin said. “We hope this is a sign of more bipartisan cooperation in the future.”

CHIP provides health insurance to nearly nine million children and adolescents from low-income families who do not qualify for their state’s Medicaid program. The CHIP program means children are more likely to have a reliable source of health and dental care and to have regular preventative care visits. It also provides access to mental health care for the estimated 850,000 CHIP beneficiaries experiencing serious behavioral or emotional disorders.
Some Progress Being Made in Stemming Opioid Crisis
Nick Zagorski

Psychiatrist Patrice Harris, M.D., says that while there are signs of progress in physicians’ prescribing practices and training in pain and addiction treatment, much more is needed to end the opioid epidemic.

- Enhance education and training.
- Support comprehensive treatment for pain and substance use disorders.
- Help end stigma.
- Co-prescribe naloxone to patients at risk of overdose.
- Encourage safe storage and disposal of opioids and all medications.

Harris told the audience that there are some signs that physicians are working to meet these goals. For instance, physicians’ and other health care professionals’ registrations with state-based PDMPs—electronic databases that monitor controlled substance prescriptions—grew from 471,896 in 2014 to 1,322,996 in 2016. These professionals aren’t just registering with the state; data show use of the state PDMPs is also on the rise. In 2016, health care professionals checked the state PDMPs more than 136.1 million times—a 121 percent increase from 2014.

A growing number of physicians are also completing courses on opioid prescribing, pain management, and addiction. According to an AMA survey, more than 118,550 physicians accessed, attended, or completed continuing medical education and other courses offered by the AMA, state, and specialty societies.

Two important prescribing statistics have also been trending in the right directions. The total number of opioid prescriptions written fell from 244 million in 2014 to 215 million in 2016; meanwhile, according to the AMA, 32,659 prescriptions of the overdose blocker naloxone were dispensed in the first two months of 2017, a record 340 percent increase from 2016. A growing number of physicians have also received certification to provide office-based medication-assisted treatment for patients with opioid use disorder.

Harris, who is in private practice and serves as an adjunct professor of psychiatry at Emory University, said that while these are signs of...
progress, there is much more work to be done to truly reverse the nation’s opioid epidemic. As physicians and organizations such as the AMA and APA consider next steps, Harris said it is important to remain “intellectually honest” about the role physicians and patients play in the continued misuse of opioids.

She noted that while reports suggest that some physicians knowingly overprescribed opioids, there are also well-intentioned doctors who may err on the side of medication when not necessary—and these two groups require different solutions. In addition, many of these prescription opioids likely got in the wrong hands because patients did not properly secure them.

Harris added that more data are needed to properly inform public policy and greater attention needs to be paid to the data already available. As an example, she cited the statistic that only 2 in 10 people with a substance use disorder get the care they need.

“I’m sure many of us can share a story about referral problems,” Harris said. “You call a treatment center, but you know what the answer on the other end is: ‘We have no space.’ No one with diabetes comes to a hospital with a blood glucose level of over 600 and gets told, ‘We don’t have a bed. Come back in four weeks.’ ”

Reprinted from Psychiatric News, Published Online on December 8, 2017
Let’s Build a Better MH Care System

Anita Everett, MD

What do we mean when we say that the mental health system in this country needs to be reformed? What are the problems, what are the solutions, and how would we even know if we got there?

Clearly, many patients are served well by skilled and caring psychiatrists and mental health professionals every day. Moreover, with the public becoming more educated about mental illness (including substance use) and the expanding armamentarium of effective treatments, stigma has declined and demand for our services has increased. Ironically, while this situation has been a positive development, it’s not necessarily the case for the many people who still do not have access to psychiatric treatment.

A recent trend in innovation and leadership literature is the notion of incorporating design thinking into planning. I have learned about the importance of design as a result of the work of our Work Group on Access and Innovation. I’d like to thank Chair John Santopietro, M.D., and Co-chair John Torous, M.D., for their leadership in this area. As it turns out, explicit attention to design is a critical element in using innovation to help solve problems. So how would we use design to think about our mental health delivery system? Let’s take a high-level view of some of the elements of design in our current system: parity, young adult considerations, and safety-net elements.

- **Parity:** Parity is an important design element of the mental health system. We have parity in commercial insurance plans, now by law. As evidenced by the November 2017 Milliman report titled “Addiction and Mental Health Versus Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates,” however, we have a long way to go with regard to enforcement of parity. Milliman found that patients’ use of out-of-network services is extremely high for behavioral health compared with general medical and surgical services and that psychiatrists are paid less for the same codes than other physicians. So while parity is an important design element for expanding access to mental health care, implementation and enforcement still fall far short of the law. The design is not fully implemented.

- **Transitional-age youth:** In the realm of mental health conditions, particularly serious mental health conditions, there is no more critical time period than the transitional stage of youth, generally between the ages of 16 and 26. This is a period wherein individuals transition from childhood into adulthood, and during that time, many serious and potentially disabling mental illnesses such as schizophrenia, mood disorders, and addictions develop. Our delivery system includes several recent developments that are designed to increase access to effective treatment for this age group. Currently, commercial insurance plans are required to allow children up to age 26 to remain covered on their parents’ plans. Recently, Congress created another design element to address the identification of early psychosis and treatment. Through the Substance Abuse and Mental Health Services Administration, federal money was added to each state’s Mental Health Block Grant to implement first-episode psychosis programs. These funds have supported the creation of nearly 200 first-episode psychosis programs in the United States, enabling us to at least begin to scratch the surface of the need. Whether these programs can be sustained, however, is yet to be seen. Research shows that the most effective programs involve wraparound services for which commercial insurers and even Medicaid are not required to cover. So while we know these programs are an effective design element of the mental health system, their future is imperiled by a lack of resources. Here again we see a good design element that is not fully implemented.

(Continued on page 7)
Safety Net. With regard to safety-net design, a foundation is the Emergency Medical Treatment and Labor Act (EMTALA), which requires emergency departments (EDs) to diagnose and stabilize all comers. Yet we all know that far too many EDs board individuals with mental illnesses, waiting for beds that they may not actually need if safe alternatives were more available. We also know that for many persons with psychiatric crises, traditional EDs are often not the best place for the diagnosis and treatment of psychiatric crises. Many communities have designed crisis services so that safe alternatives to EDs and inpatient treatment exist. Again, we see good design elements that are not fully implemented.

The lesson here? Taking a design orientation to solving problems related to the delivery of care—that is, thinking like innovators who have been successful in other areas such as business and technology—will help us increase access to effective psychiatric treatment for those who need it. We have many examples of good design elements with incomplete implementation. This leaves too many people suffering and unable to access effective treatment.

Reprinted from Psychiatric News, Published online on January 25, 2018
A Bright Future in Geriatric Psychiatry

David A Beck, MD, Associate Professor, Psychiatry and Behavioral Neuroscience and Internal Medicine, Saint Louis University

By the year 2030, just slightly less than 1 in 5 Americans will be age 65 or older. Talk about job security! Yet, job security is only 1 of the perks of being a Geriatric Psychiatrist. From research, to various clinical settings, to clinical challenges, Geriatric Psychiatry is a fascinating field.

This is an area ripe for new discoveries. Prior attempts to alleviate Alzheimer’s disease and other major cognitive disorders have been met with marginal success. Presently studies are underway looking at the earlier stages of these illnesses and various prevention strategies. Neuromodulatory techniques such as Transcranial Magnetic Stimulation (TMS), Cranial Electrical Stimulation (CES), and Transcranial Direct Current Stimulation (tDCS) hold promise as therapies to alleviate depression and anxiety in older individuals. There has also been greater attention to how lifestyle factors and modification of them can lead to healthier aging.

There are many clinical areas in which a Geriatric Psychiatrist can function. Inpatient service is very rewarding in that patients & families typically come in with high levels of stress and impairment in ability to function. Interventions are made much more quickly in this setting than in the clinic. It is rewarding to see people get better rapidly, many times with listening, support, and medication adjustment. Not all elderly individuals are ill or have many medical problems. The outpatient clinic is an opportunity to experience that. This setting gives an opportunity to develop long term relationships with patients & families. The current cohort of elderly individuals tend to be grateful for the care provided & respectful of physicians. Many older individuals manage the changes of later life quite successfully. I have had a number of patients, who were great examples of ability to maintain high functioning to advanced age. Those individuals have been a great inspiration to me.

Practicing in long term care settings is a unique experience. One of the main interventions here is educating staff. Often loneliness is a major contributor to whatever symptoms are going on & patients appreciate someone sitting & listening to them. Another highlight of this setting is that many times a seemingly minor change in medications can lead to a major improvement in functioning. Long term care is a very regulated setting, so knowing the regulations limitations of the home is key. In this situation, decreasing or stopping a medication maybe more helpful than starting something.

As people get older they tend to accumulate medical conditions. The interactions of physical & psychiatric conditions I find to be particularly intriguing. For example, is this a recurrence of depression, an adverse reaction to a medication, or a thyroid problem?

In conclusion, Geriatric Psychiatry is a great place for a rewarding and fulfilling career, with ability to function in a number of settings, potential for significant advances, and a nice mix between getting to know your patients and intellectual stimulation.
Missouri Psychiatry

Catch 22: The Journey of an International Medical Graduate

Meelie Bordoloi, MD, Child and Adolescent Psychiatry Fellow,
University of Missouri-Columbia

We found ourselves in Chicago, on a cold autumn evening some five years ago. Just like we had to adjust to the bitter cold of Chicago, so also, I had to adjust to the new medical system. Well, it was not really an adjustment, it was essentially a complete overhaul! From being a specialized physician in Clinical Pathology, I had come full circle and had to start where I began- point 0! So to continue, within two days of arriving in this country, my husband started work and I began my quest for a residency position. The first stop was at Kaplan. Kaplan, as we all know, is the Mecca of all International Medical graduates and that is where my journey began too. The challenges started then and there. Beginning with the expenditure of getting access to these resources, to having to study “an entire new way” of medical science, it was dreary and tiring. While I was trying to get the “best scores” in, I continued to keep up my spirits even while I heard horror stories about how people had been trying to get in for years without success. I did what everybody suggested, tried calling old friends who were current residents, made friends with fellow test takers, tried to network to understand more of the system. Then, of course I continued to take my steps, which along with the emotional and physical stress, burnt a hole in my pocket! While doing all of that, I tried to work on obtaining clinical externships and observerships which I think is even a bigger hurdle because on the one hand, they expect you to have some hands on experience in the US and on the other hand, you almost have no opportunities for that. Never mind that these externships and observerships are in different cities and for varying periods of time. I would actually like to mention a friend here, who has not stayed for more than a month with her husband as she has been pursuing observership and research opportunities in other places! Fortunately, for me, I toured the country only for a few months doing them which were in the first place, very hard to find. Ok, so now I have decent scores on the steps, but what after that? Well, the struggle only intensifies after that. It is now time for applications and as you have heard many times over, you need to apply to multiple programs, sometimes, a hundred or more! You hope and pray and lo behold you do get a couple of interviews! Now, the struggle peaks! Now, you find yourself in strange places, travelling late hours, spending more money that you don’t have and arriving for interviews. Fortunately, for me, I managed to get a residency spot in my preferred discipline in the first attempt. However, I know of so many who continue to struggle, both financially and emotionally till this day.

Well, you would think that the struggle ends there, but it does not! Brace yourself for the whirlwind of internship! It starts with the learning curve that is gruesome and normal for interns. However, with us, it gets a bit tricky. Along with conquering the EMR, we also have to conquer the culture! From being a medical student and professional who in my home country never could express my opinions on patient management, I had to learn to question and understand that my opinions mattered and I could be right as well! I had to be friendly with my attendings, yes that was a new one for me! Anyways, it takes a while and you learn and absorb and try your best to stay afloat and suddenly, you are in second year!

I have managed to complete my second year as well and currently I am a CAP fellow in my first year. The emotional turmoil has passed and things have been better but how I can not mention the one obstacle that is a nightmare in every IMG’s path?! The big V- Visa! The visa concerns have always been difficult over the years but with the current state of affairs, it is only getting worse. Your existence is decided by a piece of paper which you have no control over. Families are torn apart and your identity is questioned.

Anyways, just like me and so many others have overcome these challenges to get a spot in residency and go on to have successful careers, so will you all, my dear IMGs. Therefore, please be brave, continue to strive, be creative, push limits and the world will be yours!
Workplace Stress

For most people, work can be both challenging and demanding. Meeting challenges can promote growth and increase resiliency for employees and organizations. However, demands and challenges may also result in high stress, which can be costly.

Why is addressing stress important for employers?
Excessive workplace stress causes a staggering 120,000 deaths and results in nearly $190 billion in health care costs each year. This represents 5% to 8% of national health care spending, derived primarily from high demands at work ($48 billion), lack of insurance ($40 billion), and work-family conflict ($24 billion).

These are some of the harmful health effects from excessive stress:
- Damage to key brain structures and circuitry, reduced ability to cope with future stress and increased anxiety and chronic depression;
- The onset of post-traumatic stress disorder (PTSD);
- Reduced immune system functioning; and
- Increased inflammation and depression.

High on-the-job demands and insufficient resources contribute to stress. In addition, an effort-rewards imbalance with perceptions of high effort and low compensation or recognition can also contribute to work stress. Goals perceived as exceedingly difficult, rather than achievable challenges, are also factors in excessive stress, anger, and anxiety.

What can employers do?
Employers can address and reduce excessive workplace stress by focusing their efforts at the following three levels:

- **Prevention level:** by developing organization-wide policies and practices in the following key areas:
  - Training for leaders and supervisors on effective ways to reduce stress;
  - Working with employees to create challenging but realistic goals for optimal performance;
  - Communicating clearly and managing conflicts respectfully;
  - Identifying and using employees’ strengths and skills for career advancement;
  - Compensating fairly;
  - Ensuring safe work conditions;
  - Modeling work-life balance;
  - Building in opportunities to formally recognize individual and team goal achievement;
  - Creating a work climate that encourages social support and connectedness; and
  - Developing ways to reflect on positive daily workplace events and accomplishments.

Adopting effective stress reduction strategies also holds promise in preventing depression which can be costly to employers.

- **Targeted early identification and intervention level:** offer employees the following options:
  - Stress screenings and information on stress reduction and the early warning signs of mental health conditions;
  - Effective intervention programs like cognitive-behavioral therapy for stress management;
  - Programs that effectively address stress like mindfulness, relaxation, yoga and tai chi and encourage exercise, emphasizing the value to mental and physical health; and
  - Programs that improve resiliency.

Web-based and mobile stress management programs offer employers cost-effective options for reducing workplace stress.

- **Intensive individualized support level:**
  - Assist employees in accessing effective care and supports;
  - Initiate active outreach to employees out on disability;
  - Support employees in remaining engaged with supervisors and co-workers;
  - Develop effective transition and return to work policies and practices; and
  - Consider ADA accommodations that help employees stay on the job.

(Continued on page 11)
Workplace stress can significantly impact the bottom line, however can also be managed to improve productivity, employee health and to create a more positive workplace climate and culture.

Learn More

- Center for Workplace Mental Health - A Working Well toolkit for employers on leading a mentally healthy business.
- American Psychological Association - Resources for creating a psychologically healthy workplace.
- Centers for Disease Control & Prevention - Workplace health resources on stress.
- Health and Safety Executive - UK-based management standards for reducing work-related stress.
- HR Council - Workplaces That Work.
- Live Your Life Well - A website designed to help individuals cope better with stress and create more of the life they want.
- Workplace Strategies for Mental Health - Tools and resources for employers.

References


Reprinted from Center for Workplace Mental Health, American Psychiatric Association Foundation
Missouri Psychiatric Physicians Association

SPRING MEETING

“Psychopharmacology Update: Addressing the Needs of Special Populations”

in collaboration with

Missouri State Medical Association
160th Annual Convention

Saturday, March 24, 2018

at the

Renaissance St. Louis Airport Hotel
9801 Natural Bridge Road
St. Louis, Missouri

The Missouri Psychiatric Physicians Association is excited to host the program titled “Psychopharmacology Update: Addressing the Needs of Special Populations” at the MSMA meeting on March 24, 2018 at the Renaissance St. Louis Airport Hotel. Topics will include Psychiatric Manifestations of Commonly Prescribed Medication in Primary Care, Psychotropic Use in Pregnancy and Geriatric Psychopharmacology.

To register, call MPPA at 573.635.5070 or email missouripsych@gmail.com.
“Psychopharmacology Update: Addressing the Needs of Special Populations”

Agenda

7:30 - 9:00 am  General Membership Meeting

9:00 - 10:00 am  “Geriatric Psychopharmacology”
Speaker: David A. Beck, MD, Associate Professor, Psychiatry and Behavioral Neuroscience and Internal Medicine, St. Louis University

10:00 - 10:30 am  Break

10:30 - 11:30 am  “Psychiatric Care During Pregnancy and Postpartum”
A review of psychiatric management during preconception, antepartum, and the postpartum period, with specific focus on perinatal mood and anxiety disorders.
Speaker: Melanie McKean, DO, PhD, Psychiatrist, Saint Louis Behavioral Medicine Institute, Women’s Reproductive Mental Health and Wellness Program, Medical Director, Adult Eating Disorders Program, Medical Director

11:30 - 12:00 noon  Luncheon

12:00 - 1:00 pm  “Psychiatric Manifestations of Commonly Prescribed Medication in Primary Care”
Dr. Sarma will identify medications with potential to influence neuropsychiatric presentation and he will critically examine a medication list for agents that can induce neuropsychiatric adverse drug reactions.
Speaker: Subbu J. Sarma, MD, Midwest Psychiatric Consultants

Objectives
1. Describe the psychiatric manifestations of commonly used medications by primary care providers.
2. Discuss issues relevant to prescribe psychotropics to geriatric patients.
3. Changed to - Review of psychiatric management during preconception, antepartum, and the postpartum period, with specific focus on perinatal mood and anxiety disorders.

Moderator
Henry A. Nasrallah, MD, Sydney W. Souers Professor, Chair, Department of Psychiatry and Behavioral Neuroscience, St. Louis University School of Medicine
**The Mental Health Bell: A Symbol of Hope**

_Mental Health Association_

_Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness._

_-Inscription on Mental Health Bell_

During the early days of treating mentally ill patients in America, long before the discovery of antipsychotic medications, asylums often used iron chains and shackles to restrain individuals with mental illness. With better understanding and improved treatments, this cruel practice eventually ceased.

In the early 1950s, our national organization, Mental Health America, issued a call to asylums across the country requesting their discarded chains and shackles. MHA melted down these inhumane bindings and recast them into a sign of hope: the Mental Health Bell. Now the symbol of MHA, this 300-pound bell serves as a powerful reminder that the invisible chains of stigma, misunderstanding and discrimination continue to shackle people with mental illness. The bell image in our logo is a graphic representation and continual reminder of our past, the progress being made, and is a powerful symbol of our vital mission to help all Americans live healthy productive lives.

Nationally, MHA was founded in 1909 by Clifford W. Beers, a young businessman and Yale graduate, who struggled with mental illness and spent time in an asylum. He shared his story in his autobiography, “A Mind That Found Itself” which was a revolutionary act and attracted the attention of prominent scholars like William James and families such as the Rockefellers and Vanderbilts. Today, much of the work of MHA and its affiliates is guided by the Before Stage 4 (#B4Stage4) philosophy, a term coined by our national President and CEO, Paul Gionfriddo. He began using this term to describe the stark differences in how we treat cancer, diabetes and heart disease compared to mental illness. He coined B4Stage4 after experiencing the dramatic differences in the way treatment and care for his adult son with schizophrenia compared to his adult daughter diagnosed with Stage 4 breast cancer. You can read his personal story in “Losing Tim,” and follow him on Twitter @pgionfriddo.

Our affiliate, MHA of Eastern Missouri was founded in 1945 for the purpose of giving form and structure to the growing community concern for the needs of those with mental illness. MHA is the only organization in the St. Louis community concerned with the entire spectrum of mental health and mental illness.

Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal.

Our programs fill the void in public education regarding prevention and mental wellness. We provide financial management and educational support to adults with chronic and persistent mental illness. And, as an organization that does not provide treatment, we are in a unique position to offer unbiased referrals to public and private providers.

MHA works tirelessly to be this region’s go-to resource for mental health education, information, referrals and advocacy. For individuals, our mental wellness seminars teach strategies to manage stress,

(Continued on page 15)
The Mental Health Bell: A Symbol of Hope
Mental Health Association

avoid burnout and boost resilience – and to know that reaching out for help is a sign of strength. For those who need more, we offer our HelpLine for all who call us, and representative payee services and BRIDGES for individuals living with mental illness. We work with local, state and federal legislators and policy makers to increase access to integrated care and treatment and to reduce the human suffering that mental illness causes individuals, their families and our community.

In partnership with our national office, MHA of Eastern Missouri offers nine validated online screenings that include depression, anxiety, bipolar, psychosis, eating disorders, and more. Since their inception in 2016, more than 2.5 million screenings have occurred. Individuals between the ages of 11 and 24 comprise the bulk of participants; 70% of individuals score in the moderate to severe range; 66% have never been formally diagnosed. Ancillary data indicate that not only do participants feel more confident in discussing their mental health concerns with their doctor when armed with screening results, but there is a 40% increase in the likelihood that primary care physicians will take steps to help address the patient’s concerns.

With advocacy as a core component of our mission, MHA of Eastern Missouri works at the regional and state levels for access to treatment and parity for mental health. These efforts are accomplished through our agency’s Advocacy Committee, as well as our leadership roles in the Behavioral Health Network and the Missouri Federation of Behavioral Health Advocates.

To learn more about our programs or to join our advocacy network, visit mha-em.org or call us at 314-773-1399. To learn more about MHA of the Heartland in Kansas City, visit mhah.org or call 913-281-2221.

MPPA Members’ Portal Under Construction

The MPPA Website Committee is developing an online portal as an exclusive benefit for MPPA members. This is a dedicated website to allow more collaboration between members and update them on the latest organizational and Missouri psychiatry news. Features include an online discussion board, access to a member directory, the ability to pay for dues and RSVP to MPPA events, access to educational materials such as lecture slides, and many other features. Access to the portal will be included in your membership and every member will have their own personal login. We expect to launch the website in the coming months and believe the portal will allow our organization to be more cohesive regardless of our geographical boundaries.

Vikas Mandadi, MD
Website Committee Chair
**Meta-Analysis Finds Childhood Abuse, Neglect Associated with Self-Injurious Behavior**

Understanding patients’ history of childhood abuse or neglect may help determine their risk of non-suicidal self-injury, according to a meta-analysis published in the January issue of *Lancet Psychiatry*.

Non-suicidal self-injury—defined as direct and deliberate destruction of one’s own bodily tissue without suicidal intent—is estimated to affect more than 5% of adults, 17% of adolescents, and 30% of adolescents with a mental disorder. Moreover, non-suicidal self-injury is known to be one of the strongest predictors for future suicide attempts, Richard T. Liu, Ph.D., of Brown University and colleagues wrote. While most patients who engage in repeated self-injurious behavior stop within a few years, about one-fifth of patients develop a chronic pattern of self-injury.

The meta-analysis by Liu and colleagues included 71 studies that evaluated the association between childhood maltreatment (including sexual abuse, physical abuse, physical neglect, emotional abuse, and emotional neglect) and non-suicidal self-injury. The researchers found that overall childhood maltreatment was positively associated with non-suicidal self-injury (odds ratio [OR] = 3.42). The association was strongest for emotional abuse (OR = 3.03) and weakest for emotional neglect (OR = 1.84), although the analysis for emotional neglect included the fewest studies.

The association of maltreatment with non-suicidal self-injury was found to be stronger in community samples than in clinical samples, suggesting that “screening for history of childhood maltreatment might be of most benefit in community settings,” they wrote.

In an accompanying commentary, Lianne Schmaal, Ph.D., and Sarah Bendall, Ph.D., of Orygen and the University of Melbourne wrote that “Disclosure of past childhood maltreatment to a health professional can be a distressing experience. Because non-suicidal self-injury might function to distract from distress in some people, disclosures of distressing maltreatment have the potential to raise the risk of non-suicidal self-injury afterwards.” Therefore, such assessments should be done in accordance with principles of trauma-informed care.

*Reprinted from Psychiatric News*
APA members stay up-to-date on all the latest research and advances in the field through:

- Complimentary subscriptions to *The American Journal of Psychiatry* and *Psychiatric News*, delivered online or in print, as well as breaking news from *Psychiatric News Alerts*.

- Member discounts of 20% on all American Psychiatric Publishing titles (Resident-Fellow Members receive a 25% discount).

- Discounts on [PsychiatryOnline.org](http://PsychiatryOnline.org), a powerful web-based portal that features DSM-5 and *The American Journal of Psychiatry* as the cornerstones of an unsurpassed collection of psychiatric references from American Psychiatric Publishing.

Visit [www.appi.org](http://www.appi.org) for a complete listing of American Psychiatric Publishing products and to obtain your member discount.

**Not a member? Join at [www.psychiatry.org/join](http://www.psychiatry.org/join).**

For more information, call 703.907.7300 or email membership@psych.org.
Missouri Psychiatry
Newsletter of the Missouri Psychiatric Physicians Association (MPPA)
A District Branch of the American Psychiatric Association

2018 Newsletter Advertisement Order Form
Form and Payment must be received before the ad is placed in the newsletter.
Submission Deadlines for 2018 are February 15, May 30, August 15 and November 15.

___ Yes, I would like to purchase ad space in the next issue of Missouri Psychiatry, the Missouri Psychiatric Physicians Association newsletter.

___ Full Page (7.5” X 10”): $550.00
___ Half Page (7.5” X 5”): $275.00
___ Quarter Page (3.75” X 5”): $140.00
___ Eighth Page (1.8125” X 2.5”): $75.00

Number of Ads: ________________________________________________
Total Price: ____________________________________________________

Company: ___________________________________________________________________________________________________
Contact Name: ___________________________________________________________________________________________________
Address: _______________________________________________________________________________________________________
City, State Zip: ___________________________________________________________________________________________________
Phone: __________________ Email: _____________________________________________________________

Please mail this form along with your payment to the MPA Office.
Make checks payable to the Missouri Psychiatric Physicians Association
Send payment to Sandy Boeckman, MPA, 722 East Capitol Avenue, Jefferson City, MO 65101.
Email your ad to sandyboeckman@gmail.com.
If you have questions, contact Sandy Boeckman at missouripsych@gmail.com or 573-635-5070.
Media Benefits for MPPA Members

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

1. Free ad listings on the MPPA website. MPPA Members can post their research studies, job listings, events or books for 6 months on the MPPA website at http://missouri.psych.org. The listing can repost again after that period.
2. Reduced newsletter ad rates. MPPA members may place any size ad in Missouri Psychiatry, MPPA’s quarterly newsletter, for 50% off the regular rate. Missouri Psychiatry reaches nearly 500 MPPA members and associated healthcare professionals in the state and appears online at the MPPA website. It is the only publication dedicated to psychiatrists in the state of Missouri.
3. Free “Upcoming Events” listings. There is no charge for members to post upcoming meetings and special events of interest to the behavioral health community.

All ads must be camera ready in an electronic format and should include a link to the advertiser’s email address or website. Web ads may be submitted in color or black & white. Newsletter ads will print in black and PMS 294 Blue inks regardless of submission format.

Letters to the Editor

We invite readers to submit letters of not more than 500 words. 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 Physicians Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to adamb@health.missouri.edu. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

We strive to offer content in 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 missouripsych@gmail.com.

Newsletter Disclaimer: The opinions expressed herein are those of the authors and do not necessarily state or reflect the views of Missouri Psychiatric Physicians Association. Publication in this newsletter should not be considered an endorsement.

Copyright 2016 by Missouri Psychiatric Physicians Association. All rights reserved. No part of this document may be reproduced or used in any form or by any means, electronic, mechanical, or otherwise, including photocopy, recording, or by information or retrieval system, without the prior written permission of the publisher.

Guidelines for Submission to Missouri Psychiatry Newsletter

1. All submissions will be sent via email to Sandy Boeckman at missouripsych@gmail.com who will then forward the submission to the newsletter editor.
2. The length of the article should be between 600-1200 words. In addition to the article, up to five references may be added.
3. At the end of the article, the author should include a statement clarifying the presence or absence of a conflict of interest related to the article.
4. If the article includes clinical information, the author should make a statement that the identifying information of the patient has been changed and he/she has obtained the permission of the patient and/or guardian prior to publication.
5. The article will be edited by the newsletter editor. The author may be asked to clarify some information, and address comments made by the editor. The revised article will be emailed back to the editor for final review and approval.

Submission Deadlines

February 15, 2017; May 30, 2017; August 15, 2017; November 15, 2017

Advertisement Information

For advertisement information, please contact Sandy Boeckman by email at missouripsych@gmail.com.