Welcome to the first edition of the newly named newsletter of the Missouri Psychiatric Physicians Association!

I am incredibly honored and humbled to have been elected as the President of the MPPA. I would like to take this opportunity to thank Dr. Henry Nasrallah for his leadership over the past year. He created an incredible platform upon which I hope to build. I would also like to thank the MPPA Executive Council for all of their efforts and valued participation. Of course, none of this is possible without our members, who do such incredible work in representing the MPPA throughout the state of Missouri and beyond.

Years ago, I read the following quote, commonly attributed to Anne Frank: “How wonderful it is that nobody need wait a single moment before starting to improve the world.” The quote, and its sentiment, have stuck with me ever since. I go very few days without thinking about these words. So much so, that I have the quote printed on thank you cards, stationary, and on a poster in my office.

I love these words not because I feel that I am inherently kind or that I embody their sentiment. In fact, the words resonate with me for quite the opposite reason. When I am tired, feeling compassion fatigue, and thinking that I have nothing else to offer, this quote makes me remember that every little bit of kindness and grace matters, and nourishes the world. This includes picking up a piece of trash on the sidewalk, holding a door open for the person behind us, or spending that extra five minutes with a patient who is hurting.

As physicians, this concept of helping others is not novel. We heal, treat, and try to give our very best to patients. As psychiatrists, the job goes even further as we shoulder emotional pain, hear details of trauma, and navigate life’s ups and downs with our patients. We dance in multiple arenas including health care, medicine, social sciences, biological sciences, and many others. Each of you does this, and so much more, every day.

As mental health providers and physicians, we are in a unique position to advocate for our patients, many of whom are, or feel, voiceless and unheard. Being there for our patients often means advocating for them, and mental health in general, beyond the clinical setting. Gone are the days, if indeed they ever existed, where the patient-physician relationship stands alone. To truly effect change, and therefore improve mental health outcomes, we must continue to work for our patients through policy and legislative reform.

(Continued on page 2)
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Sandra Boeckman

President’s Message

Each of you has different gifts, experiences, and areas of expertise. We owe it to each other, our profession, our patients, and ourselves to give a little more wherever we can. To that end, I am asking each of you to commit, if only a little, to improving mental health in our state. Whether this means joining an MPPA committee, participating in MPPA and APA advocacy alerts, or communicating your concerns about mental health in Missouri with the MPPA or your legislators; every little bit helps.

I do not believe that these efforts should be solely our burden. In fact, I believe that we cannot, nor should we, do this alone. For too long, the house of medicine has existed in a somewhat isolated neighborhood. To be sure, we have our own areas of expertise where leadership will be required. However, we will be stronger working with like-minded professionals and advocacy groups who look to promote the highest quality care for individuals with mental illness, including substance use disorders, and their families. To disregard this would risk losing our seat at the proverbial table. Additionally, we may face difficulty maintaining credibility when we do need a conjoined effort to advocate for mental health be it in regard to patient care or the profession of psychiatry. It is for these reasons that, during my presidential year, I hope to focus on collaboration in advocacy and engagement of the Missouri psychiatric community in MPPA activities and efforts.

The MPPA would love to hear from you about your ideas and concerns! This is, after all, YOUR organization. I can be reached directly at sherifa.iqbal@missouripsych.org. We have a website (Missouri.psychiatry.org) that has been updated in the past year. You can also find us on facebook (https://www.facebook.com/missoiripsych/) and twitter (@MOpsychiatry). I hope that, with enhanced communication, increased collaboration, and improved member participation, that the coming year will be our most productive and rewarding yet.

Sherifa Iqbal, MD, DFAPA, FASAM
President MPPA
Announcing Our Newsletter’s New Name

To the MPPA members,

One of my last initiatives as President was to recommend that we give our Newsletter a catchy new name. So a contest was created, with a $300 prize, and all MPPA members were encouraged to send in a suggestion for a new name. The Editor of our Newsletter, Dr. Balkozar Adam, the President-Elect, Dr. Sherifa Iqbal, and myself, comprised the Panel of Judges to select the winner.

There were several interesting and clever entries. Each of the Panel of Judges assigned a rank of 1 to the first choice, 2 to the second choice and 3 to the third choice. The numbers were added and the winner was:

SHOW - ME PSYCHIATRY

The winning entry was sent in by Steve Harvey, MD, who will receive the prize at the MPPA Fall Conference on Saturday September 29 in St. Louis.

Thanks to all those who sent in suggestions for a new name! I encourage you to email your impressions of this new name to our Executive Director Sandra Boeckman at: missouripsych@gmail.com

The impressions will be collated and published in the next issue of SHOW-ME PSYCHIATRY!

Henry A. Nasrallah, MD

Calendar of Events

MPA EXECUTIVE COUNCIL CONFERENCE CALL
(Calls are Scheduled for 7:00 pm)
July 10, 2018
August 7, 2018
September 6, 2018
November 13, 2018

FALL CONFERENCE
Renaissance St. Louis Hotel Airport
9801 Natural Bridge Road
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September 29, 2018

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FUTURE APA MEETINGS
May 18-22, 2019
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Congratulations!

MPPA ELECTION RESULTS

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How Four Degrees of Separation Hamper the Full Integration of Psychiatry with Other Medical Specialties

Henry A. Nasrallah, MD
Immediate Past President, MPPA

One of the major challenges for psychiatric care for the seriously mentally ill is the needless and arbitrary separation of psychiatric care from general medical care. Much has been written about this in the health services arena but the chasm continues. I see at least four types of separations set apart the mentally ill from the physically ill. These separations perpetuate the misperception that mental illness is “different” and not “physical” like other medical disorders. These separations adversely affect the image of psychiatry, and often jeopardize the overall healthcare delivery for the millions of individuals dually affected with illnesses of the body and the brain.

Separation #1 is geographic. Does it make sense that community mental health centers (CMHC) are free-standing and not co-located with a general medical facility where patients can receive the full spectrum of medical care? This “separate and different” status perpetuates stigma and leads to inequality between psychiatric care and general medical care. There are also many free-standing psychiatric hospitals, not integrated into a general hospital. This is incomprehensible given how frequently psychiatric patients suffer from a wide range of serious medical conditions that require ongoing collaborative care.

Separation #2 is financial. Psychiatric care (absurdly re-labeled as “behavioral health”) is almost universally carved out by managed care and insurance companies, with worse coverage and benefits. The outrageous lack of parity between brain disorders that affect the mind (e.g. thoughts, emotions, behavior and cognition) versus the body (e.g. motor movements, sensations, gait) represents an appalling and flagrant injustice to the 60 million Americans who suffer from neuropsychiatric disorders.

Separation #3 is organizational. Psychiatric records are frequently separated from other medical records that the same patients may have. They are regarded as “more confidential” than other medical data, thus perpetuating the stigma associated with psychiatric illness as if suffering from depression or anxiety is more shameful than heart disease or cancer. This clearly precludes optimal psychiatric and medical care and leads to misdiagnosis, medication errors, and duplication of laboratory procedures. The millions of chronically mentally ill who are at high risk for serious medical disorders (such as heart disease, cancer, emphysema, obesity, diabetes, hypertension, sleep apnea, stroke) are often under-served due to this lack of integration of the medical record.

Separation #4 is cultural and linguistic. Most CMHC have devolved over the years from a medical model (psychiatry) to a non-medical paradigm (behavioral health). Sick individuals at the CMHC are “clients”, not patients, as if receiving psychiatric treatment is a business transaction, not medical care. Over the years, psychiatrists have experienced a progressively diminishing role in CMHCs compared to the standard physician leadership in general medical/surgical settings. The culture of CMHC emphasizes “therapists” rather than “medical practitioners”, yet the patients who fill the waiting rooms of these clinics suffer from brain disorders that include some of the most serious and disabling, even life-threatening, medical conditions (e.g. schizophrenia, depression, bipolar disorder, anxiety, OCD) where medical intervention, not counseling, is the primary, indispensable and critical ingredient for managing the illness.

So let’s do something about those separations. Let’s re-medicalize the system of psychiatric health care, while preserving the importance of psychosocial care, by putting the medical aspects of psychiatric illnesses front and center so they can be seamlessly managed with other co-occurring medical disorders. Serious mental illness is associated with early mortality from various medical risk factors, and often lose 10-20 years of life if they do not receive intensive medical treatment. Let’s reintegrate psychiatric practice with the rest of medicine geographically, financially, administratively and culturally. Millions of our patients will be better off without these separations.
WellHealth Clinic is a new St. Louis City-based Non-Profit 501(c)(3) IRS Tax-Exempted community health organization, promoting Integrated and Evidenced-Based health care services to low income individuals and families, developing innovative healthcare delivery.

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In November 2017, MPPA representatives reported back with executive conference call on APA Assembly meeting and Area 4 council meeting. MPPA Legislative Committee has monthly phone conferences with active participation. The executive Ms. Sandra Boeckman emails us weekly updates about the activities on Missouri Senate and House floor.

We are closely monitoring activities in the state capital in Jefferson City, Missouri where pending felony charges against Governor Greitens and talk of impeachment by members of both parties casts a shadow over the legislative session. The bills of interests include HB1253 which establishes the joint committee on substance abuse provisions and treatments has passed out of the House Crime Prevention Committee and currently in Rules and Legislative Oversight. HB1369 which revises the definition of service dogs to include animals supporting individuals with psychiatric or mental disabilities has passed out of House Veterans Committee and is also currently in the Rules Committee. HB1574 which modifies the provision of APRNs in collaborative practice agreements was voted do pass from House Professional Registration.

Regarding scope of practice issues the Missouri State Medical Association (MSMA) whose lead we often follow, reports that they recently came to an agreement with the APRNs to extend the proximity rule to 75 miles and to increase the number of APRNs a physician can collaborate with to six. On the other hand MSMA testified against a bill involving APRN “transition to practice” language similar to that passed in Illinois last year. It allows independent practice for APRNs once they have completed a two-year collaborative practice arrangement with a physician.

Following the horrific mass shooting at the Parkland, Florida high school, the Missouri Legislature seemed unfazed and forged ahead with bills to actually increase gun access, mainly by making it legal to conceal and carry firearms in more settings. On the other hand there are two bills which would prevent individuals from possessing firearms if they have been convicted of a domestic violence offense.

Finally there is a Missouri Senate bill (SB1022) which aims to provide protection for the religious beliefs of individuals in relation to their interaction with gay and lesbian individuals or couples. It seems to be similar to the bill we opposed two years ago due to the potential for discrimination against LGBT persons.

Other than legislative issues:
1. MPPA Executive Committee coordinated with the NAMI St. Louis, supporting NAMI national campaign on the Health Parity Enforcement.
2. MPPA President Henry Nasrallah has agreed to sign a letter designed by APA leadership requesting “open dialogue” on a range of mental health issues including mental health parity, early intervention and access to mental health and substance use treatment. The letter will be sent to the Missouri Congressional delegation. The APA hopes to engage Congress, the President, and the nation as a whole in this “open dialogue”.
3. CME activities:
   a. On January 30, 2018, MPPA president Dr. Henry A. Nasrallah had a CME presentation at Hilton St. Louis Frontenac St. Louis, MO. The entitle is “What the Catie Study Failed to Inform: Neurotoxicity and Neuroprotection are the Real Difference Between the First and Second Generation Antipsychotics”. It had a good turn-out with an engaging question and answer section after the presentation. Many physicians in other medical specialties and those out of town in addition to psychiatrist, as well as the representatives from pharmaceutical and insurance companies participated with good feedback. Additionally, with much discussions, MPPA executive committee is in the process of establishing the MPPA Foundation. This Foundation will promote further engagement with our constituents and the State Legislatives, as well as advance the MPPA’s initiatives and agenda.
   b. Our next CME meeting will be March 24 in St Louis in conjunction with the Missouri State Medical Association. The this year’s focus is "Psychopharmacology Update: Addressing the Needs of Special Populations". The Marketing Committee is actively broadcasting the conference among our constituency via emails, newsletter, word of mouth, and our new MPPA website (https://missouri.psychiatry.org/), especially among medical students and resident physicians.
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Visits for Suicide Ideation, Attempts More Than Doubled at U.S. Children’s Hospitals Since 2008

Surveillance studies have reported that the number of suicide ideation and suicide attempts have been increasing among children in the United States over the last decade. A study published in *Pediatrics* now shows that from 2008 to 2015 emergency department (ED) visits and hospitalizations for suicide ideation/attempts more than doubled at U.S. children’s hospitals and accounted for an increasing percentage of all children’s hospital encounters.

“Our findings that ED and inpatient children’s hospital encounters for SI [suicide ideation] or SA [suicide attempts] have increased over the past decade underscore the increasing impact of mental health disorders in youth on children’s hospital services,” wrote Gregory Plemmons, M.D., of Monroe Carell Jr. Children’s Hospital at Vanderbilt and colleagues. “Recognition of this increasing burden on children's hospitals is paramount in helping to inform future strategies for suicide prevention and treatment and to ensure that interventions to reverse this concerning trend continue to reach the individuals at highest risk.”

Plemmons and colleagues used the Pediatric Health Information System database—which contains clinical and billing data from 49 children’s hospitals in the United States—to collect information on ED visits and hospitalizations for suicide ideation/attempts by children and adolescents aged 5 to 17 between 2008 and 2015.

During the study period, the investigators identified 115,856 encounters for suicide ideation and suicide attempts at 31 hospitals (the other 18 had incomplete data during the study timeframe and were excluded), representing 1.21% of total hospital encounters. Half of the patients were aged 15 to 17, 37% were aged 12 to 14, and 13% were aged 5 to 11; 64% of the patients were girls.

The yearly rate of hospital visits for suicide ideation/attempts more than doubled over the study period, increasing from 0.66% of all visits in 2008 to 1.82% of all visits in 2015. The researchers also observed seasonal trends in visits for suicide ideation/attempts throughout the study period, with the lowest percentage of visits occurring during summer months (June to August) and the highest percentage occurring during spring and fall—during the academic year.

“[O]ur findings ... underscore the need for future work to explore the relationship between school and suicidal ideation, recognizing that the role of academics is a complex one, and there may also be other additional influences at play regarding seasonality,” Plemmons and colleagues wrote.

To read more on this topic, see the *Psychiatric News* article “Impulsivity May Be Strong Contributor to Childhood Suicides” and the *Psychiatric Services* article “Utilization Patterns at a Specialized Children’s Comprehensive Psychiatric Emergency Program.”

Reprinted from APA Psychiatric News Alert
With Early Intervention, Patients With Schizophrenia Experience Greater Improvements in Health, Function

Exposure to high job strain—a combination of high job demands (such as work pace and intensity) and low job control (such as one’s ability to make work-related decisions)—in midlife may increase the risk of mental health problems, according to a study in *Lancet Psychiatry*.

While previous studies have suggested an association between job strain and mental illness, this study provides some of the first evidence of causality on the part of the workplace.

For the study, Samuel Harvey, Ph.D., of the University of New South Wales in Sydney, Australia, analyzed data from the National Child Development Study—a large United Kingdom study that periodically surveyed over 17,000 people born between March 3, 1958, and March 9, 1958, over a 50-year period—to investigate the prospective association between job strain variables at age 45 and risk of common mental health disorders (depression and/or anxiety) at age 50.

The analysis focused on 6,870 participants who completed their surveys at age 45 and had a full or part-time job, had not recently switched jobs, and had no depressive symptoms in the past 30 days. In this group, 2,212 individuals reported low job control, 1,737 reported high job demands, and 1,768 reported high job strain (having elevated scores in both job control and job demand).

At the 50 year survey, 10% of all participants reported new symptoms of depression and/or anxiety (measured with the psychological subscale of the Malaise Inventory). After adjusting for numerous potential contributing factors, including prior psychiatric history, Harvey and colleagues found that workers with high job demands had 1.70 times the odds of developing symptoms of depression and/or anxiety at age 50; workers with low job control had 1.89 times the odds; and workers with high job strain had 2.22 times the odds.

Further analysis suggested that if workplaces could have identified and reduced all 1,768 cases of job strain, the emergence of new mental disorders would have been reduced by 14%.

The study highlights “the potential public health effect of addressing job strain factors in the workplace,” the authors concluded. “Previous research on interventions aimed at increasing employee control or improving job design has shown some promise in the promotion of mental health and reduction of stress in the workplace.”

To read more about this topic, see the *Psychiatric News* article “Rebirth of APAF’s Center for Workplace Mental Health,” by APA Past President Anita Everett, M.D.

Reducing Job Strain May Reduce Mental Health Risks in Midlife

Exposure to high job strain—a combination of high job demands (such as work pace and intensity) and low job control (such as one’s ability to make work-related decisions)—in midlife may increase the risk of mental health problems, according to a study in *Lancet Psychiatry*.

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(Continued on page 13)
Survey Finds Youth Diagnosed With Anxiety Rose From 2007 to 2012

More than 1 in 20 U.S. children had current anxiety or depression in 2011-2012, with the percentage of diagnoses of current anxiety, in particular, rising substantially from 2007 to 2012, according a report in the Journal of Developmental and Behavioral Pediatrics.

“The high degree of comorbidity of anxiety and depression ... and increasing prevalence of diagnosed anxiety collectively demonstrate the public health impact of these disorders,” wrote Rebecca Bitsko, Ph.D., of the National Center on Birth Defects and Developmental Disabilities and colleagues. “The integration of mental health and primary care may improve outcomes for children with anxiety and depression.”

Bitsko and colleagues analyzed data collected as part of the National Survey of Children's Health (NSCH) in 2003, 2007, and 2011-2012 to estimate the prevalence of anxiety or depression among youth aged 6 to 17 years. In 2003, parents were asked to report whether a health care provider had ever told them that their child had anxiety or depression. In 2007 and 2011-2012, anxiety and depression were asked about independently; if the parents answered yes, they were also asked if their child currently had depression or anxiety.

Among youth aged 6 to 17 years, the prevalence of ever being diagnosed with anxiety or depression increased from 5.4% in 2003 to 8.4% in 2011-2012—a 56% increase in diagnosed prevalence from 2003 to 2011-2012. Similarly, the prevalence of current anxiety or depression increased from 4.7% in 2007 to 5.3% in 2011-2012—a 13% increase.

Looking separately at diagnoses for anxiety and for depression, it appears that much of the increase is attributable to increases in diagnoses for anxiety, the authors reported. Current diagnoses of anxiety increased 19% from 3.5% in 2007 to 4.1% in 2011-2012. Current diagnosed depression did not change significantly from 2007 to 2011-2012.

Bitsko and colleagues noted that despite the increase in diagnosed anxiety, the estimates reported in their study are lower than in community-based studies. Co-author John Walkup, M.D. (pictured above), said those study estimates suggest a prevalence of severe childhood anxiety of 8.3%, almost twice the percentage of current diagnosed anxiety reported in the NSCH data.

“In that context, it's not surprising to see the rates of diagnosed anxiety rising,” Walkup told Psychiatric News. “If we are doing good advocacy for early identification and treatment of anxiety, we should close the gap between community samples and what you find here [in the study] in estimates of diagnosed anxiety and depression.”

For related information, see the Psychiatric News article “Childhood Anxiety Can Be Treated—the Challenge is to Recognize It.”

Reducing Job Strain continued

of the Malaise Inventory). After adjusting for numerous potential contributing factors, including prior psychiatric history, Harvey and colleagues found that workers with high job demands had 1.70 times the odds of developing symptoms of depression and/or anxiety at age 50; workers with low job control had 1.89 times the odds; and workers with high job strain had 2.22 times the odds.

Further analysis suggested that if workplaces could have identified and reduced all 1,768 cases of job strain, the emergence of new mental disorders would have been reduced by 14%.

The study highlights “the potential public health effect of addressing job strain factors in the workplace,” the authors concluded. “Previous research on interventions aimed at increasing employee control or improving job design has shown some promise in the promotion of mental health and reduction of stress in the workplace.”

To read more about this topic, see the Psychiatric News article “Rebirth of APAF’s Center for Workplace Mental Health,” by APA Past President Anita Everett, M.D.

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A District Branch of the American Psychiatric Association

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We invite readers to submit letters of not more than 500 words. Show-Me Psychiatry reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Letters should be sent by postal mail to Show-Me Psychiatry, Missouri Psychiatric Physicians Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to adamb@health.missouri.edu. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

We strive to offer content in Show-Me Psychiatry that represents our membership and encourage members to participate in its creation. For communications regarding the newsletter or to submit articles, letters to the editor, or upcoming events, please contact: Editor, Show-Me Psychiatry, 722 E. Capitol Avenue, Jefferson City, MO 65101, or missouripsych@gmail.com.

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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.

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