Celebrating Our New Name!

On September 1, 2017, based on a landslide vote of approval by the members, the Missouri Psychiatric Association (MPA) changed its name to: The Missouri Psychiatric Physicians association (MPPA). This is an important milestone worthy of celebration and contemplation.

We, MPPA members, were physicians before becoming psychiatrists. We then evolved from our noble tradition of healing the wounds of the body to mending ailing brains and anguished minds. Our education and training consume the longest duration among all the mental health professions (12 years for adult psychiatry and 13 years for child, geriatric, forensic, addictions or psychosomatic sub-specialties) which enables us to assess and treat both medical and psychiatric diseases, which very often co-occur in the same patients referred to us. Our scientific training began in our undergraduate years, and was expanded and solidified during our medical school years into the foundation on which we developed our psychiatric expertise during four years of post-MD training. We are uniquely qualified among all medical specialists to diagnose and manage psychiatric brain disorders regardless of severity or complexity. We are also the most skilled in psychopharmacology among all physicians in medicine.

During our medical school training, we trained on how to diagnose and treat failing hearts, malignant cancers, diabetes, hypertension, sore throats, liver toxicity, kidney failure, stroke, arthritis, and migraine. We delivered babies, patched up accident victims and spent countless hours in emergency rooms and intensive care units keeping critically ill patients alive. We learned how the multiple therapeutic effects of a medication is not only a balm for the target organ but may also be a potential toxin to other organs or tissues throughout the body and as a potential risk if it interacts adversely with other medications the patient is receiving.

We also learned how a disease in practically any part of the body can be associated with mental symptoms that mimic primary psychiatric disorders, and how treating the physical illness of the body may alleviate the psychiatric symptoms of the brain and mind, without the need for psychotropic medications.

As psychiatrists, we learned to assess our patients through a an advanced and complex perspective that simultaneously examines the physical and mental symptoms and to arrive at a medical and psychiatric differential diagnosis and comprehensive treatment plan that integrates biopsychosocial goals. We spent thousands of hours during our psychiatric training (many of them on night shifts or weekends) treating
President's Message continued

inpatients and outpatients and emergency room drop-ins, most of whom required a combination of pharmacotherapy and psychotherapy. Other mental health disciplines like psychology and social work always sent us the sickest suicidal, homicidal, psychotic, delirious, and bizarre patients because they know that only psychiatrists can stabilize and manage such patients. Internists and surgeons consulted us daily to diagnose and treat behavioral problems in their patients in hospitals or emergency rooms. As interns, we were required to be on call for 36 consecutive hours, sometimes as the only physician available for a given service in a hospital.

Our new name, MPPA describes who we are, where we came from, and where we are going. Our new name tells the public that we are medical doctors who specialize in psychiatric disorders who are uniquely trained and qualified to effectively and safely prescribe medications or to provide psychotherapy and psychosocial rehabilitation.

Missourians and their families can rest assured that the MPPA members, about 450 of us, are committed to meet all their mental health needs. After all, the serving and healing missions are at the core of our medical identify as psychiatric physicians.

What’s in a name? Everything! Our identity, our roots, our image, our knowledge, our range of skills, our sacrifices, our mind/body perspective, our past, present and future: our destiny.

Our new name sums up our collective professional biography so the citizens of Missouri know exactly who we are: psychiatric physicians with expertise in a wide array of brain and mind maladies manifesting in disorders of the most advanced human traits: self-awareness, thought, communication, mood, affect, impulses, cognition, addictions and behavior, throughout the life cycle from early childhood to old age.

Henry A. Nasrallah, MD

Henry A Nasrallah, MD
President, MPPA
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Internet Searches for ‘Suicide’ Increased Following Netflix Series About Teen Suicide

Google searches using terms related to suicidal ideation rose significantly in the days following the March 31, 2017, release of “13 Reasons Why”—a Netflix series about a teenage girl who dies by suicide.

The finding was reported in a research letter published Monday in JAMA Internal Medicine by researchers from multiple institutions. They found that searches using the terms “how to commit suicide,” “commit suicide,” and “how to kill yourself” were all significantly higher following the series’ release.

“13 Reasons Why” explores the suicide of a fictional teenage girl, and the final episode of the series includes a three-minute, graphic scene of her death. The series has generated widespread interest, as well as debate about its public health implications.

The researchers compared Internet searches using some 20 terms related to “suicide” in the 19 days following the premier of “13 Reasons Why” (March 31, 2017, through April 18, 2017) with expected search volumes assuming the series had never been released. Statistical modeling, using daily trends from January 15, 2017, to March 30, 2017, was used to forecast expected volumes.

All suicide queries were cumulatively 19% higher for the 19 days following the release of “13 Reasons Why,” reflecting 900,000 to 1.5 million more searches than expected. For 12 of the 19 days studied, suicide queries were significantly greater than expected, ranging from 15% higher on April 15 to 44% higher on April 18. Searches using the terms “how to commit suicide” were 26% higher during this period.

Notably, searches for suicide hotlines were also elevated, including “suicide hotline number” (21%) and “suicide hotline” (12%), as were searches using the terms “suicide prevention” (23%) and “teen suicide” (34%).

“It is unclear whether any query preceded an actual suicide attempt,” John W. Ayers, Ph.D., M.A., of San Diego State University and colleagues wrote. “However, suicide search trends are correlated with actual suicides. ... The deleterious effects of shows such as 13 Reasons Why could possibly be curtailed by following the World Health Organization’s (WHO) media guidelines for preventing suicide, such as removing scenes showing suicide, or addressed by including suicide hotline numbers in each episode. These strategies could be retrofitted to the released episodes, included in the planned second season, or applied to other programs.”

“I think the points in the research letter about not glamorizing suicide are on point,” said immediate past APA President Maria A. Oquendo, M.D., Ph.D. (pictured above), an internationally recognized expert on suicide. “This is especially important for adolescents who are impressionable. Anything that makes anyone dying by suicide appear heroic, larger than life, or unusually sympathetic is a disservice.”

Oquendo echoed the researchers in calling for adherence to WHO guidelines regarding publicity about suicide, especially highlighting the relationship of mental illness to suicide, and the fact that mental illness is treatable. “It is very important for parents to be talking to their kids if they are watching this show or others like it, emphasizing the relationship of suicide with mental illness, and that suicide is not a solution, but getting treatment is,” she told Psychiatric News.

For related information, see the APA blog post “13 Mental Health Questions about ‘13 Reasons Why’” and the Psychiatric News article “Experts Respond to Facebook’s Updated Suicide Prevention Tools.”

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How Big is Your Scope of Practice?
Jim Fleming, MD

In medical circles the phrase "scope of practice" usually is an alarm bell for physicians concerned about incursion into medical practice by non-physicians (nurse practitioners, pharmacists, nurse anesthetists and others). For psychiatric physicians the phrase evokes strong emotions and rallying cries because of concerns about psychologist prescribing. In this article, I would like to use the phrase in the broadest sense possible using a clinical vignette of a 64 year old psychiatric physician (OK, that would be me) who, at the tail end of a wonderful mission trip to Central America, acquired an unfortunate (and expensive) gastrointestinal illness.

The discussion will take us out of the medical realm, at least temporarily, but I hope to rein it back in to issues which are relevant to modern medical and psychiatric practice. Let's start by imaging our "scope" has a massive zoom lens allowing us "zoom out" to view the big picture. And considering the reasons why we became physicians in the first place, I am going make the very general assumptions that one important reason was that we wanted to be of direct help to others. Of course there numerous other professions and ways to help others and medicine and psychiatry have many unique and interesting features. However many of us, after decades of clinical practice (in my case almost 30 years), we start to wonder if we can have bigger impact than seeing one patient at a time. And as we start to reach retirement age many of us start to think about what kind of world we would like to leave behind after we finish our earthly walk. That can sometimes mean that we "zoom out" way beyond our own community or nation to address global health. See, for example experience of Dr Sherifa Iqbal, who wrote in [Missouri Psychiatry Newsletter, 1st Quarter 2017 Issue, page 12] about her work the refugee crisis. She mentions the well documented mental health effects of being a refugee but also found that a rapid expansion of her scope of practice to include basic medical care was not only necessary but immediately and significantly appreciated.

And some of us also find that “turning our scope” outside the medical world or perspective can be not only personally rejuvenating but often feels more urgent. For me, the crisis of climate change has been one of these urgent issues. And psychiatry, dealing as it does, with all matter of mental and emotional dysfunction, it often turns out that such “non-medical” issues end up being relevant to our field (see for example APA Position Statement on Climate Change*). But no one can do much on their own to affect global or planetary issues; we need to work in the context of a group effort on some level and for that we need an opportunity where we can have a meaningful role.

My opportunity came in the form of my sixth trip to the Central American country of Nicaragua where I could work with a group focused on the reforestation of the land, a factor of profound social and economic significance in this, the second poorest country in the Western Hemisphere where “slash and burn” agriculture had been the norm for decades. I hadn’t been to Nicaragua since 2008 and was dragging my feet. But when my 27-year-old son said he wanted to go on the trip, which clinched it for me. We were going there to plant trees as part of a very successful project with various international partners [www.takingroot.org].

The clinical vignette starts early in the morning on the day of our return back to the U.S. in mid-June. The clinical history could hardly be more straight forward: my son and I had eaten dinner at the same restaurant the evening prior to our flight home. I was awoken at 1:30AM by the sound of Nathan retching in the sink. Vomiting combined with diarrhea apparently allowed him to get rid of whatever was causing his symptoms within a couple of hours. Not so for me: I didn't notice any symptoms until we arrived at Passport Control in Houston about 10 hours later where a very helpful...
employee allowed me zip to the front of the line. My only symptoms were weakness, diarrhea and nausea with no vomiting but all of sufficient severity to cause us to delay our flight from Houston back to Kansas City. After a few hours rest in a hotel and attempts to rehydrate along with a tablet of self-prescribed ciprofloxacin, I felt no better so we went to the nearest hospital and walked into the emergency room. I was triaged rather quickly by a nurse and a nurse practitioner. The NP was a pleasant fellow who seemed to be attending to the history and immediately ordered blood work drawn (cbc and electrolytes certainly seemed reasonable). But in retrospect he obviously did not get the basic history suggesting an acute, food-borne digestive illness. I allowed an EKG which the NP ordered but a half an hour later, refused chest x-ray seeing no rationale for it. After returning home, on a bill for late charges, I saw that the NP had also ordered cardiac enzymes even though I presented no respiratory or cardiovascular symptoms and he knew I had reported being in good physical condition and had even ran a half-marathon two months earlier.

Adding to my distress in the ER were frontline staff who did not seem to perceive how ill I was and curtly informed me that I could not lie down or even have a pillow. After about an hour and a half of unsuccessful attempts to get comfortable by propping chairs, a backpack etc., I actually went outside and lay down on a small patch of grass immediately in front of emergency room for about 20 minutes. No one seemed to notice! After a total of two hours and hearing the name of the same person being called three times over a 10 minute period, I left AMA and my son and I returned to the hotel where at least I could rest properly. Unfortunately, after several more hours, I felt progressively weaker and more nauseous and realized that unless I got help I would not be well enough to use our delayed ticket to Kansas City. We ended up deciding to call 911 at about 2:00AM and after being taken to the ER by ambulance, within a few minutes I was in an ER bed talking with the ER doctor. He had obviously read the note from the night before and spoken with staff because after one or two questions he already knew immediately what to do. I received two IV anti-emetics and IV fluids were started.

I woke feeling a little better after about 20 minutes of the best nap I had since becoming ill about 18 hours earlier. After another hours of rest and a liter of IV normal saline I was feeling significantly better. We were pleased when the ER doctor popped back in and sent us on our way. No fancy tests were ordered and when I inquired about antibiotics, the doctor said this could actually make symptoms worse and he didn’t prescribe one. The nursing staff provided a very helpful instruction sheet mainly with dietary precautions and also mentioned avoidance of antidiarrheal since the whole point of the diarrhea was to get rid of the causative agent! All very basic stuff—natural if you will—but incredibly important and often not known even by medical personnel who are not up on the latest in traveler’s diarrhea (including me certainly). Perhaps if I had just waited awhile longer in the ambulatory area of the ER the evening before, I might have eventually gotten the same excellent care. But I was too sick, and not feeling cared for by the staff made things worse. Later I learned that the evening I walked into the ER had been unusually busy with a lot of trauma, complicated OB cases, etc. that had to be sent elsewhere so I might have been waiting much longer than I could have physically tolerated.

In any case we made it home later that day and I was glad to be over the worst of the illness, though it took a couple of weeks before I was completely back to normal with a couple of setbacks when I inadvertently went off the recommended low fat diet.

The real “indigestion” however occurred when I started receiving bills for the two ER visits. First were the provider charges: $1100 for the NP and $1700 for MD. The lab and EKG were only a few hundred but then came the real shocker: the ER charges were $3,000 for the first visit and $4,000 for the 2nd. The ambulance fee came next at $1300 for a running total

(Continued on page 8)
How Big is Your Scope continued

of $11,400***! Fortunately, the hospital happened to be in my insurance network and while I haven’t heard what the final approved charges will be I will most likely have to pay most of my remaining $5,000 deductible. Still, this seems like an awful lot of money for a few minutes of contact with two different providers. Now, most physicians can probably handle these charges based on their income but this is simply not the case for many Americans. Even with the improvements in healthcare access since the Affordable Care Act (ACA) was passed, medical debt has been estimated to account for the majority of bankruptcies in the U.S. (REF 2). And if ongoing attempts to repeal the ACA without a viable replacement plan eventually succeed, these and related problems are only likely to worsen. The APA is fully engaged with other medical groups to prevent these disastrous changes from occurring but my experience reinforced my conviction that even the current system needs fundamental change; it rewards emergency care and costly interventions (e.g. expensive diagnostic procedures and surgeries) while primary and preventive care (including the kind of work most psychiatrists do) is both much less costly and more poorly reimbursed.

On the macro level, I learned that despite my brief but uncomfortable and expensive illness, my own scope of practice is most fulfilling when I cannot only “zoom out” to the broadest views possible but also—if only for a week or two—immerse myself in something more meaningful and impactful. The physical symptoms I had were transient and almost forgotten. But the trees we planted, the farmers and communities we helped and the friendships we made and strengthened will last for decades, hopefully longer. Please permit me to end by asking: how big is your scope of practice? I hope you find the journey to answering this question as illuminating and fulfilling as I have.

FOOTNOTES
*APA Position on Climate Change: The American Psychiatric Association (APA) recognizes that climate change poses a threat to public health, including mental health. Those with mental health disorders are disproportionately impacted by the consequences of climate change. APA recognizes and commits to support and collaborate with patients, communities, and other healthcare organizations engaged in efforts to mitigate the adverse health and mental health effects of climate change. —” – APA Operations Manual (Contains APA official policy on specific subjects)

REFERENCES:
1. [A Psychiatrist’s Experience in a Greek Refugee Camp, Missouri Psychiatry Newsletter, 1st Quarter 2017 Issue, page 12]
2. Medical bills prompt more than 60 percent of U.S. bankruptcies (http://www.cnn.com/2009/HEALTH/06/05/bankruptcy.medical.bills/)
Parents of children with autism spectrum disorder (ASD) can benefit from involvement in their children’s cognitive-behavioral therapy (CBT), according to a pilot study posted online August 1 in the Journal of Autism and Developmental Disorders.

“Treatment effects occurred across all parents in depression, emotional regulation, perceptions of their children, and mindful parenting,” wrote Andrea L. Maughan and Jonathan A. Weiss, Ph.D., of York University in Toronto.

Investigators examined changes in the parents’ mental health, parenting skills, and expressed emotion following participation with their children in a randomized, controlled trial of 10 sessions of a CBT program developed to improve emotional regulation in children with ASD. CBT has emerged as an effective treatment for anxiety disorders in children with ASD who do not have an intellectual disability, the researchers noted.

Participants included 57 children with ASD and one parent of each child. Of the 57 parents, 80.7% were mothers of children with ASD (91.2% males). The children’s IQ scores ranged from 79 to 140. About 70% of parents had undergraduate university degrees. More than 90% of the children met criteria for at least one mental health problem on the Anxiety Disorders Interview Schedule for DSM-IV. Parent psychopathology and stress were measured using the Depression Anxiety Stress Scale. Child psychopathology and improvement were measured by the Clinical Global Impression Scale–Severity and Improvement.

Of the parents who had depression, their symptoms from pre- to post-intervention were significantly reduced, and overall the parents’ emotional regulation improved.

“It may be that helping children to practice the emotion regulation strategies from the CBT program also resulted in parents learning strategies that are relevant to their own coping approach,” the researchers noted.

Reprinted from APA Psychiatric News Alert
Clozapine May Lower Risk of Self-Harm in Patients with Treatment-Resistant Schizophrenia

Clozapine use by patients with treatment-resistant schizophrenia appears to have a protective effect against self-harm when compared with other antipsychotics, according to a report in *AJP in Advance*. The study also found that when compared with no antipsychotic treatment, clozapine use is associated with a decreased overall mortality rate.

Researchers in England and Denmark conducted a population-based cohort study of 2,370 individuals born in Denmark, who had been diagnosed with treatment-resistant schizophrenia after January 1, 1996. Patients were followed until death, first episode of self-harm, emigration, or June 1, 2013.

During the follow-up period, 1,372 individuals (58%) with treatment-resistant schizophrenia initiated clozapine treatment. After adjusting for confounding factors, nonclozapine antipsychotic treatment was associated with an elevated rate of self-harm (hazard ratio: 1.36) compared with clozapine. Moreover, the absence of clozapine treatment was associated with an elevated rate of all-cause mortality (hazard ratio: 1.88) compared with clozapine treatment. “This was driven mainly by periods of no antipsychotic treatment (hazard ratio: 2.50), with nonsignificantly higher mortality during treatment with other antipsychotics (hazard ratio: 1.45),” Theresa Wimberley, Ph.D., of Aarhus University in Denmark and colleagues wrote.

“The extent to which the observed excess mortality rate after clozapine discontinuation is caused by side effects from recent clozapine exposure, unobserved factors, or clozapine discontinuation remains to be investigated,” Wimberley and colleagues wrote. “This study suggests that clozapine discontinuation needs more attention with thorough evaluation, care, and monitoring of the patient.”

For related information, see the *Psychiatric News* article “Collaborative Effort Among Stakeholders Can Reduce Barriers to Clozapine Use” and the *Psychiatric Services* article “The Business Case for Expanded Clozapine Utilization.”

Reprinted from APA Psychiatric News Alert

Mark Your Calendar
Missouri Psychiatric Physicians Association
Annual Meeting
in collaboration with Missouri State Medical Association
160th Annual Convention
Saturday, March 24, 2018
at the Renaissance St. Louis Airport Hotel
St. Louis, Missouri
Missouri Psychiatric Association donates to NAMI every year to help families, may that be a child or a spouse, who may be effected by a mental illness. One in four people feel isolated and alone, afraid to face the future. Missouri Psychiatric Association helps NAMI with their fight so that families facing mental illnesses are not fighting alone.

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In the early morning hours today, the Senate rejected a scaled-down version of a Republican health care bill that would have repealed parts of the Affordable Care Act.

"With today's vote [49-51], psychiatrists and other health providers can thank the Senate that our patients will not lose access to health care," APA CEO and Medical Director Saul Levin, M.D., M.P.A., said in a statement.

Republican Sens. Susan Collins (Maine), Lisa Murkowski (Alaska), and John McCain (R-Ariz.) joined all 48 Democratic senators in voting against the bill, titled the Health Care Freedom Act.

If passed, the bill would have increased the number of uninsured by 16 million people by 2026, including 7 million who would have been on Medicaid, according to the Congressional Budget Office. It would have kept on the table for debate proposals to cut Medicaid and eliminate guaranteed coverage of the essential health benefits mandated under the ACA—provisions that APA had fought against.

APA has repeatedly reached out to members of Congress in face-to-face meetings, letters, and grassroots efforts to express concerns that the proposed bills in the House and Senate would take away access to treatment for people with mental health and substance use disorders and reduce the number of people with health insurance.

Levin noted, “There are challenges with our current health care system that Congress can and must address to improve the system overall. We need to stabilize health insurance markets and make sure all Americans have options to purchase comprehensive insurance at affordable rates, as well as continued access to mental health and substance use disorder services.

“The APA stands ready to work with members of Congress on sustainable solutions so that every American has access to quality health care, including mental health care,” he said.

For related information, see “APA Fights Hard Against Republican Health Care Bills.”

Reprinted from APA Psychiatric News Alert

In Memory of Paul Michael Packman, M.D.

Packman, Paul Michael, MD Dr. Paul Michael Packman, of University City, passed away peacefully on Thursday evening, August 3, surrounded by his loved ones. Dr. Packman was born August 5, 1938 in Saint Louis to Helen (Bernhardt) and Simon Packman. He was a psychiatrist in private practice for over forty years. He earned his undergraduate and medical degrees at Washington University in 1959 and 1963, where he was awarded the Borden Award for meritorious research. He fulfilled his military service at the National Institutes of Health in Bethesda, MD, and held research positions at Balliol College, Oxford University, England and University of Goteborg, Sweden. After a residency in psychiatry at Washington University, he went into private practice. He was Clinical Associate Professor of Psychiatry at Washington University for over 25 years. He was a board member and former president of the American Academy of Clinical Psychiatrists. He had an active full-time medical practice until one week ago. In addition to psychiatry, his passions included art, music, gardening, and travel. He was a devoted patron of the Opera Theatre of Saint Louis. He loved to joke and make bad puns. He will be remembered by all who knew him for his irrepressible spirit. Dr. Packman is survived by his brother Dr. Robert Packman (Leonard Powers) of Creve Cœur, daughter Sarah Packman (Robert Caldwell) of Hanover, NH, son David Packman of Des Peres, and special friend Hannecristl Fruhauf of San Rafael, CA. Services: Rindskopf-Roth Funeral Chapel is entrusted with arrangements. A memorial celebration will be planned for a later date. Memorial donations may be made to the Opera Theatre of Saint Louis.
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“Controversies & Advances in Psychiatric Subspecialties”
Holiday Inn Executive Center
Columbia, Missouri
Saturday, October 7, 2017

Preliminary Agenda

FRIDAY, OCTOBER 6, 2017
7:00 - 9:00 pm  Executive Committee Dinner Meeting
7:00 - 9:00 pm  Resident/Medical Student Social

SATURDAY, OCTOBER 7, 2017
7:00 - 8:00 am  Registration, Continental Breakfast, Poster and Exhibits Set-Up
8:00 - 8:45 am  “Advances in Schizophrenia”
    Speaker: Henry Nasrallah, MD, Sydney W. Souers Professor, Chair, Department of Psychiatry &
    Behavioral Neuroscience, Saint Louis University
8:45 - 9:30 am  “Personality Disorders Update”
    Speaker: Donald Black, MD, Professor and Vice Chairman, University of Iowa Department of Psychiatry
9:30 - 9:45 am  Break to View Exhibits and Posters (See pages 16-17)
9:45 - 10:30 am “Advances in Bipolar and MDD”
    Speaker: Henry Nasrallah, MD, Sydney W. Souers Professor, Chair, Department of Psychiatry &
    Behavioral Neuroscience, Saint Louis University
10:30 - 11:15 am “Anxiety Disorders Update”
    Speaker: Donald Black, MD, Professor and Vice Chairman, University of Iowa Department of Psychiatry
11:15 - 12 noon  Poster Session & Awards for Best Posters
    Moderator: Anjan Bhattacharyya, MD
12:00 - 1:00 pm  Lunch with Exhibitors
PSychologists Prescribing Open Discussion
    Moderator: Dr. Alan Whitters, President-Elect, Iowa Psychiatric Society
1:00 - 3:00 pm  INTERACTIVE BREAKOUT SESSIONS
    “Child and Adolescent Psychiatry”
    Speakers: Laine Young-Walker, MD, Associate Dean for Student Programs, Associate Professor of
    Psychiatry, Division Chief, Child and Adolescent Psychiatry, University of Missouri-Columbia; Pravesh
    Deotale, MD, Assistant Professor of Psychiatry (Child Psychiatry), Saint Louis University
    • Polypharmacy
    • Antipsychotic use for aggression
    • Address trauma
“Controversies & Advances in Psychiatric Subspecialties”
Holiday Inn Executive Center
Columbia, Missouri
Saturday, October 7, 2017

“Geriatric Psychiatry”
Speaker: George Grossberg, MD, Professor, Department of Psychiatry and Behavioral Neuroscience, Department of Anatomy and Neurobiology, Department of Internal Medicine, Division of Geriatric Medicine, Dementia, Health Aging, Saint Louis University; David Beck, MD, Associate Professor of Psychiatry/Geriatric Psychiatry, Saint Louis University
- Anti-dementia Therapies- Current and Future
- Innovative Approaches to Treating Agitation in Alzheimer’s Disease
- Promising Treatments for Late Life Depression. The Role of Ketamine and Neuromodulatory Therapies

“Addictions Psychiatry”
Speakers: Sherifa Iqbal, MD, Saint Louis University; Art Taca, MD, Medical Director, INSynergy
- Missouri vs. County PDMP
- Access to care and treatment options
- MAT training
- ASAM policy statements
- Medical marijuana
- Methamphetamine in Missouri

“Forensic Psychiatry”
Speakers: Jackie Landess, MD, JD, Assistant Professor of Psychiatry, Saint Louis University; Nicole Graham, MD, Assistant Professor of Psychiatry, University of Missouri Kansas City
- Correctional Psychiatry Issues
- Issues in Medical Malpractice

“Consultation/Liaison Psychiatry”
Speakers: Anjan Bhattacharyya, MD, Associate Professor of Psychiatry, Saint Louis University
- Managing the medical/surgical inpatient with opioid addiction
- Managing alcohol withdrawal-alternatives to benzodiazepines
- Payment for consults/making the case to a hospital system for funding Psychiatric Consultation

“General Adult Psychiatry”
Speakers: John Lauriello, MD, Chancellor’s Chair of Excellence in Psychiatry, Medical Director of the Missouri Psychiatric Center, University of Missouri-Columbia; Henry Nasrallah, MD, Sydney W. Souers Professor, Chair, Department of Psychiatry & Behavioral Neuroscience, Saint Louis University
- Precision Psychiatry
- Neuroscience literacy for clinical psychiatrists
- Biomarkers: Their multiple potential uses in psychiatry
- Unmet needs in the diagnosis and treatment of psychiatric disorders

3:00 - 4:30 pm
Group Reports and General Discussion about Missouri Psychiatry
Panel Discussion with Presenters
Moderators: Laine Young-Walker, MD, Associate Dean for Student Programs, Associate Professor of Psychiatry, Division Chief, Child and Adolescent Psychiatry, University of Missouri-Columbia; Henry Nasrallah, MD, Sydney W. Souers Professor, Chair, Department of Psychiatry & Behavioral Neuroscience, Saint Louis University
Windsor IV Ballroom

4:30 pm
Final Remarks and Adjournment
Windsor IV Ballroom
Poster Session Submission Form
Missouri Psychiatric Physicians Association
Fall Conference
OCTOBER, 2017
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Please select which category best describes your current employment status.

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Poster Title: ____________________________________________

Date of Research/Event: ______________________________________

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All additional authors (names, degrees, etc):
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2. ______________________________________________________
3. ______________________________________________________
4. ______________________________________________________
5. ______________________________________________________

I have submitted all information as if it were to be printed in the Conference materials. If accepted for presentation, I give permission for this abstract to be printed in the conference proceedings.

☐ Yes, include my information (Check here)

Submission Form and Abstracts must be submitted by September 1, 2017 to:

Sandra Boeckman, Executive Director
Missouri Psychiatric Physicians Association
722 E. Capitol Avenue
Jefferson City, MO 65101
Phone: (573) 635-5070
Fax: (573) 635-7823
E-mail: missouripsych@gmail.com
Poster Session Submission Form
Missouri Psychiatric Physicians Association

ABSTRACT

Poster Title: ________________________________________________

Abstract (250 words or less):

Submission Deadline is September 1, 2017
Missouri Psychiatry
Newsletter of the Missouri Psychiatric Physicians Association (MPPA)
A District Branch of the American Psychiatric Association

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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.

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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.
Calendar of Events

~ ~ ~ ~ ~ Conference Calls Scheduled at 7:00 pm ~ ~ ~ ~ ~

Fall Conference, General Membership Meeting and CME Training
Holiday Inn Select
Columbia, MO
October 7, 2017

Annual Meeting
Renaissance St. Louis Airport Hotel
St. Louis, MO
March 24, 2018

MPA Executive Council Conference Call
July 6, 2017
August 8, 2017
September 7, 2017
November 14, 2017