Lack of Parity is at the Core of Stigma

Of all the injustices and discriminations that mentally ill citizens and their families have to face daily, none is more egregious and irrational than the lack of parity of psychiatric disorders with other medical ailments. In a country that upholds fairness and justice for all, the parity gap between psychiatric and neurologic brain disorders defies logic and tramples on the most basic principles of common sense.

Essentially, individuals with a cerebrovascular disease manifesting as motor paralysis and aphasia are covered fully by insurance, while individuals with motor paralysis and aphasia due to catatonic schizophrenia or stuporous bipolar depression are not. This revolting and ongoing discrimination has its ugly roots in the anachronistic notions of the duality of the brain and mind, which neuroscience research has already debunked, showing that they are one and the same.

There now exists a vast neuropsychiatric literature that demonstrates the extensive symptomatic similarity between neurologic and psychiatric disorders, both of which represent diseases of brain structure and function. For example, a tumor in the prefrontal lobe can manifest with a personality disorder that insurance companies would refuse to cover, until an MRI scan reveals the tumor, at which point, and abruptly, the same illness becomes fully insurable. Similarly, a patient with a left prefrontal lobe stroke frequently presents with the classic symptoms of major depression, but there is certainly no parity in the coverage of those two neuropsychiatric disorders. A complex partial seizure focus in the medial temporal lobe can manifest as psychotic behavior that is indistinguishable from schizophrenia. Interestingly, although an avalanche of neurobiological research has revealed many structural anomalies of temporal, limbic and frontal structures, the medieval dogma of not regarding psychosis as a neurological disease continues to ignore solid scientific advances. A closed head injury with sequelae of agitation, impulsivity and violence is covered, but a patient with primary psychiatric diagnosis of severe impulse control disorder is not. A person diagnosed with a cerebritis can manifest with depression, lethargy, anxiety and cognitive dysfunction and is covered very well by insurance companies, but not so for patients with anxiety-depression syndrome displaying identical clinical features and disability.

The list of such overlaps between psychiatric (microscopic) and neurologic (macroscopic) disorders is endless, but the outrageous lack of parity for mental illness continues. The denigration of psychotherapy by insurance companies who refuse to pay for it as a legitimate medical treatment is also galling given the numerous studies of the effectiveness of psychotherapeutic interventions. And even though all serious psychiatric disorders require pharmacological therapy to improve, insurance companies still discriminate against antidepressants and antipsychotic pharmacotherapy compared to the drugs for multiple sclerosis, Parkinson’s Disease or myasthenia gravis, or migraine which can be more expensive than the psychotropic drugs (botox anyone?)

Ignorance is no longer acceptable as an excuse. The body of scientific evidence for mental illness as brain diseases that disrupt thinking, mood, emotions, behavior and cognition is irrefutable and unimpeachable, and should be

(Continued on page 2)
Missouri Psychiatric Physicians Association
Executive Council

EXECUTIVE COUNCIL OFFICERS
President
Henry A. Nasrallah, MD

President-Elect
Sherifa "Missy" Iqbal, MD

Secretary-Treasurer
Jo-Ellyn M. Ryall, MD

Immediate Past President
Laine Young-Walker, MD

APA Assembly Representatives
James L. Fleming, MD
Loon-Tzian Lo, MD

COMMITTEE CHAIRS
Addiction - Art Taca, MD
Bylaws - Anjan Bhattacharyya, MD
Child Psychiatry - Sultana Jahan, MD
Disaster Psychiatry - Sherifa "Missy" Iqbal, MD and Mirela Marcu, MD
Early Career Psychiatry - Erum Khan, MD
Ethics - Miggie Greenberg, MD
Forensic and Correctional Psychiatry - Nicole Graham, MD and Jackie Landess, MD
Geriatric -
David Beck, MD and William Redden, MD
Legislative - James L. Fleming, MD
Membership/Fellowship -
James Robert "Bob" Batterson, MD
Newsletter Editor 'Missouri Psychiatry' - Balkozar S. Adam, MD
Nominating - Laine Young-Walker, MO
Political Action - Paul B. Simon, DO, Treasurer
Private Practice - Azfar Malik
Program - Laine Young-Walker, MD
Media Relations - Tommy Horn, MD
Website - Vikas Mandadi, MD
Resident Fellow Representative - Priyanka Saigal, MD and Nathalie Boulos

EXECUTIVE DIRECTOR
Sandra Boeckman

PRESIDENT’S MESSAGE continued

unfettered from sociopolitical arguments. The real debate should focus on why insurance companies and managed care organizations are allowed to persist in their blatantly arbitrary and self-serving stance of not providing identical health benefits for psychiatric brain disorders as they do for heart disease, stroke, diabetes, cancer, and other medical disorders.

Parity is a major ethical, moral, legal, scientific and human rights issue for which the entire psychiatric community of patients, families, physicians and mental health providers should hold politicians accountable when they come asking for our votes.

Henry A Nasrallah, MD
President, MPPA

Mark Your Calendars
January CME Workshop
“What the Catie Study Failed to Inform: Neurotoxicity and Neuroprotection are the Real Difference Between the First and Second Generation Antipsychotics”
Hilton St. Louis Frontenac
St. Louis, MO
Tuesday, January 30, 2018

Spring Meeting
“Psychopharmacology Update: Addressing the Needs of Special Populations”
Renaissance St. Louis Airport Hotel
St. Louis, MO
Saturday, March 24, 2018

MPPA Executive Council Conference Call
(Calls are Scheduled for 7:00 pm)
November 20, 2017
January 16, 2018
February 6, 2018
April 10, 2018
July 10, 2018
August 7, 2018
September 6, 2018
November 13, 2018
NO MATTER THE SIZE OF YOUR PRACTICE
WE HAVE YOU COVERED

WE PROTECT YOU

All providers in your practice - psychiatrists, psychologists, social workers and other behavioral healthcare providers - can be covered under one medical professional liability insurance policy, along with the entity itself.

- Access to a comprehensive professional liability insurance policy
- Simplified administration - single bill and one point of contact
- Custom rating leverages the best premium for your practice
- Coverage for multiple locations even if in different states
- Entity coverage available
- Separate and shared limits available
- Discounted background check packages

When selecting a partner to protect your group practice, consider the program that puts psychiatrists first. Contact us today.

More than an insurance policy
(800) 245-3333 | PsychProgram.com/Dedicated | TheProgram@prms.com
**Naltrexone, Buprenorphine-Naloxone Found Equally Effective in OUD Patients Who Initiate Treatment**

Extended-release naltrexone and sublingual buprenorphine-naloxone appear to be equally safe and effective at preventing opioid relapse in patients with opioid use disorder (OUD). However, it can be harder to initiate patients actively using opioids on naltrexone (due to required detox period) than buprenorphine-naloxone. These two findings were reported in a study published in *The Lancet*.

“Both medications are effective treatments for opioid use disorders versus counseling-only approaches or compared to placebo. What is now clear is how similar the outcomes are for those initiating treatment with either medication,” Joshua D. Lee, M.D., M.Sc., of NYU School of Medicine said in a press release. “Patients wanting naltrexone but who are unable to complete detox should be encouraged to start an agonist-based treatment like buprenorphine.”

Naltrexone (an opioid μ-receptor antagonist) differs from buprenorphine both in terms of induction and ongoing care. The medication cannot be initiated until patients are fully detoxified without risking precipitated withdrawal, but once initiated, naltrexone produces no opioid-like effects and no physiological dependence. In contrast, buprenorphine (a partial agonist) can be initiated as soon as patients are in mild-to-moderate withdrawal. Unlike naltrexone, buprenorphine maintains physiological opioid dependence, and withdrawal is likely to occur on discontinuation.

Lee and colleagues randomly assigned 570 patients with OUD to receive monthly injections of extended-release naltrexone (brand name Vivitrol) or daily buprenorphine-naloxone (brand name Suboxone) for 24 weeks. Study participants were 18 years or older and had used non-prescribed opioids in the past 30 days. Unlike patients in the buprenorphine-naloxone group, who received medication shortly after randomization, those assigned to naltrexone had to complete detoxification before receiving the first injection of medication. Detoxification was defined as not using an opioid for three or more days, having urine that tested negative for opioids, and having a negative naloxone challenge.

As expected, fewer patients successfully initiated naltrexone compared with buprenorphine/naloxone (72% versus 94%). Of the 474 patients who successfully began treatment, the proportion of opioid-relapse events over the course of the study was similar (52% for the naltrexone group versus 56% for the buprenorphine/naloxone group). The proportion of participants reporting adverse events and serious adverse events did not differ between the groups, with the exception of reactions at the injection site of naltrexone, all of which were of minor to moderate severity.

“Studies show that people with opioid dependence who follow detoxification with no medication are very likely to return to drug use, yet many treatment programs have been slow to accept medications that have proven to be safe and effective,” Nora D. Volkow, M.D., director of the National Institute on Drug Abuse, said in a press release. “These findings should encourage clinicians to use medication protocols, and these important results come at a time when communities are struggling to link a growing number of patients with the most effective individualized treatment.”

For related information, see the *Psychiatric News* *PsychoPharm* article “Psychiatrists Discuss Risks, Benefits of Medications for Opioid Use Disorder.”

*Reprinted from Psychiatric News*
We’ve got you covered.

For over 30 years, we have provided psychiatrists with exceptional protection and personalized service. We offer comprehensive insurance coverage and superior risk management support through an “A” rated carrier. In addition to superior protection, our clients receive individual attention, underwriting expertise, and, where approved by states, premium discounts.

Endorsed by the American Psychiatric Association, our Professional Liability Program Provides:

- Risk Management Hotline – comprehensive 24/7 service for emergency issues
- Insuring Company rated “A” (Excellent) by A.M. Best
- Broad coverage policy includes Personal and Advertising Injury Coverage, Medical Director Coverage, Publishing of articles or books and broadcasting activities, Telemedicine Coverage, ECT Coverage, and Forensic Practice Coverage
- Many discounts, including Claims-Free, New Business & No Surcharge for claims (subject to State Approval)
- Interest-free quarterly Payments/Credit Cards Accepted
- Medical Payments Coverage: Limit of $100,000 for Medical Payments to a patient or client arising from bodily injury on your business premises
- Defense Expenses related to Licensing Board Hearings and Other Proceedings: Limit of $50,000 per proceeding with NO annual aggregate (higher limits are available up to $150,000)
- Fire Legal Liability Coverage: $150,000 liability limit for fire damage to third party property
- 50% Resident-Fellow Member Discount
- 5% Risk Management Discount for 3 hours of CME

Visit us at apamalpractice.com or call 877.740.1777 to learn more.
President Trump on Thursday directed the Department of Health and Human Services to declare the opioid crisis a public health emergency, taking long-anticipated action to address a rapidly escalating epidemic of drug use.

But even as he vowed to alleviate the scourge of drug addiction and abuse that has swept the country — a priority that resonated strongly with the working-class voters who supported his presidential campaign — Mr. Trump fell short of fulfilling his promise in August to declare “a national emergency” on opioids, which would have prompted the rapid allocation of federal funding to address the issue.

His directive does not on its own release any additional funds to deal with a drug crisis that claimed more than 59,000 lives in 2016, and the president did not request any, although his aides said he would soon do so. And he made little mention of the need for the rapid and costly expansion of medical treatment that public health specialists, including some in his own administration, argue is crucial to addressing the epidemic.

“No part of our society — not young or old, rich or poor, urban or rural — has been spared this plague of drug addiction and this horrible, horrible situation that’s taken place with opioids,” Mr. Trump said during an elaborate and emotional ceremony in the East Room of the White House, attended by families affected by opioid abuse, members of Congress and administration officials.

“This epidemic is a national health emergency.”

To combat the epidemic, the president said the government would produce “really tough, really big, really great advertising” aimed at persuading Americans not to start using opioids in the first place, seeming to hark back to the “Just Say No” antidrug campaign led by Nancy Reagan in the 1980s.

“This was an idea that I had, where if we can teach young people not to take drugs,” Mr. Trump said, “it’s really, really easy not to take them.” He shared the story of his brother Fred, who he said had struggled with alcohol addiction throughout his life and implored Mr. Trump never to take a drink — advice the president said he had heeded.

“We are going to overcome addiction in America,” the president said.

The designation of a public health crisis, formally made by Eric D. Hargan, the acting health secretary, would allow for some grant money to be used to combat opioid abuse, permit the hiring of specialists to tackle the crisis, and expand the use of telemedicine services to treat people in rural areas ravaged by opioid use, where doctors are often in short supply.

Mr. Trump said his plan would include a requirement that federally employed prescribers be trained in safe practices for opioid prescriptions, and a new federal initiative to develop nonaddictive painkillers, as well as intensified efforts to block shipments of fentanyl, a cheap and extremely potent synthetic opioid manufactured in China, into the United States.

He also said he would act to suspend a rule that currently prevents Medicaid from funding many drug rehabilitation facilities.

“We cannot allow this to continue,” Mr. Trump said. “It is time to liberate our communities from this scourge of drug addiction.”

Congressional Republicans as well as law enforcement and physicians’ groups said the president’s announcement was a crucial first step in building awareness about the opioid crisis and confronting its causes and devastating effects.

In a statement, Patrice A. Harris, the chairwoman of the American Medical Association’s opioid task force, described it as “a move that will offer needed flexibility and help direct attention to opioid-ravaged communities.”

“There is plenty of work ahead,” Dr. Harris added, “and the emergency declaration adds further urgency to this epidemic.”

But Democrats criticized Mr. Trump for what they characterized as a tepid response to an urgent calamity, arguing that his failure to request funding for the effort revealed a lack of seriousness about addressing the issue.

“America is hemorrhaging lives by the day because of the opioid epidemic, but President Trump offered the country a Band-Aid when we need a tourniquet,” said Senator Edward J. Markey, Democrat of Massachusetts. “Instead of a commitment to emergency funding for our states and communities, President Trump offered empty words and half-measures.”

(Continued on page 7)
Andrew Kolodny, the co-director of opioid policy research at the Heller School for Social Policy and Management at Brandeis University, said that no emergency declaration would do much to alleviate the impact of opioids without a substantial commitment of federal money and a clear strategy for overhauling the way the country treats addiction.

“What we need is for the president to seek an appropriation from Congress, I believe in the billions, so that we can rapidly expand access for effective outpatient opioid addiction treatments,” Dr. Kolodny said in an interview. “Until those treatments are easier to access than heroin or fentanyl, overdose deaths will remain at record-high levels.”

“America is hemorrhaging lives by the day because of the opioid epidemic, but President Trump offered the country a Band-Aid when we need a tourniquet,” said Senator Edward J. Markey, Democrat of Massachusetts. “Instead of a commitment to emergency funding for our states and communities, President Trump offered empty words and half-measures.”

Access to Mental Health Care Has Increased Under the Affordable Care Act

People with mental illness reported that they were more likely to be insured and thus better able to access health and mental health services following implementation of the Affordable Care Act (ACA), according to a new study published online today in Psychiatric Services in Advance. Effects were seen in states that had expanded Medicaid and in states that did not.

Researchers lead by Kathleen C. Thomas, Ph.D., with the University of North Carolina, Chapel Hill, examined the impact of health reform for people with mental illness. They used the Health Reform Monitoring Survey to examine health insurance, access to care, and employment for more than 1,500 people with mental health conditions pre- and post-implementation of ACA. They compared survey results from 2013, before ACA implementation (health insurance marketplaces in 2013 and federal support for state Medicaid expansion in 2014), to a similar sample in 2016, after implementation of the ACA.

After implementation, people with mental health conditions were more likely to be insured (5 percent uninsured versus 13 percent). They were also more likely to report a having usual source of care (82 percent versus 76 percent). These effects were experienced in states with Medicaid expansion and those without. The increased access to care in non-expansion states may have resulted from improved coverage of mental health services and services to help with daily living skills (such as occupational and physical therapy) under the ACA, the authors suggest.

The authors conclude that the findings “highlight important improvements in health insurance coverage and access to care achieved through ACA reforms for people with mental health conditions.” The gains in both non-expansion and expansion states “underscores the importance of improvements in the quality of health insurance coverage, such as mental health parity.”

The American Psychiatric Association is the oldest medical association in the country founded in 1844. The APA is also the largest psychiatric association in the world with more than 37,000 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA’s vision is to ensure access to quality psychiatric diagnosis and treatment.

Reprinted from Psychiatric News
The fall conference for the Missouri Psychiatric Physicians Associations was very successful. The conference took place in Columbia Missouri on October 7, 2017. An unprecedented number of psychiatrists and mental health professionals attended the conference. One of the new features included was the Interactive Breakout Sessions. There was a total of six sessions that drew the attention of the participants. Here is a summary of the sessions:

1. **Child Psychiatry – Trends and Hot Topics**
   Dr. Laine Young-Walker and Dr. Pravesh Deotale led the discussion. Several child and adolescent psychiatrists and a nurse practitioner joined the discussion.
   Topics discussed:
   - Polypharmacy—there needs to be the rationale for the use of polypharmacy. There are some cases where polypharmacy does not make clinical sense or have an evidence base for it.
   - Atypical antipsychotic use in children—the FDA’s use and approval of some medications and the importance of treatment that is not solely symptom-focused was emphasized.
   - Trauma—they discussed the pervasive nature of trauma in children and the importance of trauma-focused interventions (particularly therapy).

2. **Current Issues in Addiction Psychiatry**
   Dr. Sherifa Iqbal and Dr. Art Taca moderated the addiction psychiatry breakout session. The group had a lively discussion about current issues related to addiction. The group represented a wide variety of Professional experience and included medical students, residents and attending physicians. Topics included the use of medical marijuana, substance use, ADHD, managing pain in the context of addiction, among others.

3. **Forensic Psychiatry: Perception, Policy & Practices**
   Dr. Jacki Landess and Dr. Nicole Graham led the discussion. During the forensic psychiatry breakout session, the discussion focused mainly on issues related to correctional psychiatry, and more specifically, policy implications related to the care of the seriously mentally ill in prison and jail settings. One topic of interest was the use of restrictive formularies which make difficult if not impossible to prescribe certain psychotropic medications to patients. Another was related to the inadequacy of community resources or a mechanism to treat those with serious mental illness who need emergent psychiatric hospitalization; most jails do not have an inpatient psychiatric unit on-site, and community psychiatric hospitals generally do not feel comfortable admitting jailed patients onto their units. Methods of both pre-and post-booking diversion from jails were discussed. Ultimately, the group concluded that there is a need for more psychiatrist leaders and advocates in correctional settings, as well as a need for increased intensive community services (such as ACT teams), and diversion options.

4. **Hot Topics and Trends in Adult Psychiatry**
   Dr. Henry Nasrallah and Dr. John Lauriello led the breakout session on New Topics and Trends in Adult Psychiatry. The group had a spirited discussion on several issues that the group presented as challenges to their practice. The first was the role of benzodiazepines in practice and the strain of limiting and ideally eliminating reliance on chronic benzodiazepine use. Some practitioner’s clinics have outright banned the use of some benzodiazepines most notably alprazolam. We also discussed how the recent cautions about benzodiazepine use (cognitive decline and fall risk) have allowed us an entry into discussing this issue with patients. Similarly, they discussed the prescribing of medications for adult ADHD. Many in the group mandate some form of formal cognitive testing which includes valid and reliable tests of attention. The mandate of urine drug testing and its pros and cons was debated. In particular, the more widespread use and acceptance of cannabis and the difficulty actually knowing the specific chemical compounds being ingested and the risks for some patient with marijuana use. Finally, the group discussed a very complex case of a child who had received long-acting antipsychotics along with relatively high doses of the same oral medication. The group agreed that with two high dose failures, with some degree of certainty of adherence (at least to the injectable part) that this patient was an appropriate candidate for clozapine.

5. **Hot Topics in Geriatric Psychiatry**
   Dr. George Grossberg and Dr. David Beck led the discussion. One of the areas that was of special interest to the participants and which was clearly addressed during this session was psychopharmacology with the geriatric population.

6. **Emerging Topics & Trends in Consultation-Liaison**
   Dr. Anjain Bahattacharyya and Dr. Lewis Collins were ready to address the participant’s questions in the area of consultation-liaison. They then joined and participated in the Substance Abuse group.

Overall, the Psychiatrist who participated in the Interactive Breakout Sessions found them to be helpful and were interested in having similar sessions in the 2018 fall conference.
Missouri Psychiatric Physicians Association

WHAT THE CATIE STUDY FAILED TO INFORM:
Neurotoxicity and Neuroprotection are the Real Difference Between
the First and Second Generation Antipsychotics

Hilton St. Louis Frontenac
1335 S. Lindbergh
St. Louis, MO
Tuesday, January 30, 2018

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

Agenda

5:30 - 6:00 pm    Registration and Reception
5:30 - 9:00 pm    Exhibits (Exhibits will be provided)
6:00 - 7:00 pm    Dinner
7:00 - 9:00 pm    WHAT THE CATIE STUDY FAILED TO INFORM:
                  Neurotoxicity and Neuroprotection are the Real Difference
                  Between the First and Second Generation Antipsychotics
                  Speaker: Henry A. Nasrallah, MD, Sydney W. Souers Professor, Chair,
                  Department of Psychiatry & Behavior Neurosciences, Saint Louis University

9:00 pm    Thank You & Wrap-Up

OBJECTIVES

1. Recognize the progressive neurodegenerative changes associated with psychotic relapses and the
   importance of preventing any relapse after the first episode.
2. List the multiple molecular mechanisms of neuronal death that have been reported with haloperidol.
3. Discuss 12 neuroprotective effects of the second generation (atypical) antipsychotics.

Missouri Psychiatric Physicians Association

Medical leadership for mind, brain and body.
Missouri Psychiatric Physicians Association

WHAT THE CATIE STUDY FAILED TO INFORM:
Neurotoxicity and Neuroprotection are the Real Difference Between
the First and Second Generation Antipsychotics

Registration

Name ________________________________
Organization ____________________________
City, State Zip __________________________
Phone ___________________________ Email __________________________

☐ Yes, I am a APA/MPPA member ☐ No, I am not a APA/MPPA member ($50)

MasterCard / Visa / Discover / American Express / Check
Credit Card # ____________________________
Exp. Date ________________ CVV Code ________________

Send registration to MPPA, 722 East Capitol Avenue, Jefferson City, MO 65101
573-635-5070 ~ Fax: 573-635-7823 ~ Email: missouripsych@gmail.com

Deadline for registrations is January 25, 2018.

Accreditation Statement for CME Credit: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and Missouri Psychiatric Physicians Association (MPPA). The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 2.0 AMA PRA Category 2 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Accreditation Statement for CEU Credit: Non-physician attendees who seek Continuing Education Units (CEUs) should consult the appropriate Rules & Regulations/Statutes and/or professional registration board governing their profession in the state in which they practice and hold license.

Completing the Evaluation, Claiming Credit, and Receiving a Certificate
At the conclusion of the conference, physician participants will be provided with an opportunity to evaluate the conference and receive a CME credit certificate by completing an online evaluation accessed through the American Psychiatric Association Learning Center at education.psychiatry.org. Non-physician participants will have the opportunity to receive a certificate of attendance.
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.

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
St. Louis, Missouri

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Agenda

7:30 - 9:00 am  Executive Committee Meeting

9:00 - 10:00 am  “Geriatric Psychopharmacology”  
  Speaker: George Grossberg, MD

10:00 - 10:30 am  Break

10:30 - 11:30 am  “Psychotropic Use in Pregnancy”  
  Speaker: Melanie McKeen, DO, PhD

11:30 - 12:00 noon  Luncheon

12:00 - 1:00 pm  “Psychiatric Manifestations of Commonly Prescribed Medication in Primary Care”  
  Speaker: Subbu J. Sarma, MD
The use of attention-deficit/hyperactivity disorder (ADHD) medications during pregnancy can modestly increase the risk of some negative birth outcomes, according to a study published Friday in Pediatrics.

Ulrika Nörby, Ph.D., of Lund University in Sweden and colleagues found that infants exposed to ADHD medications during pregnancy were about 50% more likely of being admitted to a neonatal intensive care unit (NICU) than infants whose mothers never took these medications and about 20% more likely to require care in a NICU than infants whose mothers used these medications before or after but not during pregnancy.

Infants exposed to ADHD medications in utero were also more likely to experience central nervous system–related disorders such as seizures (odds ratio=1.9) and were more often born preterm (odds ratio=1.3) compared with infants who were not exposed to these medications.

“These findings warrant attention but are hardly reasons to abstain from ADHD medication during pregnancy if treatment is crucial for the woman,” Nörby and colleagues wrote. “Because women who used these drugs during pregnancy in many ways differed from the average pregnant population, it is uncertain to what extent these associations can be explained by the ADHD medication itself.”

Nörby and colleagues analyzed data from Swedish birth and medical registries, including nearly one million single births recorded between July 1, 2006, and December 31, 2014. They identified 1,591 infants (0.2%) who were exposed to ADHD medication during pregnancy (1,464 were exposed to stimulants and 165 were exposed to atomoxetine).

“Despite the authors’ effort to control possible confounding by using a comparison group who carried a diagnosis of ADHD, it is an imperfect control condition,” Kimberly Yonkers, M.D., a professor of psychiatry, epidemiology, and obstetrics, gynecology, and reproductive sciences at Yale University, told Psychiatric News. “Women who used ADHD medication were clearly different in many ways from the other two groups.”

Yonkers added that the authors did not have information related to the use of illicit substances and alcohol in these women, which could be a contributing factor. She noted that the study found women taking ADHD medications reported much higher levels of nicotine use than those who did not, so it is possible that other substance use by this group was higher as well.

Reprinted from Psychiatric News
Deconstructing Innovation
By Anita Everett, MD

What do you think of when you see or hear the word “innovation”? On a spectrum from “threat, dread, fatigue” to “exciting, energizing, and hopeful,” which end are you closer to?

With regard to psychiatry, I think we’d all agree that innovation is important to the future practice of our profession. With that in mind, APA’s Board of Trustees made “innovation” a focus of its recent retreat to give direction and support to a Board work group that is charged with exploring innovations in clinical practice.

At the retreat, Board members associated “innovation” with “inspiration,” “hope,” “disruption,” “out of the box,” “threat,” “change,” “new,” and many other terms. If we are not able to dive in and swim with innovation, we will miss an important leadership opportunity to learn how to use and harness the tools of innovation to augment the work of our profession.

It turns out that there is a science of and methodology to innovation. If you already have an M.B.A., you may know that, but for most of us at the retreat, it was a bit of a revelation. Yes, there is a vocabulary, there are standardized processes and practices, and there is a discipline to innovation. At the Carolinas HealthCare System (CHS) in Charlotte, N.C., there is a dedicated team of about six people who are charged with system wide innovations consultation. They solve problems for CHS that relate to safety, workflow optimization, person-centered design, access, and population health. A few examples of innovations in the context of health care might help at this point.

Just as classification systems apply to science (remember phyla and genus), types of innovation can also be classified. One classification is interior focused versus exterior focused. An example of an interior-facing innovation might be one that aims to improve efficiency of existing function. The use of a six sigma or lean process to create a set of procedures that enable “same-day-next day” office appointment scheduling is an example of interior innovation in health care. The same sequence of events happens once the patient is at the appointment, but the scheduling is restructured to improve access. A sustaining innovation might be something that supports “best customers.” A health care example is enhanced patient communication that occurs directly with physicians through a “my chart” function in a health system’s EMR.

Other types of innovation can be classified as low end versus new market. An example of low-end innovation is something that is anticipated to have local and maybe limited impact. Originally, Southwest Airlines was a local commuter service that offered faster transportation between cities in Texas. Initially Southwest had low-level competition, primarily with cars and buses. Now Southwest is a major aviation company with worldwide service and good market share. A low-end health care example is the “minute clinic” in a retail pharmacy that offers easy access to care for individuals with uncomplicated health issues.

New market innovation creates products and services that did not exist before. A health care example is care management that coordinates care for elderly individuals with multiple complex chronic conditions. Conditions exist in modern health care structures that support a new market for complex care coordination across providers and health systems.

The information I’m sharing in this column was just part of the orientation we received on how to think about innovation. We also learned about innovation tools such as ethnography, analogous learning, and technology augmentation. We had a “gallery crawl” that included walking through an innovations laboratory to view several posters that demonstrated aspects of innovation. A memorable poster was the one that reviewed details of suicide-related social media use among adolescents.

APA has had an industrious committee that has been thinking about technology. The Board’s new work group—the Ad Hoc Work Group on Access and Innovation in Psychiatric Care—will add to its work and will help more of our members learn about, embrace, and maybe even harness innovation. We want to use innovation to augment things like patient engagement and outcomes while we preserve the core of what is uniquely special and healing about the practice of psychiatry. Stay tuned!
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**, 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.


For more information, call 703.907.7300 or email membership@psych.org.
Psychiatric Volunteering: How Can You Help?

By Sherifa Iqbal, MD, FAPA, FASAM

When a major disaster or emergency situation occurs, psychiatrists understand that the people affected not only need food and shelter, but also emotional support. We are trained to respond empathetically and intuitively to the suffering of others. Perhaps more than other specialties, we recognize the toll that major stressors take on both mental and physical health.

The American Red Cross has integrated mental health teams into its disaster services since the early 1990s. At that time, the goal was to provide support to volunteers on a disaster relief operation. While disaster mental health teams still support volunteers, the mission has expanded over the years to meet the types of needs seen during responses to disasters such as the recent hurricanes affecting the gulf states and Puerto Rico. As awareness and knowledge have increased regarding the psychiatric impact of traumatic and disaster-related events, the contributions of disaster mental health volunteers have become increasingly important and recognized.

Most Red Cross chapters or regions have a disaster mental health team which is made up of independently-licensed masters level (or higher) mental health professionals including psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, professional clinical counselors and nurses with specialty certification. There are six Red Cross chapters that cover the entire state of Missouri so there are plenty of volunteer opportunities for Missouri psychiatrists.

I am currently a volunteer for the American Red Cross Greater St. Louis Chapter. I am a disaster action team member and a mental health supervisor for the disaster mental health team. I am incredibly proud and grateful to be a volunteer for the American Red Cross. The Red Cross offers its volunteers enormous flexibility in training, location and time commitment. I have had opportunities to deploy to disaster areas nationally as well as provide outreach to home fire survivors and first responders. For local mental health outreach, I am often able to provide support, at my own availability, for as little or as much time as my schedule allows, from my own home.

My volunteer experience has helped me grow as a provider and, I hope, as a person. I am continually humbled by the enthusiasm, dedication and selflessness of my fellow volunteers. There is a global shortage of psychiatrists and this need is only amplified during a disaster. The Red Cross has made addressing the mental health of those it serves a priority and psychiatrists are in a unique position to help with this effort.

Volunteers constitute nearly 90 percent of the American Red Cross workforce. This allows the organization to respond to nearly 64,000 disasters every year. There is a wealth of talent, compassion and expertise among Missouri’s psychiatrists and I cannot help but think how wonderful it would be if even a small amount of that could be directed toward volunteer efforts. Every contribution made by MPPA members, whether time or money, is very much needed and appreciated.

The APA has recently updated its website to address the needs of members looking for volunteer experiences. This information can be found in the disaster and trauma section of psych.org. The resources include volunteer opportunities, related publications, educational modules, and information on ethical and liability considerations for the physician volunteer.

Additionally, the American Psychiatric Association Foundation has developed a disaster relief fund to support the efforts of the American Red Cross Disaster Services Program. Donations are tax-deductible to the extent permitted by law and can be made at www.americanpsychiatricfoundation.org.

To learn more about volunteering with the American Red Cross, visit redcross.org or email the author at sherifa.iqbal@missouripsychiatry.org

The author has no financial conflicts to disclose.
In response to remarks by President Donald Trump this week that the deadly shooting in a Texas church Sunday morning was “a mental health problem,” APA called on the administration and Congress to strengthen and improve access to quality mental health care.

“We are deeply saddened by the senseless violence in a house of worship this weekend,” said APA CEO and Medical Director Saul Levin, M.D., M.P.A., in a statement following the shooting in which 26 people were killed and more than 20 injured when a gunman opened fire at a Baptist church. “We extend our deepest sympathies to the victims, the families, and the community of this tragedy.”

He added that though the president and lawmakers have made comments associating acts of violence with mental illness, research has consistently shown that people with mental illness are not more likely to be perpetrators of violence, but more likely to be victims. In his statement, Levin requested that lawmakers not perpetuate stigma by making premature statements.

“If lawmakers believe it is a mental health issue, why are they not seeking to ensure that more resources are being put into treating those with mental health issues?” Levin asked.

Levin said that for policymakers who are sincere about addressing mental health, a first step is to protect “essential health benefits” in the Affordable Care Act (ACA), which include treatment for mental illness and substance use; those essential health benefits have been targeted in repeated Republican attempts to repeal or replace the ACA.

“More designated funding should be appropriated to the National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism at the National Institutes of Health to focus on new research to help increase new knowledge on how to prevent, treat, and cure mental illness and substance use disorders,” Levin added. “In addition, APA calls on the administration, the Congress, and state legislators to take needed steps to ensure that access to mental health programs remain intact so people with mental illness and substance use disorders are getting the care they need. The American Psychiatric Association stands ready to help you achieve that goal.”

Reprinted from Psychiatric News
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.
Calendar of Events

January CME Workshop
“What the Catie Study Failed to Inform: Neurotoxicity and Neuroprotection are the Real Difference Between the First and Second Generation Antipsychotics”
Hilton St. Louis Frontenac
St. Louis, MO
Tuesday, January 30, 2018

Spring Meeting
“Psychopharmacology Update: Addressing the Needs of Special Populations”
Renaissance St. Louis Airport Hotel
St. Louis, MO
Saturday, March 24, 2018

MPA Executive Council Conference Call
(Calls are Scheduled for 7:00 pm)
November 20, 2017
January 16, 2018
February 6, 2018
April 10, 2018

American Psychiatric Association
Annual Meeting
New York City
May 5-9, 2018