**President’s Message**  
*By Azfar Malik, MD, MBA, DFAPA*

**Importance of leadership in Psychiatry**

I am honored to assume the responsibility of leading the MPPA. I was in line for this position after John Lauriello, but he unfortunately had to step down earlier than expected in order to chair a psychiatry department on the east coast. Dr. Henry Nasrallah, our past president (who is now running for president of the APA), had asked me to serve as president elect a year ago. Although I remain very busy as the President and CMO of CenterPointe Behavioral Health Systems and Chairman of Psych Care Consultants in addition to managing my private practice, I feel that, at this time in my career, doing something larger for the field of psychiatry and our patients is an important personal goal.

Psychiatrists are in a unique position given their knowledge and perspective. We understand the need to focus on long-term outcomes and prevention of recurrence since most psychiatric illnesses are chronic and progressive in nature. Psychiatrists need to be active leaders in team-based care for the betterment of patients, especially since the cost of care increases in psychiatric illness in tandem with the complexity of medical co-morbidities.

As the care provider model changes, psychiatrists need to supervise and actively educate other mental health professionals including nurse practitioners, physician assistants, social workers, as well as primary care physicians. We are the only ones qualified to understand the etiology and pathogenesis of these disorders, especially in the context of our developing understanding of neurotransmitters and brain circuitry. We need to train our psychiatric providers to understand evidenced based medicine and the value of non-pharmacological treatments. In addition to the biological components of the disease state and treatment options, we must educate our peers about the psychosocial components of psychiatry as well.

A major challenge that we are facing now is one of limited resources. Psychiatrists cannot possibly see all the patients who suffer from major or minor psychiatric illnesses, yet we are still responsible for the care of this population. We need to develop tools to facilitate the care of these patients. This should include treatment algorithms for inpatient and outpatient settings and clear guidelines for early referral to specialists, both of which would help suboptimal management and disease progression. We need to devise a system in which new and innovative treatments can be applied early in the disease to avoid illness becoming chronic and treatment-resistant.

(Continued on page 2)
**EXECUTIVE COUNCIL**

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**President’s Message**

Currently, treatments for these illnesses are dictated by systems of care and payors with minimal input from standard paradigms of treatment. In some cases, these paradigms may need to be more clearly devised by our associations and communicated by the clinician to the payors. Algorithms and guidelines that are well established in other disease states, such as congestive heart failure or stroke, help create benchmarks to track and allow for standardized care. Our task at hand is to develop such robust protocols in psychiatry. In creating these, we should keep the balance of caretaking and cost in mind. Fiscal responsibility is an important part of patient care medicine today and is being treated as such in other medical fields. Psychiatry can no longer afford to be left behind.

AZFAR MALIK, MD, MBA, DFAPA
President / CMO, Center Pointe Behavioral Health System
Assistant Clinical Professor, Department of Psychiatry
Saint Louis University

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**Congratulations**

**New Life Members of APA**

Mehrunissa Ali, MD
Lee’s Summit, MO

Satnam Mahal, MD
Columbia, MO

Azfar Malik, MD
Saint Louis, MO

Jeffrey Schulman, MD
Saint Louis, MO

Steven Segraves, MD
Leawood, KS

Claudia Viamontes, MD
Saint Louis, MO
The MPPF Board of Directors continues to work to achieve the foundation’s mission and functions.

1. Mission: The foundation is formed to engage exclusively in scientific, educational, and charitable activities, fully consistent with section 501© (3) of the Internal Revenue Code.

2. The MPPF was organized exclusively to perform the following functions:
   
   A. **PROFESSIONAL EDUCATION.** The Foundation will develop and fund educational offerings and projects, including in collaboration with others, designed to improve and enrich professional knowledge and skills of psychiatrists and other medical and mental health professionals in the prevention, diagnosis and treatment of psychiatric brain disorders. This may include programs to encourage healthier personal and professional lifestyles.

   B. **PUBLIC EDUCATION.** The Foundation will encourage and sponsor educational programs, including in collaboration with others, to increase awareness and advance knowledge of psychiatric brain disorders and effective treatments available today. The Foundation may support educational efforts aimed at employers, the media, persons living with a mental disorder and their families, to encourage a better understanding of the causes, treatment and prevention of psychiatric disorders and their treatment. The Foundation may also support efforts to remove barriers to access to psychiatric care.

   C. **RESEARCH AND DISCOVERY.** Support of research projects by members of the MPPA which aim to advance the biopsychosocial understanding and management of psychiatric disorders. *This will include identification and remediation of the social determinants of mental health.*

   D. **RECOGNITION OF ACHIEVEMENT.** The Foundation may provide some recognition of achievement to individuals or groups who have excelled in advancing the purposes of the Foundation.

   E. **SUPPORT OF MPPA.** The Foundation will provide support to the Missouri Psychiatric Physicians Association in its efforts to achieve the Foundation’s objectives such as education and research.

3. In addition to the Board of Directors, represented by the executive committee, the board is looking at establishing three additional committees.

   a. **Public Relations Committee:** members include Dr. Sherifa Iqbal and Dr. Jim Fleming. This committee is preparing guidelines and recommendations for the MPPF Media Award.

   b. **Advisory Council:** this will be comprised of 8-10 community leaders, excluding psychiatrists. Nominations will be made by board members. This council will support the MPPF in achieving its goals.

   c. **Fundraising/Finance Committee:** Dr. Sherifa “Missy” Iqbal (president) and Dr. Azfar Malik (treasurer). This committee will oversee the financial status of the MPPF and explore opportunities for potential donations.

4. The MPPF is in the process of finalizing a logo to represent the foundation’s goals.

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**Donations are payable to Missouri Psychiatric Physicians Foundation (MPPF)**

722 E. Capitol Avenue, Jefferson City, MO 65101

Donations can also be made online at:

https://missouri.psychiatry.org/advocacy/mppa-foundation

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**Calendar of Events**

**Executive Council Conference Call**

(Calls are Scheduled for 7:00 pm)

- January 14, 2020
- July 14, 2020
- November 17, 2020

**Advocacy Day**

March 11, 2020

**MPPA/MSMA Spring Conference**

Saturday, April 4, 2020

Renaissance Hotel

St. Louis, MO

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**APA Annual Meetings**

- April 25-29, 2020
  
  Philadelphia, PA

- May 1-5, 2021
  
  Los Angeles, CA
The 20th century brought about incredible technological advancement, including the widespread use of electricity, improvements in transportation, and progress in our understanding and treatment of many diseases that had previously meant death for much of the human population. The realm of psychiatry was no different. A recognition that mental health disorders were caused by biological, physiological, and social factors instead of the “gods and devils” of the past, brought about improved diagnostic classifications and highly effective evidence-based treatments for patients with mental disorders. However, now that we are closing in on the centennial birthday of some of these advancements, it is important to point out that we have become increasingly reliant on therapy and medication for many of the most common disorders. For a certain portion of the patient population, these are amazingly effective treatments. Unfortunately, for the segment of the spectrum who are labelled “treatment resistant,” this has led to a never-ending merry-go-round of meeting with multiple therapists, or trying medication after medication until intolerance develops and/or the treatment fails. For this group of patients, new tools from a different toolbox must be utilized. That toolbox is called Neuromodulation.

Mood and anxiety disorders are some of the most common mental health problems in the world. By 2030, depression will be the leading cause of disease burden worldwide, according to projections of the World Health Organization. Furthermore, according to the CDC, NIMH, and health statistics released by the government of Missouri, 8.1% of adults in the U.S. above age 20 suffered from depression in any given 2-week period in 2013-2016, with Missouri having a staggering 20% rate of depression. Additionally, anxiety disorders affect 40 million adults in the United States age 18 and older each year, amounting to 18.1% of the population. These sobering statistics reveal how big this problem is—and we, as clinicians and researchers, see this every day in our practice and laboratories. Even more eye-opening is the fact that there is a group in this population who cannot be helped by conventional methods.

Last year, the University of Missouri’s Department of Psychiatry started a new Neuromodulation clinic with the mission of treating these very individuals. Our clinic is targeting patients with moderate to severe treatment-resistant anxiety and depression who may not have reached significant improvement with their medications and therapy; we are also targeting those who want to look at more invasive methods to treat their disorders. The modalities of this clinic include Electro-Convulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Cranial Electrostimulation Therapy (CES), Vagus Nerve Stimulation (VNS), and Deep Brain Stimulation (DBS) for Obsessive Compulsive Disorder (OCD), and specialty medication treatments such as intravenous (IV) ketamine and esketamine nasal spray.

Now a year after initiation, this type of Interventional Psychiatry looks to be advancing the mission of our clinic. These modalities have proven to be especially beneficial for those individuals in the treatment-resistant group. Many individuals who have seen little relief from depression and anxiety for a decade are now able to hold down jobs, improve their social relationships, and improve their overall quality of life. The clinic’s current response and remission rates for depression using TMS are 60% and 34%, respectively. In many cases, these patients have tried and failed a lifetime of conventional treatment methods. ECT continues to show the greatest effectiveness, especially in severe depression with catatonia and psychosis. It is also an option for those whose insurance may not pay for TMS treatment. IV ketamine was offered in the inpatient psychiatry ward.

(Continued on page 5)
Starting in November 2018, it is considered a novel approach by offering Intravenous therapy in inpatient psychiatric units, which is performed entirely by a psychiatric team. This treatment modality has shown promise in acutely depressed and suicidal individuals, although at this time the durability of response seems limited. The recent addition of esKetamine to our clinic looks to be helpful in our outpatient setting for those patients who have not responded to conventional treatment. We use CES to help inpatient clients’ deal with anxiety and sleep-related issues during their inpatient stay as an alternative to medications or as an adjunct to their current medications. Over the last year, we introduced it to our outpatient patients as well. This treatment is beneficial for those who suffer from anxiety and sleep problems and who would like to try a non-habit-forming medication-free approach. They also like being able to perform this treatment at home. Our other, more invasive, tools of VNS and DBS have yet to be deployed, but it will give additional options to a certain group of patients, and hopefully help give them relief from a lifetime of distress.

Interestingly, it is not just the effectiveness of these treatments that seems to be benefiting patients, but also that these options are introduced at one location. They now have multiple options to choose from when conventional approaches have failed. Furthermore, patients who once thought medication was the only course of action are now realizing that other paths are available. This seems to give them renewed hope that they do not have to suffer through these diseases for the rest of their lives, and that they may yet be able to be happy and productive.

Like most new approaches, many of these methods have been questioned and scrutinized for their effectiveness in the psychiatric community. This is prudent, given the flawed but popular theories of psychiatry in the past such as phrenology, and more recently the internet—which makes easy promises of cures using visually appealing, but scientifically untested products. However, given that many of these neuromodulation modalities are decades old and their safety and effectiveness have been well-tested in both the research and clinical settings, patients should be educated that they have these options. As discussed previously, medication and therapy will be helpful to many individuals who suffer from depression and related diseases. For the other percentage of patients, these additional methods may be a better option.

It remains to be seen where the direction of treatments for the treatment-resistant population will take us. In the future, targeted brain stimulation may prove to be the answer. For now, however, all possibilities should be introduced to patients in the effort to offer them options in their chronic struggle with these diseases.
Emergent Issues in Psychiatry
Balkozar Adam, MD

On the last Saturday of September 2019, another successful MPPA Annual Fall Conference took place in Columbia, Missouri. The conference was attended by over 75 Psychiatrist, resident physicians, medical students, and other clinicians. The MPPA program committee, chaired by John Lauriello, M.D. and later by Jo-Ellyn M. Ryall, M.D agreed that emergent issues in psychiatry needed to be addressed. Catatonia and delirium were viewed as critical areas that psychiatrists frequently deal with and need to understand the advances in research on these topics. Jo Ellen Wilson, M.D., MPH, presented on these two topics. With the challenges clinicians face in accurately understanding the needs of the LGBTQ population, James R. (Bob) Batterson, M.D. DFAPA, DFAACAP, informed the participants about the rapid changes in acceptance of the gay population in American culture and helped increase awareness of clinicians of the special needs of this population. A clinical perspective of the Endocannabinoid system was presented by Donald D. Bohnenkamp, M.D. The presenter helped the participants gain a better understanding of how the endocannabinoid system works and how exogenous cannabinoids affect the brain. Because of the changes in current medical marijuana laws in Missouri, Arturo C. Tara, Jr., M.D. presented on the history of the cannabis plant and the history of marijuana policies in the U.S. The last topic of the conference was on the emergency departments approach to psychiatric patients. Christopher Sampson, M.D., FACEP, summarized the available research regarding the management of psychiatric patients in the emergency department and recognized alternative treatment for psychiatric patients.

There were 13 posters included in the poster session. The posters were submitted by Psychiatrists, Resident Physicians, medical students, nurse practitioners, and other providers. The topics varied from treatment of catatonia to suicide, to the use of the Mediterranean diet in Parkinson’s disease. In addition, there were ten different Exhibitors who provided valuable information on different medications, products, and services that were beneficial for clinicians to learn about.

Overall, the fall conference was a great success and the participants found it to be informative and enlightening. They are currently looking forward to the MMPA Spring Conference in April 2020.
“Disaster, Research, Response and Resolution”
Missouri Psychiatric Physicians Association
Spring Conference
Renaissance St. Louis Airport Hotel, 9801 Natural Bridge Road, St. Louis, Missouri 63134
Saturday, April 4, 2020

Tentative Agenda

7:30 - 9:00 am
General Membership Meeting

9:00 am
**INTRODUCTION**
Jo-Ellyn M. Ryall, MD

9:15 - 10:15 am
**“Disaster Mental Health Response: Showing Up in the Show-Me State”**
LEARNING OBJECTIVES:
1. To understand different types of disaster settings that may require disaster mental health assistance
2. To understand local disaster mental health response systems and how to engage when needed
3. To understand best practices in disaster mental health
Sherifa Iqbal, MD, MPH, MBA, DFAPA, FASAM, Disaster Mental Health Regional Lead for American Red Cross of Missouri and Arkansas

10:15 - 11:15 am
**“Mental Health Response to Natural Disasters: Experience from Large Hurricane Evacuee Shelters”**
LEARNING OBJECTIVES:
1. Identify the role of psychiatrist during the response to a natural disaster.
2. List risk factors for vulnerable populations during a disaster.
3. Differentiate between normal responses to disasters and potential psychiatric problems.
Carol S. North, MD, MPE, DLFAPA, Medical Director, The Altmusler Center for Education & Research, Metrocare Services, The Nancy and Ray L. Hunt Chair in Crisis Psychiatry and Professor of Psychiatry, Director, Division of Trauma & Disaster, The University of Texas Southwestern Medical Center

11:15 - 11:30 am
Break

11:30 - 12:30 noon
**“Mental Health Response to Mass Shootings”**
LEARNING OBJECTIVES:
1. Review mental health findings from research studies of mass shootings.
2. Examine results of 4 consistently studied mass shooting incidents using structured diagnostic interviews.
3. Discuss recommendations for mental health response to mass shootings in the broader context of mental health response to disasters more generally.
Carol S. North, MD, MPE, DLFAPA, Medical Director, The Altmusler Center for Education & Research, Metrocare Services, The Nancy and Ray L. Hunt Chair in Crisis Psychiatry and Professor of Psychiatry, Director, Division of Trauma & Disaster, The University of Texas Southwestern Medical Center

12:30 - 1:00 pm
Luncheon

12:30 - 1:30 pm
**“New Modalities of Treatment, Neuromodulation, NMDA Receptors Antagonists and VMAT 11 Inhibitors”**
LEARNING OBJECTIVES:
1. To understand mechanism of Neuromodulation and how it alters the disease states.
2. Understand the role of NMDA receptors and Inotropic Glutamate receptors,
3. Understand how to treat Tardive dyskinesia with VMAT 11 inhibitors.
Azfar Malik, MD, MBA, DFAPA, President/CMO, Center Pointe Behavioral Health System, Assistant Clinical Professor, Department of Psychiatry, Saint Louis University
Member Spotlight

“Getting to the Inner Circle - The Long Hard Way!”
Jo-Ellyn Ryall, MD

I was born and grew up in New Jersey, attending Douglass College of Rutgers University, majoring in Chemistry. I was the first member of my family to go to college.

I attended Medical School at Washington University in St. Louis 1971-75. What did I do? Studied, tried to keep my head above water, learned to cook, and had no idea about organized medicine, except I received information on American Medical Student Association (AMSA). Volunteered once at “People’s clinic”. Later I learned that the Medical Student Section of the AMA was started during the years that I was in Medical School.

Following graduation, I attended the residency in Psychiatry at Washington University in St. Louis 1975-78. Then I worked for Malcolm Bliss Hospital and started my private practice. I was in solo practice until 2011 when I joined Psych Care Consultants.

I joined APA and Eastern Missouri Psychiatric Society and started attending Dinner meetings at the Medical Society building about 6 times a year. Dinner was the same each meeting: steak, potato, salad and dessert. Open bar, no condiments. I brought the plastic lime for Gin and Tonics and friend Pat Newton brought the A-1 sauce for steaks. We were immediately accepted in the fold. The members wanted to sit with us because we brought the condiments, but, more important because we were young, interesting women.

1978-80 Committee of Women of EMPS was very active. I served as Secretary. We had lunchtime meetings with the main purpose of electing women to the Executive committee of Eastern Missouri Psychiatric Association (EMPS). I also drove the Superintendent of my Hospital because she had vision problems. This is a great way to get to know the Boss.

In 1979 I joined the St. Louis Metropolitan Medical Society, the Missouri State Medical Association and the AMA. Attended the psychiatric part of the MSMA meeting in St. Louis.

In April 1980, I went to KC for Missouri Psychiatric Association meeting at the MSMA meeting and learned that the delegation from St. Louis had some empty spaces and was appointed an alternate Delegate (promoted to Delegate) to the MSMA House of Delegates. I have remained a Delegate from St. Louis since that time.

May 1980 Maria Manion was elected the first female President of EMPS, so our committee on Women successfully completed our task. I was appointed her Program Chair, (also attended EMPS Council meeting). I arranged speakers for 6 meetings and the meeting at the MSMA. I also was the Councilor at Large for EMPS from 1980-82.

May 1982, I was elected President-elect of EMPS and President in 1983-84. (This is when I learned to fly and was licensed as a private pilot in 1984). Three psychiatrists owned a Grumman Tiger and we called our corporation, Tri-Psych.

In the mid 1980’s I was the Insurance committee chair for 2 years. This was the time that the psychiatrists were dealing with managed care for the first time and their goal was to cut psychiatric benefits. This was a very depressing time for me since I am a patient advocate and these companies were the ENEMY!

In 1986 I was appointed as the Chair of the Public Affairs Committee, a position I held for 18 years. During that time, we started the Mental Illness Awareness Coalition and presented programs to the

(Continued on page 9)
Member Spotlight
“Getting to the Inner Circle - The Long Hard Way!”
Jo-Ellyn Ryall, MD

public. The Coalition joined several organizations including NAMI of St. Louis, Mental Health Association, EMPS, Depressive/ manic Depressive Association several hospitals, Recovery Inc. We won an APA Award for Coalition building. The group also went through the forming, norming, storming, and reforming stages before it died in 2003.

In Jan 1986, I became a councilor of the St. Louis Metropolitan Medical Society for 3 years and in 1989 I was the Vice President.

In 1986 I was elected Vice Speaker of the MSMA for 3 years and Speaker of MSMA for three years. Learned the skills on the job. Now I serve as Parliamentarian.

In 1986 I was asked by APA to replace Barbara Buchanan on the Section Council of the APA to the AMA. At that time there was one delegate and the alternate and 8-9 reference committees, so members were recruited to cover the committees. I went to my first AMA meeting in Dec 1986 in Las Vegas. At that AMA meeting the Young Physicians section (states only) was started and I was present though I did not represent MO. Later I was the Alt Delegate to the YPS and then Delegate, until I got too old at 40.

In the fall of 1988, one of the Missouri Delegates left the state and there was a vacancy for an Alternate Delegate to the AMA. I applied to the MSMA Council and suggested I would be able to go for half price since I was also representing Psychiatry. I was appointed and then elected to a regular term every 2 years until I became a Delegate in 1994-2007.

In 1987 I ran for the Council on Constitution and Bylaws of the AMA and was appointed to the Bylaws council of APA. I lost the first race but ran again in 1988 and was elected to the first of my 2 four-year terms. I served as Chair 2004-06. The council undertook the immense task of rewriting the Bylaws, reducing the size by about 1/3 and making it more reader friendly. I ran for Board of Trustees of the AMA in 2007 but lost. Later I helped David Barbe get elected to the BOT and later President of AMA.

In 1993, I was elected as Deputy Rep from EMPS to the Assembly of APA. I attended my first Assembly meeting in 1994. This was a different meeting than the AMA or MSMA. There were long discussions on action papers, which were amended at great length on the floor of the Assembly. Gradually, I got into the rhythm of the Assembly.

In 1997 I was elected Rep from EMPS because Roy Wilson became the Director of the Department of Mental Health in MO and moved to Central Missouri. The Speaker of the Assembly, Dr. Dale Walker, asked me to head an ad hoc committee to introduce the Assembly to Reference Committees. That way the Action Papers could get hearings and get edited before a major discussion in front of the entire Assembly. It is working well.

In 2001 I was elected Dep Rep for Area 4 and May of 2006 I became the Rep of Area 4. Dr. Michael Blumenfield appointed me as Chair of the Procedures Committee of the Assembly in 2006. This fit well with my Bylaws experience. I ran but lost elections to become Recorder and Speaker.

Since 2010, the 3 district branches merged into the Missouri Psychiatric Physicians Association. I have been active in the MPPA serving as President, Secretary-Treasurer, PAC chair and now Program Chair for this year.

This is an example of a professional life dedicated to service in the medical political arena. I could not have done this work to the same extent, if I had children. I was married and divorced and opted not to become an “unwed” mother. I have had cats and then dogs, and I now have 2 poodles, Emma and Willie.

I have learned that organized medicine helps us join forces to succeed against the forces that oppose medicine and try to come between our patients and (Continued on page 16)
Put your holiday shopping dollars to good use with Amazon Smile! The Missouri Psychiatric Physicians Foundation (MPPAF) participates in Amazon Smile, and through that program your eligible purchases (millions of eligible items!) a small donation is generated to us from Amazon. It costs you nothing extra. All you need to do is log into your Amazon account at https://smile.amazon.com/, select Missouri Psychiatric Physicians Foundation as your charity, and then Amazon takes it from there. You can check your activity to see how much your Smile purchases have generated for the MPPF in your account.

If you shop at Amazon, please consider changing to Amazon Smile to help the MPPAF. It’s quick and easy, and thousands of dollars can be generated collectively just by your ordinary Amazon shopping. This holiday season, give a boost to the Foundation by choosing Amazon Smile. Every little bit counts!

The Missouri Psychiatric Physicians Foundation is a charitable organization that supports professional and public education about mental health, research, advocacy for our patients and profession; and works to address social determinants affecting the mental health of Missourians.

The MPPF has a variety of ways for you to make your donation on Giving Tuesday (or any other day!):

- **Online**: [https://missouri.psychiatry.org/advocacy/mppa-foundation](https://missouri.psychiatry.org/advocacy/mppa-foundation)

- **By Mail (Check)**: make check payable to the Missouri Psychiatric Physicians Foundation and mail to: 722 East Capitol Avenue, Jefferson City, Missouri 65101.

- **By Mail (Credit Card)**: download donation form at [https://missouri.psychiatry.org/apa_db_missouri/media/Advertising%20Promotion/Foundation-Donation.pdf](https://missouri.psychiatry.org/apa_db_missouri/media/Advertising%20Promotion/Foundation-Donation.pdf) and mail to: 722 East Capitol Avenue, Jefferson City, Missouri 65101.

- **By Phone**: Call 573.635.5070

As a reminder, The Missouri Psychiatric Physicians Foundation is a 501 (c) (3) exempt organization and all donations made to the MPPAF are tax deductible under IRS Section 170.

I hope you will join me in giving to this worthy cause and supporting both the field of psychiatry and the mental health of our community!
October 21, 2019
Exec. Director Sandra Boeckman
Missouri Psychiatric Association
722 E. Capitol Avenue
Jefferson City, MO 65101-4009

Dear Sandra,

Thank you for your generous sponsorship donation of $600.00 on September 23, 2019 in support of our 2019 NAMI St. Louis "Unmasking Beautiful Minds." This event takes place on Saturday, November 16, 2019 at The Chase Park Plaza - Royal Sonesta Hotel. Since you received no goods or services as a result of your donation, it qualifies in full as a charitable contribution for tax purposes.

Your support will allow us to continue our work to provide education, support and advocacy to children and adults living with mental illnesses and their families. With your support, we are able to increase our level of service to the community, reach out to more children and families, and strive to change attitudes and end discrimination against those who live with mental health conditions.

Because of you, we are able to continue to help improve the quality of life of persons experiencing a mental health conditions, and their families, caregivers and friends through our education, advocacy, support, leadership and customer-centered services.

Your support helps us transform lives. We are grateful you have chosen to support NAMI St. Louis' work and the families we serve.

Sincerely,

Christine Patterson, Ph.D.
Executive Director

NAMI St. Louis is a 501 (c)(3) non-profit organization, EIN 43-1143899. For this reason, your donation is eligible as a tax deduction according to IRS regulations. You received no goods or services in exchange for this donation. For additional information, please speak with your tax consultant.
Early Career Psychiatrists (ECPs) are psychiatrists who are within their first seven years after completion of training (ACGME accredited residency/fellowship). ECPs who are APA members are also members of their district branch (APA, 2019).

In our study, the goal was to identify and address challenges facing ECPs. Eight survey questions were emailed to psychiatrists, who are members of the Missouri Physician Psychiatric Association (MMPA). Forty psychiatrists completed the survey. The electronic survey was anonymous to the researchers. Summary of the eight questions and the responses were as follows:

1. Question: How many years have you been practicing independently?
   Response: Ranged between 1-5 years.

2. Question: How comfortable are you with your medical knowledge and training when managing your patients independently?
   Response: 57% replied that they are fully comfortable.

3. Question: How comfortable are you being the team leader?
   Response: 60% replied that they are fully comfortable.

4. Question: How comfortable are you dealing with the administration? Do you feel supported?
   Response: Only 32% reported that they are fully comfortable.

5. Question: How comfortable are you with your salary?
   Response: Only 20% reported that they are fully comfortable.

6. Question: How comfortable are you with managing your finances, benefits, bills, mortgage, health insurance, and retirement?
   Response: 33% answered fully comfortable.

7. Question: Did you change employers since you started your job?
   Response: 70% replied no.

8. Question: In your opinion, how can MMPA help you with transitioning from training to independent practice?
   Response: A small group did not believe MMPA can do anything to help. Amongst the group that believed MMPA could make a difference, their main suggestions can be divided into two clusters.

   A. Suggestions that can be applied during residency training:
      For example, giving more data about a real job market to senior residents, more financial and legal education.

   B. Suggestions after completing training:
      For example, formal mentorship programs, legal education, financial advice such as contract negotiation, tips about running a business, paying off student loans, networking opportunities, and job support for family and significant others. In addition, having a job posting section on the MMPA website about job opportunities specifically for Missouri was also suggested.

Discussion:
Careers in psychiatry go through developmental stages (Teshima et. Al., 2019). A literature review revealed authors mapped the developmental stages of career development to Eric Erickson's theory of psychosocial development 5th stage, “identity versus (Continued on page 13)
role confusion” (Munley, 1977; Ng, et. Al., 2019). This stage seems to correlate with the challenges facing early career psychiatrists clearly. ECP’s struggle until they find their own professional identity. They are also negotiating with social interactions to fit in. Those who are unsuccessful with this stage tend to experience role confusion. During the transitional phase of an early career psychiatrist, it is not uncommon to have an internal conflict between balancing the new role of a multidisciplinary team leader and at the same time, delegating work without micromanaging team members. It is also a change for ECP’s to be an educator for residents, fellows, and other trainees like NPs and PAs. The need to stay up-to-date in their knowledge, attend and participate in conferences to keep up with the most recent advances as well as reading the literature, becomes just another thing that needs to be mastered. Identifying and managing inadequate team members, providing feedback, and initiating disciplinary actions and remediation plans that can be perceived negatively by these trainees is another test for ECP’s performance. When ECP’s salary increases compared to resident salary, and they enter into a different tax bracket, it may lead to a financial burden for ECP’s. Unfortunately, there is no training in residency or fellowship about managing finances, although this is an integrated part of training in other schools like dental school. Financial illiteracy of early career psychiatrists has been marked as one of the main challenges faced by ECP’s. Most early career psychiatrists are satisfied by their medical and psychiatric knowledge, as this is an integral part of residency and fellowship training. However, there is very limited education about finances, billing, malpractice insurance, benefits, health insurance, or how to negotiate a job contract, etc.

Early years of psychiatry practice is a crucial phase for career development for psychiatrists. Early career psychiatrists need to be prepared to face the challenges of this transitional role. Preparedness can be started as early as during residency training and continued in the early career phase as well. To support the ECP with board certification, assistance in the form of reduced fees for attending conferences and CME activities could be beneficial. In addition, formal mentorship programs are crucial, whether peer mentorship or provided by senior mentors.

Study Limitations: Survey questionnaire was emailed to all psychiatrists, not only ECPs. Mid and advanced career psychiatrists participated. The survey was only administered to members of the MMPA local branch for the APA in the state of Missouri. For the purpose of summarizing the results, we only included answers "fully comfortable/uncomfortable" and excluded "partially comfortable or somewhat comfortable.”

Disclosures: The authors are early career psychiatrists.

Reference:


Psychiatric Shortages/Residency Slots
Erin Connors, Senior Media Relations Specialist
Corporate Communications and Public Affairs
American Psychiatric Association

By the Numbers:
Psychiatry is getting more competitive in the U.S. The number of residency training slots is increasing:
**In 2012 there were 1,117 slots, but 2017 it was up to 1,495 slots, and in 2019 there were 1,740 slots.** That’s 64% more slots in just 7 years.
The fill rate for those slots has also increased. In 2019, the fill rate was 98.85%.

In general, more U.S. medical school grads are going into psychiatry. In 2018-- 5.5% of graduating U.S. medical students matched to psychiatry residencies—in 2013 it was 4.2%.

*See below for the increases over time (***)*

What will drive those numbers?
- More GME funding for residency positions in psych would certainly help grow our numbers at a time when demand is high.
- Continue to communicate with med students all the values and benefits of the field.

(***) U. S. Allopathic Seniors Matched to PGY-1 Positions by Specialty, 2013-2018

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</table>

Psychiatry (%)

(Sources: NRMP and ACGME)

Other important tools for addressing the workforce shortage include telepsychiatry and integrated care.
Telepsychiatry/telemedicine is a powerful tool to connect people with psychiatrists. It is especially helpful for people who live in rural areas or who find it hard to meet with a psychiatrist in person.
- Integrated care allows mental health and substance abuse treatment to be offered in a general medical setting, such as a primary care office. As mental health services are integrated into other health settings, it will be easier for psychiatrists to reach more patients and focus on those with the greatest need.
- More than 80 randomized controlled studies have shown that a particular model of integrated care, known as the Collaborative Care Model, is the most effective way to deliver mental health care with a primary care setting. [https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care](https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care)


Why are medical students choosing psychiatry?
- Psychiatry allows you to really **get to know your patients** and spend more time with them. Psychiatrists are trained medical doctors who **understand the whole person**.
- The **stigma of mental illness is not as prevalent-- especially in younger populations**. Mental health is often discussed openly on social media and in the news.
- **Lifestyle benefits**: specific office hours, the option of utilizing telepsychiatry to reach more patients, and flexibility with teaching or research time.
- They can choose a sub-specialty and focus specifically on children and teens, the elderly, forensic psychiatry, and addiction psychiatry.
- Integrated care: Psychiatrists often work closely with primary care physicians, both side-by-side and as consultants.
- Psychiatrists also work in a variety of settings, including private practices, clinics, general and psychiatric hospitals, university medical centers, community agencies, courts and prisons, military settings, rehabilitation programs, emergency rooms, and hospice programs.
- About half of the psychiatrists in the U.S. maintain private practices and many psychiatrists work in multiple settings.
People Who Smoke Tobacco May Be at Higher Risk of Developing Depression and Schizophrenia, Researchers Say

CNN (11/6, Guy) reports, “People who smoke tobacco may be at a higher risk of developing depression and schizophrenia,” researchers concluded after studying “data from 462,690 individuals of European ancestry using an approach called Mendelian randomization.”

Healio (11/6, Gramigna) reports investigators “found ‘strong evidence’ that smoking is a risk factor for both schizophrenia (OR = 2.27; 95% CI, 1.67-3.08) and depression (OR = 1.99; 95% CI, 1.71-2.32), and these results were consistent across both smoking initiation and lifetime smoking.” What’s more, “genetic liability to depression increases smoking (beta = 0.091; 95% CI, 0.027-0.155), but evidence was mixed for schizophrenia (beta = 0.022; 95% CI, 0.005-0.038) and very weak for an effect on smoking initiation,” the study revealed.

The findings were published online Nov. 6 in Psychological Medicine.

Medicinal Cannabis Not Currently Proven Effective for Mental Illnesses, Analysis Suggests

Reuters (10/28, Kelland) reports a review of scientific studies analyzing “the impact of medicinal cannabinoids on six mental health disorders” suggests that “evidence is weak for whether medicinal cannabis treatments can relieve mental illnesses such as anxiety, depression and psychosis,” for which reason the researchers say “doctors should prescribe them with great caution.” The findings were published in The Lancet Psychiatry.

Also reporting are TIME (10/28, Ducharme) and MedPage Today (10/28, Hlavinka).
individual doctors do not have time to visit the legislators on a regular basis or even write every time some issue that affects us comes up. We rely on the staff of the APA and AMA and our state organizations to plead our cause. The leaders are called upon to travel to the legislature to testify in front of hearings about Psychologists prescribing, open formularies, mental health appropriations and Mental Health Parity to name a few issues. Get active and go to White Coat Day.

There are times that you want to clone yourself to accomplish all that is asked of you. What I learned is that you start early and say yes to the volunteer opportunities that interest you. If you appear at meetings and are interested, you will be appointed and elected to positions in your district branch. That can lead to a trail of opportunities that you have to weigh and see which you will choose.

Choose wisely, but choose to join and support with money if not time and talent. Remember you cannot do it alone and organized medicine provides support, educational opportunities and a chance to change policies.
Regional and national newspapers in the United States are falling short of meeting guidelines for reporting on suicide deaths, suggests a report in *JAMA Network Open*. An analysis of coverage following the deaths of Kate Spade and Anthony Bourdain in June 2018 in print newspapers with a minimum circulation of 200,000 shows that the publications adhered to only about half of the national recommendations for reporting on suicide, such as avoiding details of lethal means or use of a sensational headline.

“News media coverage of suicide is associated with an increased risk of subsequent suicides, with the strongest associations following newspaper reporting of celebrity suicides,” wrote Arielle H. Sheftall, Ph.D., of the Ohio State University College of Medicine and colleagues. To educate the media about these risks, leading experts in suicide prevention, public health, and media from the American Foundation for Suicide Prevention, Annenberg Public Policy Center, Columbia University Department of Psychiatry, government agencies, and more in 2001 published the guideline “Recommendations for Reporting on Suicide.”

“Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death,” according to this document. “Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.”

Sheftall and colleagues analyzed the coverage of the deaths of Spade and Bourdain in the following newspapers: *The Chicago Tribune, Denver Post, Houston Chronicle, Los Angeles Times, New York Times, Seattle Times, Tampa Bay Times, USA Today, Wall Street Journal*, and *Washington Post*. Specifically, the authors assessed guideline adherence by the newspapers in the days following the deaths using 14 items derived from “Recommendations for Reporting on Suicide.” These items included avoiding details of notes left behind or location of death, providing information about warning signs of or risk factors for suicide, and listing the National Suicide Prevention Lifeline phone number. The researchers scored the articles by adherence to each guideline (1 for yes; 0 for no; total score: 14).

Overall, the newspapers adhered to a mean of 7.4 of the 14 specific guidelines; none of the newspapers adhered to 80% of the specific guidelines. All of the newspapers adhered to the two following guidelines: “avoided single-cause explanation of suicide death” and “avoided referring to suicide as a growing problem, epidemic, or skyrocketing.” In contrast, none followed recommendations to “share a hopeful message that suicide is preventable” or to “convey that suicidal behaviors can be reduced with mental health support and treatment,” according to the authors.

The findings point to “widespread opportunities for improvement,” Sheftall and colleagues wrote. They noted that steps taken in Canada in April 2014 to establish reporting guidelines for suicide and create checklists for journalists to promote adherence were associated with increased adherence to these guidelines following the death of Robin Williams by suicide in August 2014. “A collaboration between U.S. media staff, governmental agencies, and other stakeholders when updating and disseminating the recommended reporting guidelines for suicide may increase adherence, which in turn might reduce preventable harm,” they concluded.

For related information, see the *Psychiatric News* article “Preparing for a Sequel: ‘13 Reasons Why’ and Suicide Contagion” by Michael Fadus, M.D., and the *Psychiatric Services* article “Increases in Demand for Crisis and Other Suicide Prevention Services After a Celebrity Suicide.”

Reprinted from *Psychiatric News*
ADHD Medication May Reduce Risk of Injuries in Youth with Co-Occurring Developmental Disorders

ADHD medication may reduce the risk of unintentional injuries in youth with ADHD and co-occurring neurodevelopmental disorders, such as autism, suggests a study in the Journal of Child Psychology and Psychiatry.

While previous studies have found a negative association between ADHD medication use and risk of injuries in children and adolescents, this is the first observational study exploring risk in children with ADHD and a co-occurring neurodevelopmental disorder, wrote Laura Ghirardi, M.Sc., of the Karolinska Institutet in Stockholm and colleagues.

Ghirardi and colleagues used data from Sweden’s Total Population Register and National Patient Register to identify individuals aged 5 to 18 who had received an ADHD diagnosis between 2006 and 2013, including those who had also been diagnosed with the following neurodevelopmental disorders: autism spectrum disorder, communication disorders, intellectual disability, learning disorders, and motor disorders. They then gathered information from the Prescribed Drug Register on the patients’ use of ADHD medications, including methylphenidate, amphetamine, dexamphetamine, lisdexamphetamine, and atomoxetine.

The researchers tracked the youth’s inpatient and outpatient visits reporting injury until the end of 2013, the youth aged out of the study, or death, whichever came first. They then compared the rate of injuries during periods when the youth were taking ADHD medication with the rate of injuries during periods they were not taking medication. Of the 9,421 children and adolescents with ADHD included in the analysis, 2,986 had a co-occurring neurodevelopmental disorder; 1,390 had autism spectrum disorder. The rate of any unintentional injury and traumatic brain injury was lower during periods when the youth were taking ADHD medication compared with when they were not taking ADHD medication. Youth with co-occurring neurodevelopmental disorders were 12% less likely to have an unintentional injury and 73% less likely to have a traumatic brain injury when taking ADHD medication.

The findings have “clinical and public health relevance, considering the high rate of comorbidity among [neurodevelopmental disorders] and the fact that unintentional injuries are relatively common among children and adolescents,” the authors wrote.

For related news, see the Psychiatric News article “Many Youth With ADHD Fail to Take Stimulants as Prescribed.”

Reprinted from Psychiatric News

AD/HD Prevalence Continued to Climb Among US Adults Within Past Decade, Research Suggests

CNN (11/1, Howard) reported, “The prevalence of attention-deficit/hyperactivity disorder [AD/HD]...has continued to climb significantly among adults in the United States within the past decade,” researchers concluded. Investigators “found increasing rates of adults diagnosed with” AD/HD “within the Kaiser Permanente Northern California health system between 2007 and 2016, regardless of whether they were first diagnosed as a child or adult.” The study revealed “there was ‘a 43% increase in the rate of adults being newly diagnosed over the 10-year period,’ said” the study's senior author.

The findings were published online Nov. 1 in JAMA Network Open. HealthDay (11/1, Preidt) and Healio (11/1, Gramigna) also covered the study.
Adverse Events in Childhood May Raise Health, Socioeconomic Risks in Adulthood

A study published this week in the Morbidity and Mortality Weekly Report adds to the growing body of evidence indicating that experiencing adverse events in childhood such as abuse or witnessing intimate partner violence increases the risk of numerous negative health and socioeconomic outcomes in adulthood.

Researchers from the Centers for Disease Control and Prevention used data from more than 144,000 respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) from 2015 to 2017. The BRFSS is an annual state-based telephone survey of adults in which participants report on their health behaviors and whether health care professionals had ever diagnosed them with a health condition. The researchers drew the data from 25 states that had added questions to the BRFSS to assess participants’ exposure to eight types of adverse childhood experiences, including physical, emotional, or sexual abuse; household member substance misuse, incarceration, or mental illness; parental divorce; or witnessing intimate partner violence.

Overall, 60.9% of participants had been exposed to at least one type of adverse childhood experience, and 15.6% had been exposed to four or more. The more types of adverse childhood experiences participants were exposed to, the more likely they were to engage in risky health behaviors or have chronic health conditions or socioeconomic challenges as adults. For example, participants who were exposed to four or more types of adverse childhood events were five times more likely to have depression, roughly three times more likely to have chronic obstructive pulmonary disease or smoke, and nearly twice as likely to have coronary heart disease, drink heavily, or be unemployed compared with participants who reported no exposure to adverse childhood experiences.

The researchers noted that the prevalence of adverse childhood experiences was higher among people aged 34 years and younger, possibly because of differences in risk among people in that age group, their willingness to disclose their history, or their ability to recall adverse childhood experiences.

“Strategies to prevent adverse childhood experiences in the first place and to intervene with those who have been exposed to adverse childhood experiences might help to reduce prevalence of engaging in health risk behaviors [such as smoking or drinking] in young adulthood and subsequent negative health outcomes," the researchers wrote. “These strategies might also help to break the multigenerational cycle of adverse childhood experiences as these age groups are most likely to start families or raise children.”

For related information, see the Psychiatric News article "Positive Childhood Experiences May Counteract Adverse Experiences" and the Psychiatric Services article “State Legislators' Opinions About Adverse Childhood Experiences as Risk Factors for Adult Behavioral Health Conditions.”

Reprinted from Psychiatric News

Mark your Calendar
MPPA Advocacy Day
Wednesday, March 11, 2020
Use of Telepsychiatry Nearly Doubles From 2010 to 2017, Study Finds

Nearly twice as many mental health facilities in the United States offered telepsychiatry in 2017 than in 2010, according to a study published in Psychiatric Services. Telepsychiatry was most commonly offered by facilities in underserved and rural areas.

“Facilities with telepsychiatry offer a variety of services to a wide range of populations, and the increased use of these services among populations with greater barriers to access, such as those residing in rural and underserved areas, continues to show promise that such services will be made available to patients with the greatest need,” wrote Stanislav Spivak, M.D., of Johns Hopkins University School of Medicine and colleagues.

Spivak and colleagues analyzed national data from the Substance Abuse and Mental Health Services Administration’s National Mental Health Services Survey (NMHSS) collected between 2010 and 2017. The survey asked facilities that provide mental health treatment if they provided telepsychiatry—defined as “the ability for health care providers, working from a distance using telecommunications technology, to communicate with patients, diagnose conditions, provide treatment, and discuss health care issues with other providers to ensure quality health care services are provided.” The researchers compared the ownership, licensing, funding, and treatment setting of those facilities that reported offering telepsychiatry in 2017 with those that did not. They also asked state mental health agency officials whether telemedicine was reimbursed by state funds and/or Medicaid funds, and if the state had initiatives to expand the use of telemedicine.

In 2010, 15.2% (n=1,580) of the facilities surveyed reported using telepsychiatry; in 2017, that number grew to 29.2% (n=3,385) of the facilities surveyed. But the authors noted “considerable variability” among states, with less than 15% of facilities offering telepsychiatry in some states compared with over 60% in others. The increase in the proportion of facilities with telepsychiatry from 2010 to 2017 was highest in states with a rural population of 40% or more, the authors noted.

“Facilities that offered telepsychiatry had higher odds of being funded by federal and local government sources, as well as by private insurance, self-pay, and grant funding compared with facilities without telepsychiatry,” Spivak and colleagues wrote. In contrast, facilities offering telepsychiatry were less likely to be funded by Medicaid than those without telepsychiatry—a finding the authors described as “puzzling, as the federal Medicaid statute allows reimbursement of telemedicine as a regular service.” The lower odds of facilities using telepsychiatry receiving funding from Medicaid “may reflect the effect of state Medicaid regulatory hurdles,” they wrote.

State funding may also explain the variability in telepsychiatry from state to state. States that did not provide direct state funding for telemedicine had lower odds of offering telepsychiatry services (19.3% vs. 29.8%), the authors noted.

For related information, see the Psychiatric News article “Telepsychiatry: Who, What, Where, and How.”

Reprinted from Psychiatric News
Help elect candidates who will represent your interests in the Missouri General Assembly, and state and local campaigns. Join the Missouri Psychiatric Physicians Political Action Committee, MoPPPAC, the political voice of the Missouri Psychiatric Physicians Association.

What is the MO Psychiatric Physicians PAC?
MoPPPAC is an organization that accepts volunteer contributions to help strengthen the Missouri Psychiatric Physicians Association’s (MPPA) participation in elective processes at state and local levels.

Why does MoPPPAC exist?
1. State and local candidates who will advocate for Missouri Psychiatrists need the financial support of the medical community to win elections.
2. The Missouri Psychiatric Physicians Association advocates in the legislative arena with other organizations that have PACs. As long as organizations with interest adverse to those of the Missouri Psychiatric Physicians Association have PACs, the MPA needs one, too.
3. A PAC is part of a balanced strategy for legislative advocacy and political action.

How does your PAC investment affect your bottom line?
Lawmakers’ decisions in areas such as taxation, regulations and health care directly affect the profitability of your practice. Government policy affects not only your business; it affects your patients. MoPPPAC can contribute to a significant number of pro-medicine candidates. By pooling your political contributions with other Psychiatrists, you receive a greater return on your investment.

Who may contribute?
Anyone who wants to help elect candidates who support Psychiatry can contribute to the MoPPPAC.

Who directs MoPPPAC?
MoPPPAC operates under the direction of PAC officers and directors who are members of the American Psychiatric Association and the Missouri Psychiatric Physicians Association. The MoPPPAC Board of Directors may elect other members from time to time to serve as PAC officers and directors.

Who decides how MoPPPAC funds are spent?
The Board consists of officers and directors who serve on behalf of the Missouri Psychiatric Physicians Association. The Board approves all disbursements over $500. The PAC president approves disbursements of $500 or less.

What factors determine MoPPPAC’s support of a candidate?
- MoPPPAC membership input.
- A candidate’s strong voting record on mental health care and other issues affecting the practice of psychiatry and psychiatric patients.
- A candidate’s willingness to support the goals and mission of the Missouri Psychiatric Physicians Association.

MoPPPAC funds are used for purposes that are consistent with the goals and missions of the Missouri Psychiatric Physicians Association and the American Psychiatric Association.

How to Join?
Complete and return the Membership Form to MoPPPAC with your contribution. Note: MoPPPAC can accept only checks and money orders at this time, no credit cards. Maximum contribution is $5,000. Contributions to the PAC are not tax deductible.

Enclosed is my check or money order for:
- $365 Dollar-a-Day Club
- $100 Capitol Club
- $250 Speaker’s Club
- $500 Senator’s Club
- $1,000 Congress Club
- $2,500 President’s Club
- Other $________ MoPPPAC Club

The amounts recommended are suggestions only. An individual or medical practice may donate more or less than the suggested amount. The amount donated by a contributor, or the refusal to donate, will not benefit or disadvantage you. Only U.S. Citizens or Green Card holders may contribute. Contributions to the PAC are not tax deductible. Make checks payable to MoPPPAC and return to 722 E. Capitol Avenue, Jefferson City, MO 65101.
# NEWSLETTER ADVERTISING ORDER FORM

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

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Number of Ads: ____________________________________________________________

Total Price: ______________________________________________________________

Company: __________________________________________________________________

Contact Name: __________________________________________________________________

Address: __________________________________________________________________

City, State Zip: __________________________________________________________________

Phone: _____________________________ Email: ___________________________________

Mail order form and payment to MPPA, 722 E. Capitol Avenue, Jefferson City, MO 65101
Make checks payable to the Missouri Psychiatric Physicians Association
Send ad submission to missouripsych@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 Show-Me Psychiatry, MPPA’s quarterly newsletter, for 50% off the regular rate. Show-Me 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. 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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Guidelines for Submission to Show-Me 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.

6. Submission Deadlines

   February 15
   May 30
   August 15
   November 15

Advertisement Information

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

“Disaster, Research, Response and Resolution”
Missouri Psychiatric Physicians Association
Spring Conference
Renaissance St. Louis Airport Hotel
9801 Natural Bridge Road
St. Louis, Missouri 63134
Saturday, April 4, 2020