

Missouri Psychiatry

Newsletter of the Missouri Psychiatric Association (MPA)

A District Branch of the American Psychiatric Association



PRESIDENT'S MESSAGE

1st Quarter ~ 2017

By Laine Young-Walker, MD

The Missouri Psychiatric Association has been diligently working to actively engage residents, recruit new members, increase participation in our events, and to advocate for mental health issues at the state legislature. This year there have been some exciting changes within our organization which include: adding the Forensic and Correctional Committee to the Executive Committee, adding a resident's corner to our newsletter, establishing a new webpage that is more user friendly and continuing our advocacy at the state legislature.

One of the initiatives for this year was to engage residents across the state. The new highlight of the resident's corner in the newsletter has allowed MPA to engage psychiatric residents in the Kansas City, St Louis, and Columbia areas. You can see their first spotlight in this newsletter. We are very excited to offer an opportunity for residents to present posters at the fall meeting in Columbia.

Please join us for our next event in Kansas City. The MPA conference "Current Challenges in Medicine: Physician Burnout and the Opioid Crisis" will be held at the Sheraton Kansas City Hotel at Crown Center on April 1's from 9-1. This conference will be held in conjunction with the MSMA meeting.

We are encouraging members who meet the criteria for Distinguished Fellow of the American Psychiatric Association to apply. Distinguished Fellowship nominations must be submitted by the district branch to APA by **July 1, 2017**.

Requirements for nomination include:

- Not less than eight consecutive years as a General Member or Fellow of the APA.
- Certification by the American Board of Psychiatry & Neurology, the Royal College of Physicians & Surgeons of Canada, the American Osteopathic Association or equivalent certifying board.
- Nomination is initiated by your local District Branch/State Association.
- Three letters supporting your nomination must be received from current Distinguished Fellows or Distinguished Life Fellows.

Also the psychiatrist should have made significant contributions in at least 5 of these areas

- Certification by the American Board of Psychiatry & Neurology, the Royal College of Physicians & Surgeons of Canada, the American Osteopathic Association or equivalent certifying board.
- Involvement in the work of the district branch, chapter, and state association activities.
- Involvement in other components and activities of APA.

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Missouri Psychiatric Association

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PRESIDENT'S MESSAGE CONTINUED

- Involvement in other medical and professional organizations.
- Participation in non-compensated mental health and medical activities of social significance.
- Participation in non-medical, non-income-producing community activities.
- Clinical contributions.
- Administrative contributions.
- Teaching contributions.
- Scientific and scholarly publications.

If you are interested in becoming a Distinguished Fellow and meet the criteria for nomination please contact Sandy.

Our new website is being edited now and will soon be available. Be sure to check out our new website www.missouripsych.org.

Sincerely,

Laine Young-Walker

Laine Young-Walker
MPA President (2016-2017)

NEW

Distinguished Fellows/ Fellows

Sara R. Catania, DO
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FDA Moving Toward CES Neuromodulation Approval for Home Use: Are We Ready?

*Jo-Ellyn Ryall, MD
MPA Secretary-Treasurer*

Cranial Electrotherapy Stimulation (CES) devices have had FDA Clearance for home use by prescription for over twenty years, and yet have been kept in the more restrictive Class III status, like ECT. In January of 2016, FDA published in the Federal Register their proposed final rule, with the intent to move CES devices to Class II for the indications of Anxiety and Insomnia. Adequate peer-reviewed studies that were not funded by the manufacturers, and a record of safe use, support this decision. The leading CES device has been in use in some military and VA medical centers for over twelve years. CES should not be confused with Transcranial Direct Current Stimulation (tDCS), which is a higher powered, less sophisticated waveform for targeted neurostimulation, and remains experimental and investigational. In fact, 43 leading neuroscientists issued a warning letter on tDCS in the July 2016 issue of *Annals of Neurology*. CES also should not be confused with Transcranial Magnetic Stimulation (TMS) which is administered in clinical settings for patients with Major Depressive Disorder under certain circumstances.

Much is asked of psychiatrists in today's healthcare environment. We are seeing sicker-and-sicker patients, often with less-and-less time, to maintain a viable practice. Most patients with stress and sleep disturbance are managed by primary care and women's health physicians and nurse practitioners.

Because of a lack of insurance reimbursement for CES, manufacturers have marketed mainly to concierge and conventional or integrative medicine practices whose patients have the resources to move forward with home use of this technology. As insurance coding changes, and this impediment is removed in the next two or three years, widespread utilization is likely, both in office, and at home by patients. Some psychotherapists administer CES during session because of the calming, beneficial effect, although best results often occur with daily use at home. Patients with Fibromyalgia often benefit substantially.

As with any new, or newly-recognized, technology, bumps along the road to implementation can occur. I recently became aware of a patient of a St. Louis psychiatrist who had benefited from one CES device during clinical use, and then ordered a device from a different manufacturer over the internet. This patient had poor results from the mail-order device, and was sent this device without a prescription from a Missouri-licensed prescriber. The Missouri State Medical Association House of Delegates passed a resolution that says that MD's, DO's and the PA and Nurse Practitioners working with them should prescribe the devices.

Caution will be necessary as these devices gain more widespread recognition, and as we are asked to advise our primary care colleagues. It is important that we review the scientific literature and gain experience with this technology, given the widespread prevalence of Anxiety and Insomnia in the psychiatric patient and general population. I personally have prescribed the leading CES device over the last four years, with about an eighty percent success rate on reducing anxiety. My experience includes about fifty patients in my private practice, as well as regular use with patients in a residential Chemical Dependency unit. And I use Alpha-Stim myself as an aid for relaxation at the end of a stressful workday.

Regarding our patients with addiction, many of them seek benzodiazepines, which are contraindicated for them. Their heightened Anxiety during treatment has been greatly improved with CES in the Chemical Dependency unit. Insurance reimbursement will allow them to benefit from an effective treatment after discharge, at home, despite their financial situation.

I encourage each of you to learn more about the various treatment modalities available and the exciting progress being made in the "Alphabet Soup" of neuromodulation: ECT, DBS, VNS, TMS, and CES. Feel free to contact me with questions.

Bring Back the Asylum

(As a Modern Medical and Therapeutic Community)

Henry A. Nasrallah, MD

One of the fallacies psychiatric care is that we have done the seriously mentally ill a great favor by moving them into the community to be mainstreamed, and shutting down those “awful” institutions. But a reality check would reveal that the seriously and permanently mentally ill have not done well at all following the deinstitutionalization of the past 30 years. Consider the following common adversities that individuals with chronic schizophrenia and related psychoses routinely face in the community these days:

Incarceration

The jails and prisons of our country are bulging with mentally ill individuals. Patients have been transformed to felons, and the environment they now live in can be much worse than the old state hospitals.

Poverty

Patients barely have enough to live on, and most are unable to meet basic subsistence needs of food and shelter.

Homelessness

A large proportion of the homeless population has mental illness, and life on the street is definitely worse than the institutions of the past.

Victims of Crime

The mentally ill are more frequently victims of crime than they are the perpetrators of crime in the bad neighborhoods they usually live in.

Substance Abuse

A large majority of the seriously mentally ill abuse alcohol and drugs, although they cannot afford the detrimental mental and physical consequences of street drugs.

Loneliness

Most of the seriously mentally ill lead a life of isolation and quiet desperation in the community. Very few have access to social activities, friends, or

intimate partners as ordinary people do.

Medical Illness

The physical health of most individuals with schizophrenia is to say the least, dismal. Their sedentary life style, poor nutrition, and high rate of smoking all lead to elevated cardiovascular risk factors that can be compounded by the metabolic side effects of the medications they must take to control their psychotic and mood symptoms. The CATIE study and many others showed that almost half the patients with schizophrenia meet criteria for the metabolic syndrome. Add the risks of hepatitis and HIV from intravenous drug abuse, the numerous medical complications of alcohol, the exposure to infections in the crowded, urban, unsanitary places they live (including homeless shelters) and the chances of physical ailments increase logarithmically.

Lack of Primary Care

Although afflicted with many medical illnesses, including diabetes, hypertension, and dyslipidemia, the CATIE study and others report that a large proportion of schizophrenia patients never received assessment or treatment for their metabolic disorders. Talk about adding insult to injury! The community mental health centers provide psychiatric care but unfortunately do not regularly connect their patients to primary care clinics.

High Mortality

The high rate of death among community-based schizophrenia patients is appallingly high. About 12% of persons with schizophrenia die of suicide, but the highest cause of death in schizophrenia is cardiovascular disease. Recent studies of mortality in the seriously mentally ill in several states showed that the average years of life lost is between 26-29 years.

The Many Advantages of a Modern Asylum

For all the above reasons, I often wonder why not reinvent the old institution and re-introduce it as a better option for the seriously mentally ill? What if

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Bring Back the Asylum continued

we can create a better asylum, a therapeutic community for persons with chronic schizophrenia, whose severe brain disease and cognitive deficits prevent them from being able to lead a “normal” life in the “real world.” Such a “kinder, gentler asylum” would have numerous advantages for the seriously mentally ill, including the following:

- Daily psychiatric assessments by professional psychiatric staff
- Monitored medication adherence to prevent relapse and deterioration
- Early detection and management of side-effects
- Good, balanced diet designed by dieticians
- Regular exercise with certified Therapists
- A drug and alcohol- free environment
- Primary care services (annual physicals and management of medical conditions)
- Structured therapeutic activities (occupational, social, vocational and cognitive)
- Educational classes on site
- Part-time paid employment in the institution (yes, like the good old days: farming, woodshop, bakery, laundromat, etc.), which gives patients dignity and a “meaning” to their lives
- Computer training and email access
- Stable mailing address and phone
- Legal services (in case they need it)
- Supervised community trips to malls, parks, ballparks, family, visits, etc.
- Opportunity to participate in IRB approved scientific studies and clinical trials (with compensation) to discover the causes and better treatments for schizophrenia
- Smoking cessation programs
- Security services to protect them against crime 24/7
- Early suicide detection and Intervention
- Autopsy services after death with harvesting of brains for a brain bank (with informed consent) to advance neurobiological discoveries of psychosis
- Continuity of care
- A single integrated electronic medical record
- Increased odds of a full remission and, ultimately, recovery.

Lessons to be Learned

Some would argue: That’s outrageous! We should never go back to the institutional setting! The mentally ill should receive treatment in the “least restrictive setting.” They should be able to “exercise their civil rights,” etc. My response to that would be: Yes, that’s what we thought 40 years ago, but judging from what has happened, we were wrong: de-institutionalization has become “trans-institutionalization” into jails and prisons, where the restrictive environment is far worse than the old asylum. We have learned the harsh consequences of throwing cognitively disabled people into the community and expecting them to exercise their civil liberties and “freedom”, which they may not have the capacity to do due to self-neglect and negative symptoms, putting them at many grave risks.

Our Patients Deserve Better

In Italy two decades ago, the politicians decided to shut down state hospitals and to “free” the chronically institutionalized mentally ill into the community. Well, thousands of them literally died within a few months. This atrocity was described in a book [*Last Days of Maniano* by Mario Tobino] by an Italian author. Let us not confuse idealism with the harsh reality of disabling brain diseases. A modern, gentler, kinder asylum may be just what the seriously mentally ill need, rather than being incarcerated and criminalized for their medical illness, becoming homeless, addicted to drugs, being medically ill with no treatment and dying young. Our patients deserve better than the current broken mental health system. Let us act and stop bemoaning what is happening to the mentally ill in our country. It should be a medical, ethical, and a social solution, not a legal one.

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:

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January 6, 2017

Dr. Jo-Ellyn M. Ryall
Missouri Psychiatric Association
722 E Capitol Ave
Jefferson City, MO 65101

Dear Jo-Ellyn,

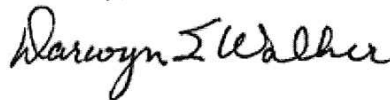
Thank you! We received your \$500.00 donation to NAMI St Louis and it means so much to us and the families we serve. Your gift provides individuals with proactive management skills for coping with a chronic but treatable illness as well as advocate for those whose illness has become disabling so that they may have dignity and quality of life.

Until there is a cure, providing skills and coping strategies for family members and friends who make up an individual's support team is paramount to a successful treatment plan. Because of you, families throughout the St. Louis region maintain access to no cost education and support programs that strengthen and empower them in assisting their loved ones.

If you would like to explore ways to get more involved with our NAMI family, I invite you to contact Sharon Lyons, our Director of Volunteers, at (314) 962-4670 or email sharon@namistl.org.

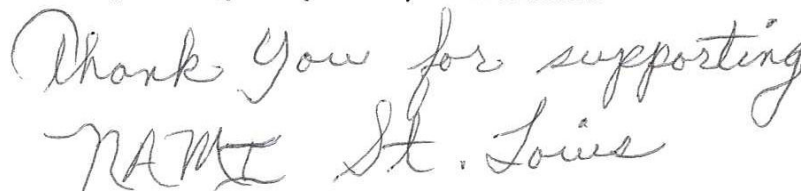
Your support is helping families cope with a challenging illness and live their best possible life. Thank you for entrusting us with your gift.

Sincerely,



Darwyn E. Walker
Executive Director

NAMI St. Louis is a 501 (c)(3) non-profit organization. For this reason, your gift is eligible as a tax deduction according to IRS regulations. You received no goods or services in exchange for this gift. For additional information, please speak with your tax consultant.



The Affordable Care Act's Impact on Mental Health and Substance Use Disorders

Mental illness is very prevalent in the United States with almost everyone having a family member, friend, or coworker struggling with a mental health problem. According to the National Institute of Mental Health, over 68 million Americans experienced a psychiatric or substance use disorder in the past year.

Prior to the Affordable Care Act (ACA), people with bipolar disorder, schizophrenia, major depressive disorder, substance use disorders, and other mental health issues struggled to obtain insurance coverage to help them access care. The ACA changed that by requiring coverage of necessary services to treat mental illness.

Consequently, the ACA has made it easier for Americans to gain mental health coverage, and improving their chance for healthier and more productive lives while reducing the stigma around mental illness.

Below are five areas with notable impact: private insurance reforms, Medicaid expansion, mental health parity, Essential Health Benefits (EHBs)/preventative care, and integrated care.

Private Insurance Reforms

Staying on Parents' Coverage Until Age 26

- Since passage of the ACA, mental health treatment increased by 5.3 percentage points among people ages 18-25; mental health uninsured visits declined by 12.4 percentage points, while private insurance visits increased by 12.9 percentage points.¹

Coverage for Pre-Existing Conditions

- Under the ACA, insurance plans cannot deny individuals coverage or charge more due to a pre-existing health condition. This includes both mental illnesses and substance use disorders.

Medicaid Expansion

- Among the 5.3 million Medicaid expansion-eligible individuals with a mental illness or

substance use disorder, over 50% have already gained access to coverage under Medicaid expansion initiatives nationwide.²

- Several states that expanded Medicaid reported that they anticipated reductions in general funds needed for treatment of the uninsured, ranging from \$7 million to \$190 million in 2015. States that choose to expand Medicaid may achieve significant improvement in their behavioral health programs without incurring new costs.³
- Medicaid expansions under the ACA have decreased the rates of uninsured individuals, and have improved access to mental health care and outcomes of low-income patients. If Medicaid were expanded in all states, approximately \$230 million in additional revenue would go to community health centers, thus potentially increasing capacity to provide behavioral health services.⁴
- Since Medicaid expansion 1.6 million Americans have gained access to substance abuse treatment, which has been critical as states seek to combat the opioid abuse epidemic.⁵

Mental Health Parity

- Predating the ACA, the 2008 Mental Health Parity Law (MHPAEA) requires parity in financial and treatment limitations in large group health plans and state and local government plans. This provides protections to an estimated 103 million people.⁶
- MHPAEA extended parity protections to individuals covered by Medicaid managed care plans and the Children's Health Insurance Plan (CHIP).
- ACA further extended parity protections under MHPAEA to individuals covered by the Medicaid expansion. Approximately 23 million people in these programs access mental health and substance use disorder services.⁷
- The ACA also expanded parity requirements under MHPAEA to non-grandfathered individual and small group market plans, covering an additional 48 million people.⁸

(Continued on page 9)

The Affordable Care Act continued

EHBs & Preventative Care

- Services to treat mental illness and substance use disorders are defined as an Essential Health Benefit that must be covered under insurance plans covered by the ACA.
- Under the ACA, plans must cover preventive services, such as depression screening for adults and adolescents, behavioral assessments for children, alcohol misuse screening and counseling for adults, alcohol and drug use assessments for adolescents, and tobacco use screening for all adults and cessation interventions for tobacco users.⁹
- Early intervention following the first episode of a serious mental illness can improve long-term health outcomes.¹⁰
- Prevention and early treatment programs for mental illness have cost-benefit ratios between 1:2 and 1:10. Every \$1 investment yields \$2 to \$10 savings in healthcare, justice, educational and lost productivity costs.¹¹

Innovation Funding to Support Integrated Care

- The ACA provides funding for states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions, including mental illnesses and substance use disorders. As of September 2016, 19 states and the District of Columbia had developed a total of 28 approved Medicaid health home models.
- The Center for Medicare and Medicaid Innovation (CMMI) funds large-scale demonstration projects and pragmatic trials of new models of services delivery for patients with mental health and substance use disorders. Funding has been provided to train 3,500 psychiatrists in the Collaborative Care Model. Three decades of research and over 80 randomized controlled trials have identified the Collaborative Care Model as being effective and efficient in delivering integrated care in a variety of settings to improve outcomes and patient satisfaction, while lowering costs.^{12,13}

at jregan@psych.org or K.J. Hertz at kjhertz@psych.org

Mental Health Services Improve Health Outcomes at a Lower Cost

- ⇒ Depression alone has an annual negative economic impact of \$210.5 billion¹
- ⇒ Mental illness causes more lost workdays and impairment than arthritis, asthma, back pain, diabetes
- ⇒ Nearly 86% of employees treated for depression report improved work performance¹
- ⇒ An estimated \$25-\$48 billion could be saved annually through effective integration of mental health and other medical care

References

1. Saloner, B., & Cook, B. L. (2014). An ACA Provision Increased Treatment For Young Adults With Possible Mental Illnesses Relative To Comparison Group. *Health Affairs*, 33(8), 1425-1434. doi:10.1377/hlthaff.2014.0214
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13. Unützer J et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." *American Journal of Managed Care*. Feb 2008;14(2):95-100.

If you have questions, please contact Jeffrey P. Regan

“The Endocannabinoid System and Marijuana Abuse”

Donald Bohnenkamp, MD

Assistant Professor of Psychiatry,

Washington University School of Medicine in St. Louis

Chase Park Plaza, St. Louis, MO ~ Thursday, January 26, 2017





Missouri Psychiatric Association

'CURRENT CHALLENGES IN MEDICINE: PHYSICIAN BURNOUT AND THE OPIOID CRISIS'

Sheraton Kansas City Hotel at Crown Center
Kansas City, Missouri
Saturday, April 1, 2017

Agenda

MARK YOUR
CALENDAR!

- | | |
|--------------------|--|
| 7:30 - 9:00 am | Executive Committee Meeting |
| 9:00 - 10:20 am | <p>"Physician Burnout"</p> <p>Physician dissatisfaction and burn-out are epidemic as a result of increasing loss of professional autonomy. When clinical practices are administered as businesses that care more for financial profit than for professional excellence and patient well-being, physicians feel there is less meaning and satisfaction in what they do. Large scale surveys show how physicians in various specialties are adapting. The risk of physician burn-out will be discussed in relation to both organizational culture and individual personality features. Physician well-being can be enhanced both by changes in the current culture of medicine and health promotion in physicians. Character traits can be cultivated to enhance personal adaptability in ways that provide meaning and satisfaction, including efforts to transform organizational conditions that dehumanize patient-physician relationships and thereby impair the efficiency and effectiveness of medical care.</p> <p><i>Speaker: C. Robert Cloninger, MD, PhD, Renard Professor of Psychiatry, Director of Center of Well-being, Washington University School of Medicine</i></p> |
| 10:20 - 10:30 am | Break |
| 10:30 - 11:50 am | <p>"Opiate Crisis in America"</p> <p>Dr. Jo-Ellyn Ryall will present cases of patients she has worked with in conjunction with a discussion of the US Surgeon General's outreach to every physician in the country.</p> <p><i>Speaker: Jo-Ellyn Ryall, MD; Kelly O'Leary, BS (R)(T)(R)(T)</i></p> |
| 11:50 - 12:00 noon | Break |
| 12:00 - 1:00 pm | <p>Luncheon</p> <p>"How to Avoid Burnout"</p> <p>Being burned out is a familiar complaint. It is often associated with work, although caring for children probably comes in a close second. Oddly, one rarely hears it after a vacation, no matter how strenuous. Biking through France, for example. But 'burnout' is more than a complaint, it is an actual syndrome.</p> <p><i>Speaker: Charles Van Way, III, MD, Emeritus Professor of Surgery, University of Missouri, Kansas City</i></p> |

A Psychiatrist's Experience in a Greek Refugee Camp

Sherifa Iqbal, MD, FAPA, FASAM

The burden of mental illness creates enormous suffering as well as health and economic impacts. Mental health diagnoses are four of the ten leading causes of disability worldwide. The World Health Organization (WHO) estimates that in 2015, there were 450 million people with mental illness globally. Members of displaced populations are especially vulnerable to stress as many have had traumatic experiences of violence and loss. Adding to these difficulties are the determinants of transitioning to a new environment, loss of autonomy and limited access to having basic needs met. WHO estimates that after the acute onset of a major emergency, one in six people (10-15%) have mild to moderate mental health symptoms. Another 3-4% will have severe mental illness, to the extent that they have a markedly decreased ability to complete activities of daily living. An unprecedented 65.3 million people globally have been displaced from their homes since 2015. Among them are nearly 21.3 million refugees, over half of whom are under the age of 18.

There are over 57,000 refugees in Greece alone and they have little to no access to mental health assessment and treatment. Over the past year, temporary camps including tent sites in vacant factories and warehouses have been set up to host refugees in Northern and Central Greece. This situation was never expected to last this long and agonizingly, the weeks have turned into months with no predictable end in sight. Due to economic issues in Greece, quality, timely and accessible community level health care is not always available to Greek citizens and it is nearly non-existent for refugees. This includes mental health care. While NGOs and other humanitarian groups attempt to provide such services, there are large gaps in care delivery with some camps receiving no mental health services.



This past summer, I had the opportunity to volunteer as part of a medical mission to Thessaloniki, Greece. Like many of you, my heart was touched by the stories of the refugees fleeing Syria and my mind was haunted by the media images of suffering, desperation and fear. I knew that, in whatever small way, I had to do something to help. Finding an organization that had an interest in selecting a psychiatrist to join a medical team proved to be difficult. After many months, phone calls and emails, I was selected to join a team sponsored by Salaam Cultural Museum and

Swiss Cross who were servicing the Frakapor and Karamanlis camps. While I have been able to travel and learn about various mental health systems in Africa, South America and Asia, nothing had fully prepared me for what I experienced in Greece.

I knew that my good intentions, psychiatric knowledge and supply of medications were not going to be enough to make me effective in this setting. I contacted the organizations directly to find out how I could be most helpful. I asked who was providing mental health care currently. The answer? No one. What medications were being prescribed for those with mental health conditions? None. How were they handling mental health issues, including psychosis? Yoga. It had previously been felt that there was no point in starting mental health treatment as there was no one to continue it. As is often the case, physical issues were deemed more important than mental well-being. Upon arrival to the camps, I realized that I had only been given partially correct information. Doctors Without Borders had a psychologist that visited one of the camps weekly and, in fact, there were no yoga classes.

These camps were originally meant to be transient in nature and neither the Greek government or the well-

(Continued on page 13)

A Psychiatrist's Experience continued

meaning NGOs had prepared for a longer term situation. This is changing. At the time of my mission, it was obvious that better infrastructure was required as everyone realized, with increasing hopelessness and frustration, that the refugees were not leaving the camps anytime soon. A repeated sentiment from various refugees was that the loss and physical danger in Syria were terrifying but the agony and psychological trauma of no end point to this ordeal were worse. As one of my fellow volunteers was told by a refugee: "In Syria, I expected to die at any moment. Now in Greece, I'm actually dying every day."

In August of 2016, the camps were crowded, unsanitary and extraordinarily hot. Food rations were meager, bland and unpredictable in delivery. Extension cords were running everywhere and the camp was a sweltering fire hazard. Boredom was a common complaint though people tried to stay as busy as they could. A former tailor mended donated clothes. A restaurant owner had a small falafel stand. The barber helped keep heads shorn in light of the lice epidemic. The NGO and Greek government efforts were poorly coordinated. There was often competition as to who was running what which caused either an overlap or absence of services. Around the time that I was leaving Greece, International Medical Corps was in Thessaloniki, performing a needs based assessment which promised to create a more focused, cohesive approach to the humanitarian efforts.

In addition to providing mental health assessment, I found myself back in the throes of basic internal medicine; treating rashes, conjunctivitis, infected mosquito

bites, diarrhea and fevers. I quickly learned that my specialty mattered very little when most days I was the only physician in the camp. Something (me) was better than nothing. I had never been so grateful for the eight months of inpatient internal medicine and four years of weekly outpatient medicine clinic that I endured at UMKC. We had a large supply of donated hydrocortisone cream and it was something quick, effective and tangible to give to people who were beyond miserable from itching. I became known as Dr. Cream and this interaction provided an opening to screen people for mental health issues.

While the camp conditions were deplorable, the sense of community was strong. Women chatted and helped each other with childcare. Men formed inter-camp soccer leagues. Children fought, played and attended a makeshift school. People looked after each other. More often than not, I knew about a refugee who needed something due to a concerned friend in a neighboring tent grabbing my hand and pulling me over. These refugees, in spite of a lack of very basic human rights, are survivors and they continue to make the best of what they are given, though of course, they deserve so much more.

I have reflected daily about my time in Greece. I sum up the trip with this thought: I have never felt more helpless or more helpful in my entire life. Would I go back? Absolutely. I plan on it. Help can be provided to refugees both domestically and abroad. This can take many different forms, if travel is not possible. If anyone is interested in finding out more about how they can help in this or other crisis psychiatry situations, I hope that you will contact me through the MPA.

(Continued on page 15)



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Residents' Corner

*Dr. Katherine Edwards and Dr. David Ash
University of Missouri-Columbia*

The Missouri Psychiatric Association is pleased to announce a new resident-driven initiative that will be included in our quarterly newsletter. This initiative, to be known as the "Residents' Corner", will allow residents and fellows to submit original case reports or studies, with subsequent review and possible publication in our newsletter. The initial review and editing of submitted articles will be completed by residents, allowing this project to be highly resident-focused. The spirit of this endeavor is to foster development in the academic process of writing and reviewing manuscripts and to increase participation in the Missouri Psychiatric Association, as well as the American Psychiatric Association.

Manuscripts will be accepted quarterly for publication (deadlines for 2017 submissions are 02/15, 05/30, 08/15, and 11/15). Guidelines for submitting

manuscripts will include that authors must be residents or fellows (at least one of whom is an MPA/ APA member), word count must be between 600-2000 words, paragraphs should appear with a double-spaced format, and up to five references may be added. At the end of the article, the author should include a statement identifying the presence or absence of an associated conflict of interest. Additionally, if clinical information is included, the author should clarify that identifying information has been changed, and that permission has been obtained from the patient and/or guardian prior to publication. Two manuscripts will be accepted per quarter for publication. If you are interested in taking part in this valuable new project, please forward manuscripts to Sandra Boeckman at missouripsych@gmail.com.

A Psychiatrist's Experience continued

Dr. Iqbal has no conflicts of interest to report.

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Opiate Epidemic in Kansas

KPS Spring Meeting

Presenters

*Dr. David Willey, MD
Dr. Bob Twillman, PhD
Anthony Singer, JD*

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Resolve to Implement the Right Direction Depression Initiative in 2017

Clare Miller

When one of your employees has depression, he or she can feel lost in the woods alone. Right Direction can help employees take the first step on the path to health.

If you're a regular *Mental Health Works* reader, you're likely already aware of Right Direction, the depression awareness initiative we offer in collaboration with Employers Health, an employer coalition based in Ohio.

Right Direction is a first-of-its-kind initiative to raise awareness about depression in the workplace and its effect on productivity. It promotes early recognition of symptoms and works to reduce the stigma surrounding depression. Right Direction's secret weapon is undoubtedly its unofficial mascot - a bear in a necktie - that draws employees in and encourages engagement on a topic often viewed as taboo.

Right Direction gives employers tools to make the case for action with senior management, including educational presentations about depression and its effect on the workplace; the "Field Guide," a toolkit which includes a step-by-step implementation plan; as well as corresponding promotional resources, such as posters, intranet copy, PowerPoint templates and an employee website. The materials are free and can be customized with your company's logo and information on how employees can access services through the company-sponsored employee assistance program and health benefits.

Since it launched in 2013, Right Direction has expanded its library of award-winning free materials employers can use to increase understanding about depression and encourage more employees to reach out for help when they need it. As we close out 2016, I wanted to draw your attention to some of our new materials so you can include them in your plans for 2017 - and invite you to check out all that we have available for your workplace.

- **Mental Health Observances Calendar:** use our calendar of mental health observances to infuse messages about mental health into your 2017 health and wellness communications plan.
- **New interactive field guide:** we reconfigured our implementation "field guide" to make it easier for you to connect the specific tools and resources available at each step of your company's journey, recognizing that each company's path is as unique as they are.
- **Employer newsletter:** delivered bimonthly, this newsletter delivers fresh new content for employees, as well as tips and case studies from other companies for successful rollouts.

Check out all the materials available by accessing the library for employers.

What sets Right Direction apart from other initiatives is its focus on how depression affects someone at work. Symptoms of depression not only include a deep feeling of sadness and loss of interest in activities, but difficulty thinking, concentrating, or making decisions, problems with sleep, and loss of energy or fatigue - symptoms that can seriously impact an employee's ability to perform successfully at work.

In addition to the terrible human cost imposed by depression, there is a significant economic impact, currently estimated to be \$210 billion a year, with \$105 billion associated specifically with absence, disability and presenteeism. (Greenberg 2015) Despite the fact that one in ten people have depression, people often suffer for years before seeking treatment. (Kessler, 2006)

Employers are in a position to positively change this path by increasing awareness about the depression and encouraging employees to get help. By taking on

(Continued on page 17)

Resolve to Implement the Right Direction continued

a highly-stigmatized condition like depression, employers send a powerful message to employees and create a culture that supports mental health.

Make 2017 the year you take on depression at your company!

Clare Miller is the director of the Partnership for Workplace Mental Health and can be reached at cmiller@psych.org or 703-907-8673.

Right Direction is an effort from the Partnership for Workplace Mental Health, a program of the American Psychiatric Association Foundation and Employers Health Coalition, Inc., and is supported by Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Lundbeck U.S.

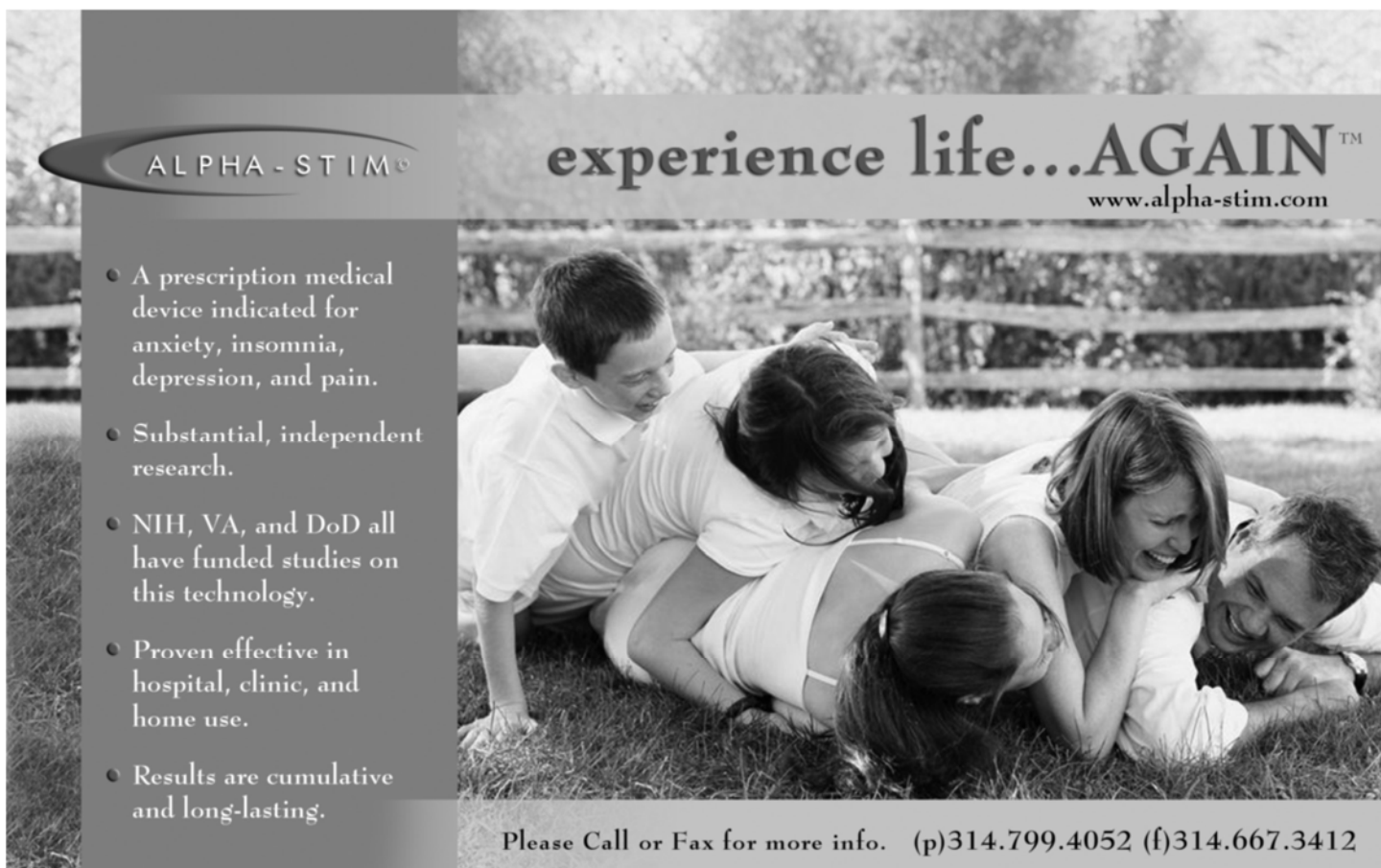
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News for APA District Branches

What's New at the APA?

APA issued a letter to leaders in Congress calling on them to ensure that Americans with mental illness and substance use disorders continue to have access to the care that they need. The letter comes as Congressional Republicans consider legislation on insurance coverage. "As Congress considers significant reforms to health insurance coverage this year, it is critical that any such reforms do not undo the gains which have been made over the past several years for individuals with mental illness, and that any such reforms only further enhance coverage and access to lifesaving evidence-based care."

On Jan. 3, APA President Maria A. Oquendo, M.D., began a new role as Psychiatry Department Chair at Penn Medicine. In this new role, Oquendo will lead a large department whose faculty members practice and conduct research in psychiatry and behavioral health, including depression, schizophrenia, eating disorders and substance use disorders.

February Course of the Month | 2017

Each month, members have free access to an online CME course on a trending topic. The February course is Myths and Misperceptions of Opioids and Cannabis presented by Nora Volkow, M.D., of the National Institute on Drug Abuse (NIDA). Volkow's presentation discusses misconceptions that contribute to the opioid epidemic,

the inappropriate treatment of opioid use disorders, and highlights the ongoing research efforts to better understand both the positive and negative potential of cannabis. A calendar featuring all the Members' Courses of the Month for 2017 is also available online.

Get ready for MINDGAMES!

MINDGAMES, the APA's national residency team competition, is a fun way for residents to test their knowledge on patient care, medical knowledge, and psychiatric history while earning bragging rights for their program. Registration opens Jan. 23 for the preliminary qualification exam, which residents can complete Feb. 3-17. The top three teams will advance to the national MINDGAMES final competition, at the APA Annual Meeting. Visit [MindGames](#) for more information.

Listen to the Latest Research through the AJP Podcast

Do you find yourself constantly on the go with no time to catch up on the latest psychiatric research? AJP Audio brings you the highlights from each issue of The American Journal of Psychiatry. Each episode features discussion of three articles that also serve the basis for the AJP CME courses. Subscribe to receive automatic updates.

2016-2017 100% Club Announced

2017 marked another great year for the 100% Club – with more than 100 residency programs meeting the requirements to be recognized for the 2016-2017 year. In addition to the benefits of

membership, 100% Club residents and their programs receive exclusive benefits like a practice resource gift, chief resident welcome kits, and access to free SET for Success for the program director.

Registration Now Open for the 2017 APA Annual Meeting

Join us at this year's Annual Meeting in San Diego from May 20-24, 2017. APA's Annual Meeting is the premier psychiatry event of the year. With over 450 educational sessions and courses, there is no better event to help you expand your knowledge, network, and meet certification and licensure requirements. Members receive a steep discount on registration. <http://psychiatry.org/psychiatrists/meetings/annual-meeting>

Evaluate New Tech on APA's Mental Health Apps Page

Dozens of health care management apps are available, and deciding which, if any, to use can be confusing. APA is helping psychiatrists navigate mobile health technologies to determine whether an app will work for you and your patients. This resource includes information on how to evaluate apps and opportunities for additional guidance.

Take the Next Step in Your Career

Become a Fellow of the APA and earn the FAPA designation. Fellows are committed to psychiatry and the ongoing work of the APA. Be among the prestigious 25% of APA general membership. There are no additional fees or dues payments, just complete the application.

Patients Need Your Help to Enforce Mental Health Parity

With all the recent discussion of the future of the Affordable Care Act (ACA), members have asked about the impact of the ACA's destiny on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA is a separate statute that applies to large group employer plans (+50 people), Medicaid managed care arrangements and nonfederal government plans that do not opt out. The ACA expanded MHPAEA to Medicaid expansion plans, Exchange Plans and to the individual and small group markets. Right now, MHPAEA impacts almost all insurance products on the market, and your patients need your help in dealing with possible parity issues and ensuring access to care.¹ What can you do?

1. Work with your patients to recognize potential parity violations and complain when they experience one.

One of the most common things APA has heard from regulatory authorities is that violations cannot exist because no one is complaining! Twenty states have been granted money by the federal government to enforce parity in the state. Regulators need to hear from you to know where to look for problems. You must not be silent.

Here are some potential parity violations²:

- A. Pre-authorization including blanket preauthorization requirements for all mental health or substance use disorder (MH/SUD) services, treatment facility preauthorization requirements not applied to medical/surgical services, or more stringent medical necessity review or prescription drug preauthorization requirements than those applied to medical/surgical services;
- B. Fail-first protocols, requiring an individual to fail to achieve progress with a less intensive form of treatment before a more intensive form is covered;
- C. Probability of improvement requirements, for example, offering coverage of continuing treatment only if improvement is demonstrated or probable;
- D. Written treatment plans, requiring treatment

plans completed by specified professionals, within a certain time, or on a regular basis where similar requirements are not applied equally to medical/surgical coverage;

- E. Other limits or exclusions, including:
 - Excluding chemical dependency services in event of noncompliance,
 - Excluding coverage for residential treatment,
 - Geographical limitations on MH/SUD services not imposed on medical and surgical services, or
 - Facility licensure requirements not imposed on medical/surgical facilities.

Each of these is explained in detail here: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>

If you or your patients experience these issues, go to this consumer portal, and complain. <https://www.hhs.gov/mental-health-and-addiction-insurance-help> Federal authorities have assured us that there are benefits experts available to help with the problem and/or steer people to the right place.

2. Help your patients ask for documents from their insurance plan when their care is denied.

The Substance Abuse and Mental Health Services Administration (SAMSHA) recently issued a new consumer rights publication that specifies what documents patients are entitled to get from their plans, if they ask, when their MH/SUD care is denied. It is important to get further information from the plans and SAMSHA has made clear that the patient is entitled to information both on the MH/SUD side of the plan and from the medical/surgical side of the plan to determine if MH/SUD is treated differently. These documents include: the plan's medical necessity criteria, utilization review standards, and its analyses performed to verify whether the plan complies with MHPAEA. We suspect that many plans do not actually do the required analysis under MHPAEA and therefore cannot comply. SAMSHA's Consumer Rights publication provides for discovery

(Continued on page 21)

Patients Need Your Help continued

from the health plan of a wealth of information and patients need to take advantage of it. See, SAMHSA's publication here:

<http://store.samhsa.gov/shin/content/SMA16-4992/SMA16-4992.pdf> . If you need assistance once a document request is made and the documents are produced or not produced, please contact Maureen Bailey at mabaily@psych.org.

3. Do not substitute a consumer complaint to enforcement authorities for an appeal.

Patient have only a limited amount of time to appeal a denial of a claim. Filing a complaint with a regulatory agency is not a substitute for an appeal. Help your patient appeal denials and include in the appeal a claim that the action may violates MHPAEA. Also include in the appeal a request for the documents in the SAMSHA publication above. Many denials are reversed on appeal, particularly when the appeal advances to the external stage and an independent third party. Don't give up, when the patient's claim is not appealed, the plan wins.

4. Post the APA's parity rights poster in your office.

This poster clearly and simply explains the parity law and the steps to take when a violation is suspected. Share the link with colleagues. The poster can be found here <https://psychiatry.org/File%20Library/Psychiatrists/Practice/Parity/Parity-Poster.pdf>

5. Tell APA about your experiences.

APA is in regular contact with state and federal authorities tasked with enforcing the parity laws and they need feedback about patients' experiences getting MH/SUD care which may implicate the parity laws. If APA is able to collect sufficient data, APA can better relay to the authorities what is working and not working with parity enforcement. Contact mabaily@psych.org.

For patients, parity means reasonable access to care. For psychiatrists, it means the ability to practice medicine without unnecessary interference so that you can spend your time in patient care rather than intentional hurdles to block care. Psychiatrists have made substantial gains in making parity a reality, but it requires vigilance and your participation. Keep up the good work!

References

¹ *Currently, broad bipartisan support for parity remains and the outlook for the parity extensions under the ACA depends on what repeal and replace does.*

² *It can be complex to demonstrate an actual parity violation, but there is no need for you to do the legal analysis. You should report any of these potential violations to the enforcement authorities.*

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APA Shares Concerns Over Immigration Executive Order

On January 27, President Donald J. Trump signed an executive order placing a temporary ban on immigrants from seven countries - Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen.

As you know, the American Psychiatric Association is composed of a diverse community of psychiatrists and works in collaboration with medical professional organizations and mental health professionals from around the world—including from those countries under the immigration ban. We assure you that we are dedicated to supporting all our members and our patients who are affected by these new restrictions.

We share member concerns on how this executive order may affect physicians, medical students, residents, international scientific education, research and collaboration, as well as patient care. According to the Association of American Medical Colleges, 260 people have applied for medical residency from the seven countries impacted by the executive order. We also share member concerns about patients who are impacted by this ban or are from the affected countries who live here now and may be traumatized by this action.

The U.S. currently ranks 23rd in the world for the number of psychiatrists per 100,000 population. According to the National Institute of Mental Health, more than 68 million Americans experienced a psychiatric or substance use disorder in the past year. This executive order will have significant repercussions for the mental health system due to psychiatric workforce shortages, as more than 25% of our members are International Medical Graduates (IMGs) who often practice in rural and underserved areas where care is desperately needed.

The American Psychiatric Association, along with numerous other national medical associations, requests that the Administration provide clarification and guidance on the scope of this order and take the immediate steps necessary to prevent the order from interfering with the entry or return to the United States of physicians holding J-1 or H-B1 visas so that the order does not negatively affect timely patient care for Americans whom they serve. We are in the process of signing on to letters with the Council of Medical Specialty Societies and the Association of American Medical Colleges that will be sent to the Administration voicing our concerns.

We are following this situation closely and will work with our members and other mental health and medical organizations to support those members in our community who are understandably anxious and concerned.

Sincerely,



Maria A. Oquendo, M.D., Ph.D.
President, APA



Saul Levin, M.D., M.P.A.
CEO and Medical Director, APA

Media Benefits for MPA Members

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

1. Free ad listings on the MPA website. MPA Members can post their research studies, job listings, events or books for 6 months on the MPA website at <http://missouri.psych.org>. The listing can repost again after that period.
2. Reduced newsletter ad rates. MPA members may place any size ad in *Missouri Psychiatry*, MPA's quarterly newsletter, for 50% off the regular rate. *Missouri Psychiatry* reaches nearly 500 MPA members and associated healthcare professionals in the state and appears online at the MPA 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 Association, 722 E. Capitol Avenue, Jefferson City, MO 65101 or by email to adamb@health.missouri.edu. Clinical opinions are not peer reviewed and thus should be verified independently.

Newsletter Submissions

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

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Guidelines for Submission to Missouri Psychiatry Newsletter

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

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Calendar of Events

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

MPA/MSMA 159th Annual Convention

“Current Challenges in Medicine: Physician Burnout and the Opioid Crisis”

Sheraton Kansas City Hotel at Crown Center, Kansas City, MO

April 1, 2017

APA Annual Meeting

San Diego, CA

May 20-24, 2017

MPA Executive Council Conference Call

August 9, 2017

Fall Conference,

General Membership Meeting and CME Training

Holiday Inn Select, Columbia, MO

October 7, 2017
