



Massachusetts Psychiatric Society

your information source for psychiatry in Massachusetts

Issue 266 October 2026

www.psychiatry-mps.org

FROM THE PRESIDENT

Anderson Chen, MD



Strengthening Our Community

Dear MPS Members,

Psychiatry in Massachusetts is navigating a period of heightened stress, scrutiny, and reflection. Many of us are feeling the weight of this moment in different ways—professionally, personally, and as members of a broader psychiatric community. At times like these, I believe it is especially important that we remember the strength that comes from standing together.

One of the most important roles of the Massachusetts Psychiatric Society is to provide a professional home for psychiatrists across the Commonwealth. Beyond advocacy and education, MPS should be a place where colleagues can come together, support one another, exchange perspectives, and navigate the challenges facing our profession with a sense of shared purpose. There is strength in our collective voice, but equally important, there is strength in simply knowing that we have a community of colleagues around us.

As I think about what I hope MPS can accomplish this year, I keep returning to a simple question: What does it mean for a professional society to truly serve its members? I believe the answer has to extend beyond any single conference, advocacy initiative, or educational program. It means listening to what our members are experiencing, responding to the challenges they face in practice, creating opportunities to learn from one another, and building a community that psychiatrists genuinely want to be part of.

That is the philosophy behind many of the initiatives you will see from MPS in the coming months. Some will focus on education and ensuring that our members have access to leading experts and current clinical knowledge. Others will focus on supporting our residents and fellows as they begin their careers. Still others will simply create opportunities for us to gather as colleagues and get to know one another outside of our daily work.

These efforts may look different, but they share the same purpose. We want MPS membership to feel meaningful. Whether you have been involved with MPS for decades or are encountering the organization for the first time, I hope you will find something here that helps you professionally, connects you with a colleague, or reminds you of the value of belonging to a broader psychiatric community.

With that in mind, we will be hosting a Psychiatrist Reflection and Support Town Hall. Recent events have affected many psychiatrists in different ways, and we want to create an open virtual space for members to reflect, share experiences, and support one another in a respectful and confidential setting. Whether you wish to speak or simply listen, you are welcome. Our goal is to strengthen our community and remind one another that none of us has to navigate challenging moments in our profession alone.

Even as we support one another through difficult moments, MPS continues to advance its educational mission. I am particularly excited about the tremendous work underway for our 37th Annual Psychopharmacology Update, which will be held virtually on Saturday, November 7, 2026. For nearly four decades, this conference has provided an opportunity to bring psychiatrists together around one of the foundations of our clinical practice: thoughtful, evidence-based psychopharmacology.

This year, we have assembled an outstanding group of experts to address clinical questions that psychiatrists encounter every day, including areas where treatment decisions can be particularly challenging. The program will include David N. Osser, MD, discussing an appraisal of hypnotics for chronic insomnia; Dost Öngür, MD, PhD, addressing clozapine-resistant schizophrenia; Ruta Nonacs, MD, PhD, discussing menopausal mood disorders; Margaret Weiss, MD, PhD, addressing insomnia in ADHD; and Afrah Mohammad, MD, presenting a nicotine cessation pharmacotherapy algorithm. I will also have the opportunity to present a

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**MASSACHUSETTS
PSYCHIATRIC SOCIETY**

860 Winter Street
Waltham, MA 02451-1411
Phone: 781-237-8100
Fax: 781-464-4896
www.psychiatry-mps.org

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Mental Health Parity: Why Access to Psychiatric Care Matters

A patient with serious mental illness presents for follow-up after a recent psychiatric hospitalization. The patient has insurance and is technically entitled to outpatient behavioral health services. Yet finding an in-network psychiatrist has been difficult. The first available appointment is several months away. The provider directory lists clinicians who are not accepting new patients, do not treat patients with the level of illness required, or are no longer practicing at the listed location. The patient is eventually offered an appointment with an out-of-network clinician, but the cost is prohibitive.

From an insurance perspective, this patient has behavioral health coverage. In clinical practice, they do not have meaningful access to care.

This distinction sits at the heart of the Mental Health Parity and Addiction Equity Act (MHPAEA), enacted in 2008 to prevent health plans from imposing more restrictive financial requirements and treatment limitations on mental health and substance use disorder (MH/SUD) care than on comparable medical and surgical care. Yet nearly two decades later, substantial disparities persist. The challenge is no longer simply establishing that behavioral health should be covered. It is ensuring that coverage translates into timely, clinically appropriate, and usable care.

For psychiatrists, this is not an abstract insurance-policy issue. It is a clinical issue—and increasingly, an advocacy issue.

Parity is About More Than Coverage

Mental health parity is often discussed in terms of copayments, deductibles, or whether a particular service is technically covered. These are important protections, but they represent only one part of the problem.

Many of the barriers patients encounter are non-quantitative treatment limitations, or NQTLs. Examples include medical-necessity criteria, prior authorization and concurrent review, formulary design, standards for admission to provider networks, reimbursement rates, step therapy, restrictions on out-

of-network care, and geographic or provider-type restrictions. MHPAEA requires plans to apply these limitations to mental health and substance use disorder benefits comparably to medical and surgical benefits.

This matters because an insurer does not need to explicitly say “no” to mental health treatment to create a barrier. A plan can make psychiatric care functionally inaccessible through a combination of restrictive utilization management, inadequate networks, inaccurate provider directories, low reimbursement, or administrative requirements that discourage clinicians from participating.

The clinical consequences can be substantial. Psychiatric illness is often episodic, and delays can occur at precisely the point when timely treatment is most important. For a patient experiencing a first episode of psychosis, worsening depression, medication instability, or a transition from inpatient to outpatient care, several weeks or months without appropriate follow-up can represent a clinically meaningful gap.

The result is a particularly important concept for psychiatry: coverage without access is not meaningful parity.

The Evidence: A Persistent Disparity

Unfortunately, the available evidence suggests that behavioral health remains meaningfully different from medical care in how insurance coverage functions. A 2024 RTI International analysis of commercial claims data from 2019–2021 found that behavioral health services were substantially more likely to occur out of network than medical/surgical care. In 2021, behavioral health office visits were out of network 3.5 times as often as medical/surgical office visits. For psychiatrist visits specifically, the disparity was even greater: psychiatrist office visits were out of network 8.9 times as often as visits to medical/surgical specialist physicians. These disparities persisted across the study period from 2013 through 2021 and could not be explained solely by workforce shortages.^[1]

The Massachusetts findings are particularly striking. Patients in Massachusetts received behavioral health office visits out of network 14.1 times more frequently than medical/sur-

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potential algorithm for treatment-resistant depression.

Importantly, we have designed this conference to be practical. Our goal is not simply to review the literature, but to help clinicians translate current evidence and expert experience into decisions they can use in their own practices. The day will conclude with a panel discussion where attendees can bring questions on psychopharmacology directly to the day's speakers and hear how experts approach some of the difficult prescribing decisions that arise in real-world clinical care.

I hope many of our members will join us on November 7. I also encourage you to share the conference with colleagues, trainees, and other mental health professionals in your networks who may be interested in attending. One of our goals is to extend the educational reach of MPS and make the expertise within our psychiatric community accessible to as many clinicians as possible. If there is someone you work with who would benefit from these discussions, please consider forwarding the program information and inviting them to join us.

Our educational efforts will continue beyond the conference as well. We are actively bringing together a series of leading experts in women's mental health to provide members with timely, up-to-date information on important developments in the field. Psychiatry continues to evolve rapidly, and part of our responsibility as a professional society is to make it easier for our members to remain connected to emerging evidence, leading experts, and one another.

Just as importantly, we want to make sure that this sense of community begins early in a psychiatrist's career. On Wednesday, September 23, MPS hosted a virtual Introduction to MPS for Resident-Fellow Members, bringing together new and current residents and fellows from across Massachusetts to learn more about MPS and the opportunities available through both MPS and the American Psychiatric Association.

During the orientation, residents and fellows were introduced to MPS educational programs, networking and leadership opportunities, advocacy efforts, membership resources, and ways they can become involved throughout their training. Residency is about more than developing clinical knowledge and skills—it is also a time when many of the professional relationships, mentorships, and communities that support us throughout our careers begin to take shape.

We hope the orientation helped residents and fellows see MPS as a professional community they can turn to during training and continue to be part of throughout their careers. We encourage our members, especially those involved in residency programs and medical education, to continue sharing MPS opportunities with residents and fellows and encouraging them to become involved in the MPS community.

Finally, I continue to believe deeply in the value of simply bringing psychiatrists together. With that in mind, I am especially excited for our MPS Winter Gala on Thursday, December 3, 2026. We are intentionally keeping the evening focused primarily on what many of us value most: an opportunity to socialize and connect with one another. Rather than a long formal program, the evening will center around a reception and time to catch up with longtime colleagues, meet new ones, and build relation-

ships across our psychiatric community.

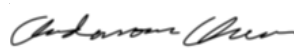
This year's gathering will also have a little extra significance. Beginning next year, our headquarters will move from 860 Winter Street in Waltham to 133 Boston Post Road in Weston. As a result, this Winter Gala could potentially be our last major in-person MPS gathering at 860 Winter Street. For those who have attended meetings, programs, and gatherings there over the years, I hope this gives us one more reason to make the evening particularly memorable—a chance to celebrate the connections and history we have built there while also looking forward to the next chapter for MPS.

I hope you will consider joining us on December 3. The evening is not intended to take up your entire night or add another lengthy professional obligation to your calendar. Come for the reception, enjoy some time with colleagues, make a new connection or two, and help us celebrate our community. Particularly during demanding periods in our profession, I think there is real value in creating opportunities for psychiatrists simply to be together.

There will always be challenges facing psychiatry, just as there will always be new opportunities to learn, advocate, and improve the care we provide. My hope is that MPS can increasingly be the place where all of those pieces come together: a community that supports its members, advances our knowledge, welcomes the next generation of psychiatrists, strengthens our collective voice, and gives psychiatrists across Massachusetts a genuine sense of connection and belonging.

We have much to look forward to in the months ahead, and I look forward to seeing many of you at our Town Hall, Psychopharmacology Update, educational programs, and Winter Gala.

Warmly,



Anderson Chen, MD
President, Massachusetts Psychiatric Society

(continued from page 2) Resident Fellow Member Corner

gical office visits—14.4% compared with 1.0%.

Reimbursement disparities provide part of the explanation. In 2021, average reimbursement for medical/surgical clinician office visits was 21.7% higher than for behavioral health clinicians. Medical/surgical specialist physicians were reimbursed 24.9% more than psychiatrists and 28.8% more than psychologists. These differences matter because reimbursement is one of the mechanisms through which health plans determine the size and composition of their networks. When reimbursement and administrative requirements make participation unattractive, clinicians may remain outside networks. Patients then face higher costs, fewer choices, and longer searches for care.

Importantly, the RTI analysis found that provider shortages alone do not adequately explain these disparities. The persistence of substantially greater out-of-network utilization for behavioral health, even relative to primary care, suggests that network design and reimbursement practices themselves warrant scrutiny.

The Patients Most Affected

The consequences of these barriers are not evenly distributed.

Patients with serious mental illness often depend on continuity. A person with schizophrenia, bipolar disorder, or another severe and persistent psychiatric illness may need regular medication management, psychotherapy, case management, and coordination with primary care and social services. Disruptions in any one part of that system can destabilize the larger treatment plan.

The same is true during transitions in care. Discharge from an inpatient psychiatric unit is not the endpoint of treatment. It is often the beginning of a particularly vulnerable period in which patients need rapid outpatient follow-up, medication management, and assistance reconnecting with community services.

For these patients, a useful measure of parity cannot stop at whether a behavioral health benefit exists. It should also consider whether patients can obtain care within clinically appropriate timeframes, whether providers are actually accepting patients, whether clinicians have the expertise needed to treat their conditions, and whether services remain available across levels of care.

This broader perspective is particularly important in psychiatry because the patients with the greatest clinical needs may also face the greatest difficulty navigating fragmented systems.

Non-quantitative Does Not Mean Clinically Unimportant

One of the most important concepts in contemporary parity enforcement is the focus on NQTLs.

A plan may not explicitly impose a higher copayment for psychiatric treatment, yet still create a substantially more restrictive pathway to receiving that treatment. Prior authorization requirements, utilization management, reimbursement practices, provider-network standards, and other administrative processes can function as meaningful barriers even when they do not appear as a dollar amount on an insurance card.

This is why parity analysis increasingly requires attention to how policies operate in practice rather than simply how they are written.

Federal guidance has emphasized comparative analyses of NQTLs, including the factors, processes, strategies, and evidentiary standards used to determine how limitations are applied. The goal is not merely to ask whether an insurer has a parity policy, but whether that policy is implemented comparably across behavioral health and medical and surgical care.^[3]

The distinction between written policy and actual operation should be familiar to psychiatrists. We routinely recognize that a treatment plan can look appropriate on paper while failing to meet a patient's needs in practice. Insurance parity deserves the same scrutiny.

Parity Needs Enforcement, Not Just Legislation

The challenge facing parity is therefore not simply the absence of laws. It is implementation and enforcement.

The federal government has acknowledged that the challenge extends beyond the original 2008 statute. The 2024 MHPAEA Final Rule sought to strengthen requirements surrounding NQTL comparative analyses, outcomes data, and discriminatory factors. However, in May 2025, the Departments of Labor, Health and Human Services, and Treasury announced that they would not enforce the portions of the 2024 rule that were new relative to the 2013 rule while litigation and reconsideration proceeded. The Departments emphasized that the underlying statutory requirements of MHPAEA, including the comparative-analysis requirements enacted by the Consolidated Appropriations Act of 2021, remain in effect.^[4]

This enforcement uncertainty makes organized advocacy particularly important.

APA has continued to advocate for stronger parity enforcement and greater transparency. In July 2026, APA endorsed H.R. 9551, the Mental Health Parity Enforcement and Funding Act, which would authorize civil monetary penalties for parity violations and provide \$30 million annually for five years to strengthen enforcement by the Department of Labor's Employee Benefits Security Administration. The bill was introduced in June 2026 and referred to the House Committee on Education and Workforce.

The broader goal is straightforward: insurers should not merely attest that they comply with parity requirements. They should be able to demonstrate that their policies actually produce comparable access.

Massachusetts: A Strong Foundation

Massachusetts provides an important example of why state-level advocacy matters.

Massachusetts has built a relatively strong framework for behavioral health parity. State law directs relevant agencies (including the state's Office of Patient Protection) to implement and enforce federal and state parity requirements and specifically identifies issues including prior authorization, utilization review, network admission standards, reimbursement rates, network adequacy, geographic restrictions, and denials of authorization, payment, and coverage.^[5]

Massachusetts has also undertaken extensive behavioral health parity market conduct examinations. Beginning in 2023, the Division of Insurance initiated examinations of 21 insurance carriers across 13 insurer groups. The examinations have reviewed utilization review, prior authorization,

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denials, network adequacy, reimbursement rates, geographic restrictions, and provider complaints. The Division has indicated that future examinations will expand to areas including claims, comparative analyses of NQTLs, third-party administrator auditing, and the use of artificial intelligence by health insurers.^[6]

Massachusetts also explicitly incorporates parity requirements into its Medicaid framework. State law requires the Office of Medicaid and its contracted health plans and behavioral health management organizations to meet applicable federal parity requirements for MassHealth enrollees.^[7]

Yet the RTI findings demonstrate that strong laws on the books do not automatically translate into equitable access in practice. Massachusetts' exceptionally large disparity in out-of-network behavioral health utilization should therefore be viewed not as evidence that parity efforts have failed, but as evidence that continued measurement and enforcement are necessary.

From Clinician to Advocate: What Can MPS Members Do?

Parity advocacy does not require every psychiatrist to become an insurance-law expert. It begins with becoming sufficiently informed to recognize when an administrative barrier may represent a systemic access problem.

1. Learn the basic parity framework.

The federal Department of Labor's MHPAEA self-compliance tool is a useful starting point. It explains the distinction between quantitative treatment limitations and NQTLs, the six benefit classifications, and the types of utilization-management and network practices that fall under parity scrutiny. APA's parity resources provide additional clinician-oriented education.

2. Start seeing insurance barriers as clinical data.

When patients cannot find an in-network psychiatrist, encounter repeated prior authorization denials, discover that listed clinicians are unavailable, or cannot access an appropriate level of care, document those experiences. Individual stories become especially powerful when clinicians can identify recurring patterns.

APA has emphasized the importance of measuring operational indicators such as out-of-network utilization, active network participation, wait times, provider-directory accuracy, reimbursement comparisons, denial rates, and prior-authorization burden.

3. Use Massachusetts' existing mechanisms.

Clinicians and patients should know that parity concerns can be brought to the appropriate state and federal regulators. MPS members can familiarize themselves with the Massachusetts Division of Insurance, Office of Patient Protection, and relevant Attorney General resources, particularly when patterns of denials, inadequate networks, or other barriers emerge.

4. Support federal parity legislation and enforcement.

MPS members can amplify APA's advocacy by contacting federal legislators about strengthening MHPAEA enforcement, including support for legislation such as H.R. 9551. Organized psychiatry is most effective when legislators hear

directly from physicians who can explain how seemingly technical insurance practices affect real patients.

5. Bring parity into MPS advocacy.

Finally, MPS members can support advocacy efforts that treat behavioral health as an integral component of health care quality. This means supporting effective parity enforcement, communicating with legislators and regulators about barriers encountered by patients, participating in professional advocacy efforts, and sharing concrete clinical examples when administrative practices interfere with appropriate care.

Advocacy is Clinical Practice

Psychiatrists often encounter the consequences of insurance policy in the most tangible way possible: a patient who cannot obtain the care we believe they need.

For patients with serious mental illness, continuity can be particularly important. A psychiatric benefit that exists only on paper does little for a patient who cannot find a participating clinician, afford the available option, or navigate the administrative requirements necessary to receive treatment.

Mental health parity was never simply about making insurance cards look equal. It was about recognizing that mental health and substance use disorders deserve comparable treatment in the design, administration, and enforcement of health insurance benefits.

As psychiatrists, we should hold our health systems to that standard.

Parity is not merely a law to defend. It is a clinical standard worth measuring and an advocacy priority worth advancing.

References

1. RTI International. Mental Health Parity and Addiction Equity Act: Access to Behavioral Health Services and Provider Networks. Washington, DC: U.S. Department of Labor; 2024.
2. Massachusetts Attorney General's Office. Attorney General's Office Behavioral Health Parity Agreements. Commonwealth of Massachusetts; 2020.
3. U.S. Department of Labor, Employee Benefits Security Administration. Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act. Washington, DC: U.S. Department of Labor.
4. U.S. Department of Labor. New Mental Health and Substance Use Disorder Parity Rules. Employee Benefits Security Administration; 2025.
5. Massachusetts General Laws. Chapter 32A, Section 22B. Mental health parity and addiction equity law enforcement; procedure; reporting. Commonwealth of Massachusetts.
6. Massachusetts Division of Insurance. CY 2024 Mental Health Parity Summary Report. Commonwealth of Massachusetts; 2026.
7. Massachusetts General Laws. Chapter 118E, Section 82. Requirement that division meets parity requirements described under federal Mental Health Parity and Addiction Equity Act. Commonwealth of Massachusetts.
8. American Psychiatric Association. Advocacy and policy materials regarding enforcement of the Mental Health Parity and Addiction Equity Act.

Call for Nominations for MPS Leadership

Each year the MPS elects members to leadership positions for the next term beginning on April 28, 2027. The Nominating Committee will begin to solicit nominations from the membership. The committee encourages broad participation in the election process and to fully represent the diverse membership of our organization.

Positions for Nomination:

- President-elect (3 years total – President-elect, President and Immediate Past President)
- Treasurer (2-year term)
- APA Representative (1 position - 3-year term)
- MPS Councilor (2 positions - 3-year terms)
- Nominating Committee (2 positions – 2-year terms)

Information about Positions:

The MPS Council meets almost monthly (8 times per year) on the 2nd Tuesday of the month with some. Council members must participate in a minimum of 70% of the Council meetings each year. In addition, to Council meetings, the Executive Committee (Presidents, Secretary, Treasurer and Senior APA Representative) meets on the 2nd Tuesday of the month, albeit a lesser frequency. APA Representatives are expected to attend two Area 1 meetings in the New England Area (which currently have been virtual) and two APA Assembly meetings per year (November and at the APA Annual Meeting in May).

The Nominating Process

The Nominating Committee will meet in October and November to set the slate of candidates for the 2027 election.

To submit either the name of a colleague or your name for a leadership position, please send a brief bio which includes your current practice setting, subspecialty (if appropriate), specific areas of interest, and past roles or participation in MPS to our Administrative Director, Debbie Brennan (dbrennan@mms.org). The deadline for nominations is Friday, October 9, 2026. All Nominating Committee correspondence is strictly confidential. If you submit someone else's name, please let us know if you have communicated your nomination to the person. The Nominating Committee will consider all nominations and will select a slate of candidates to be presented to the MPS membership in the spring prior to the election which will take place via electronic ballots. The new leadership will be announced at the Annual Meeting on April 27, 2027.

Please do not hesitate to contact us if you have any questions.

Jhilam Biswas, MD, DFAPA, Nominating Committee Chair

Margaret Cheng Tuttle, MD, MS, MM, FAPA President-Elect & Nominating Committee Co-Chair

Anderson Chen, MD, President

Call for Nominations

2027 MPS Outstanding Psychiatrist Awards

MPS Awards Committee is soliciting nominations for the 2027 MPS Outstanding Psychiatrist Awards

Please consider nominating a colleague who you believe is deserving of this honor. Self-nominations are also welcome.

1. Nominee should be a Member of the Massachusetts Psychiatric Society.
2. Please send the following:
 - a. Nomination letter
 - b. Curriculum Vitae of nominee
 - c. A letter of support (if nominee has an academic appointment, a letter from the department head would be helpful).

The award categories are as follows:

Lifetime Achievement: This award is given to a senior psychiatrist who has made significant contributions over the course of his/her career which is now winding down.

Advancement of the Profession: This award is given to a psychiatrist who has advanced an area of the profession by highlighting and/or clarifying an area which has been in the background, bringing it forward, and developing it; e.g., women's issues, disaster psychiatry, refugee issues, etc.

Clinical Psychiatry: This award is given to a psychiatrist who is an outstanding clinician; someone who is known for having worked to clarify a particular area of interest or type of therapy and practiced it successfully.

Education: This award is given to a psychiatrist who has made a significant contribution to psychiatric education, e.g., establishing a residency, creating a nationally attended course, developing educational materials which can be used nationally for medical student or resident teaching. Being training director per se is not enough.

Research: This award is given to a psychiatrist who has made significant contributions to the development of an area of psychiatric research.

Public Sector: This award is given to a psychiatrist who has worked in the public sector and has been influential in reorganization or in leadership in that area or who has significantly influenced the political system in lobbying for patient's welfare.

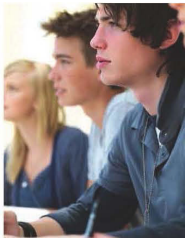
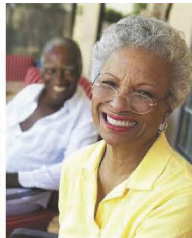
Early Career Psychiatry: A psychiatrist who is in the first 10 years after completing residency (not fellowship training) who has done something outstanding in any of the above categories.

Please send your nominee's name, the award you are nominating for and a brief reason for the nomination to Mayuri Patel - mpatel@mms.org or call 781-237-8100 x1 by January 30, 2027.

Thank you!

Fe Erlita D. Festin, MD, DLFAPA

Chairperson of MPS Awards Committee



Saturday, November 7, 2026

8:15 a.m.–4:00 p.m.

Virtual Program

Massachusetts Psychiatric Society's 37th Annual Psychopharmacology Update

Program Overview

Each year the psychopharmacology update course chair and co-chair review feedback from the previous year including suggestions for topics of interest. Also, the organizers have extensive experience consulting with psychiatrists who have psychopharmacology questions and become aware of prescribing issues that are not well understood by practitioners. From these sources a set of presentations was developed. The program begins with an appraisal of hypnotics for chronic insomnia. A second speaker will focus on Clozapine-resistant schizophrenia. This will be followed by a speaker describing menopausal mood disorders, ending the

morning sessions with a potential algorithm for treatment resistant depression. The program continues with a discussion on insomnia in ADHD, followed by the final lecture on nicotine cessation pharmacotherapy algorithm. After a lunch break, there is a discussion on integrating focal psychotherapy interventions into routine pharmacotherapy. The program will end with questions and answers on any topic in psychopharmacology with a panel of the day's speakers.

Learning Objectives

At the conclusion of this activity, participants should be able to:

- Prescribe medications without being subject to undue influence by drug company marketing.
- Know when it might be appropriate to use hypnotics for chronic insomnia.
- Select the most evidence-supported medications for efficacy and safety for patients with schizophrenia.
- Appreciate the evidence-based way of prescribing in menopausal mood disorders.

- Select the most evidence-supported medications for efficacy and safety for patients with treatment resistant depression.
- Select the most evidence-supported medications for efficacy and safety for patients with insomnia in ADHD.
- Select the most evidence-supported medications for efficacy and safety for patients with nicotine use disorder.

[CLICK TO REGISTER ONLINE](#)

AMA Credit Designation Statement

The Massachusetts Psychiatric Society designates this live activity for a maximum of 6.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Accreditation Statement

The Massachusetts Psychiatric Society is accredited by the Massachusetts Medical Society to provide continuing medical education for physicians.

REGISTRATION FEE

[] MPS/APA/MMS MEMBER	\$175
[] NON-MEMBER	\$225
[] RESIDENT/FELLOW	\$15
[] MEDICAL STUDENT (PROOF OF MEDICAL SCHOOL REQUIRED)	\$0

NEW OFFERING:

Want access to the program recordings, too? Register for the **bundle** to attend the live sessions and receive fully edited recordings. (*Recordings will be shared approximately one week later once edited*)

[] MPS/APA/MMS MEMBER	\$225
[] NON-MEMBER	\$275
[] RESIDENT/FELLOW	\$65

Questions?

**Call (781) 237-8100, 8 a.m.–4 p.m. Monday
thru Friday**

**Please note the link for the conference will be
sent on November 6**



Program Schedule

8:15-8:30 a.m.	Welcome and Introduction <i>Anderson Chen, MD, Activity Chair</i> <i>David N. Osser, MD, Activity Co-Chair</i>
8:30-9:30 a.m.	An Appraisal of Hypnotics for Chronic Insomnia <i>David N. Osser, MD</i>
9:30-10:30 a.m.	Clozapine-Resistant Schizophrenia <i>Dost Öngür, MD, PhD</i>
10:30-10:45 a.m.	BREAK
10:45-11:45 p.m.	Menopausal Mood Disorders <i>Ruta Nonacs, MD, PhD</i>
11:45-12:45 p.m.	A Potential Algorithm for Treatment Resistant Depression <i>Anderson Chen, MD</i>
12:45-1:30 p.m.	LUNCH
1:30-2:30 p.m.	Insomnia in ADHD <i>Margaret Weiss, MD, PhD</i>
2:30-3:30 p.m.	Nicotine Cessation Pharmacotherapy Algorithm <i>Afrak Mohammad, MD</i>
3:30-4:00 p.m.	More Questions and Answers <i>Panel of the Speakers</i>

Save the Dates

Upcoming Virtual Conferences

We're excited to share our upcoming lineup of engaging and informative **virtual conferences**—mark your calendars!

✦ **Psychotherapy Conference**
Saturday, January 30, 2027

✦ **Risk Avoidance & Risk Management Conference**
Saturday, February 27, 2027

Stay tuned for additional details and registration information in the coming months—we look forward to your participation!

Save the Date!

❄️ MPS Winter Gala & Social Reception ❄️

Join us for a festive **MPS Winter Gala & Social Reception** on **Thursday, December 3**, at the **Massachusetts Medical Society**.

Bring your family and enjoy an evening of **good food, conversation, and connection** with MPS colleagues, friends, and loved ones. **Children are welcome!**

 **December 3, 2026**

 **6:00 p.m.**

 **Massachusetts Medical Society**
860 Winter Street, Waltham, MA

✦ **More details to follow!**

We hope you can join us for a warm and enjoyable evening as we celebrate the season together. ❄️

FREE APA Course of the Month

Each month, APA members have free access to an on demand CME course on a popular topic. [Click here to access the Course of the Month and sign up for updates about this free member benefit.](#)

Committee Happenings

Retirement Committee Meeting

The next Retirement Committee meeting will be held on **Wednesday, October 28, from 7:00–8:30 p.m. via Zoom.**

We will begin the new academic year with a discussion on “Reflections on the Retirement Process from Different Points of the Journey.”

The discussion will explore four stages of the retirement journey:

- Anticipating retirement
- In the process of retiring
- Recently retired
- Several years into retirement

Four committee members will share their reflections on the stage they are currently experiencing, as well as recollections from previous stages.

If you do not receive the announcement, please contact Mayuri Patel at mpatel@mms.org.

An Invitation to Join the MPS Women in Psychiatry Committee

The Women in Psychiatry Committee welcomes new members to join for the 2026-2027 academic year. The committee brings together women psychiatrists across Massachusetts at every career stage for mentorship, community, and leadership development. Our mission is to create a supportive environment where women in psychiatry can share experiences, develop leadership skills, explore scholarly and clinical interests, and build networks that strengthen their careers and communities. The committee remains committed to supporting women across all practice settings.

Highlights from the 2025-2026 academic year included a joint career panel with the MPS C-L Psychiatry Committee, featuring Drs. Josh Leo (BIDMC), Polina Teslyar (BWH), Ilana Braun (DFCI), and Kaila Rudolph (BMC). Dr. Huma Farid, Director of the BIDMC Academy and Division Chief of General OB/GYN, spoke on mentorship and sponsorship in academic medicine and introduced the idea of building a “mentoring board of trustees.” Dr. Brett Young, Chair of Obstetrics and Gynecology at Mount Auburn Hospital, led a negotiation skills workshop on knowing your priorities, building leverage, and negotiating with humanity. Members also gathered to set committee goals and share their experiences as women in psychiatry.

This year, the committee will continue to center the experiences and issues of women in psychiatry, with mentorship and leadership development remaining its core commitments. In addition to sessions for career development, mentorship, and networking, we will host sessions focused on women’s mental health and reproductive psychiatry. We will meet every two months.

We welcome all women within MPS seeking connection, guidance, and a collaborative space to learn and lead together. Whether you are a resident starting to think about your career trajectory or an attending looking to mentor future generations, we encourage you to join to connect with other women psychiatrists. To learn more about us and our recent meetings, please visit our committee page at <https://www.psychiatry-mps.org/committee-on-women>, where you will also find recordings of certain past sessions. To join the committee, please contact Mayuri Patel at mpatel@mms.org.

Best,

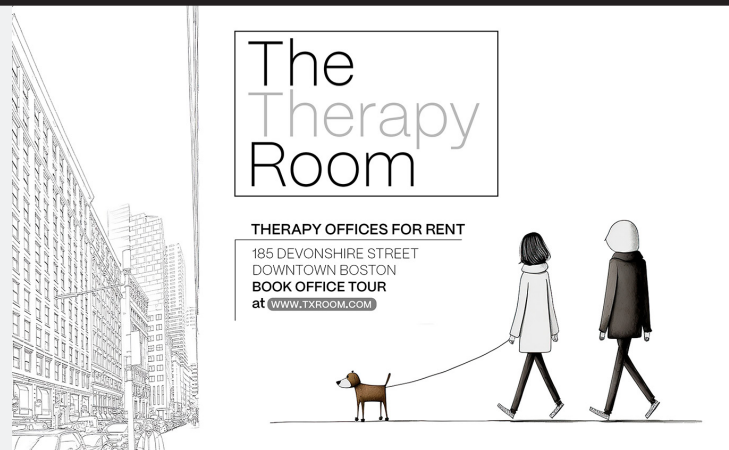
MPS Women in Psychiatry Committee

Katiuska Ramirez, MD, Co-Chair (BIDMC); Haley Euting, MD, Co-Chair (CHA); Samina Mahesar, MD, MCRC, Co-Chair (BILH); Rayah Touma Sawaya, MD, MPH, Resident Co-Chair (BMC, PGY-4); Diana Kim, MD, Resident Co-Chair (BMC, PGY-3)

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Winchester - Offices for rent in charming, fully renovated 19th century building on Main Street. High ceilings, large windows, beautifully furnished, with WiFi, common waiting rooms. Full or part-time. For more information, contact Dr. Michael Marcus at mwm82@aol.com



Downtown Boston – The Therapy Room: Private psychotherapy offices for rent full-time, part-time, or by weekday at 185 Devonshire Street. Turn-key, fully furnished offices designed specifically for mental health practices, with flexible rental options and transparent pricing (see website for details). Optional access to a community of 75+ clinicians for referrals, resources, and support. View current availability and pricing, or book an office tour at www.txroom.com. Questions: Dr. Tomasz Vav, 617-706-2601 | txroom@txroom.com.

New Book from Ronald W. Pies, MD: The 36 Virtues of the Talmudic Sages

How should we conduct ourselves as moral beings? What character traits should we cultivate in order to live decent, ethical lives?

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Psychiatrist and ethicist Dr. Ronald Pies describes 36 key ethical values that will help guide persons of any faith toward a more fulfilling life. Available on [Amazon.com](https://www.amazon.com)



Online Registration Now Open!

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Renaissance Arlington Capital View Hotel, Arlington, VA

Sunday, November 15 - Monday, November 16, 2026

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Reminder.....

The MPS welcomes article submissions from its members!

Your submission can be something you are passionate about and think members would like to read about. The deadline for submissions is the 10th of the month.

Reach out to Mayuri Patel at patel@mms.org for details to submit your article today!

Join Beth Israel Lahey Health Behavioral Services (BILHBS) as the Assistant Medical Director and lead medical operations and clinical quality across all Community Behavioral Health Center (CBHC) services, including Ambulatory Clinic, Urgent Care, Mobile Crisis Intervention (MCI), and Community Crisis Stabilization (CCS).

Key Responsibilities

- **Clinical Operations:** Oversee medical staff, refine models of care, and align services with strategic vision alongside the Ambulatory Medical Director.
- **Team Leadership:** Provide clinical supervision to Psychiatrists, NPs, Nurses, and Medical Assistants. Offer ongoing staff consultation and academic enrichment (lectures/workshops).
- **Direct Care & On-Call:** Deliver psychopharmacology services as needed and coordinate/provide on-call medical coverage.
- **Documentation:** Complete progress notes and documentation within 48 hours.
- **Stakeholder Engagement:** Represent BILHBS at state and local meetings, including MassHealth and Commonwealth leadership.
- **Compliance:** Ensure adherence to HIPAA, SAMHSA, CARF, DMH, DPH, BSAS, and state regulations.

Qualifications

- **Credentials:** MD with active MA Physician License, DEA registration, and Board Certification in Adult and Child & Adolescent Psychiatry.
- **Experience:** Background in CBHC settings preferred.
- **Key Skills:** Demonstrated expertise in psychiatric risk assessment, management, and clinical documentation.

Pay Range:

\$350,000.00 USD - \$370,000.00 USD

The pay range listed for this position is the annual base salary range the organization reasonably and in good faith expects to pay for this position at this time. Actual compensation may be determined based on several factors, that may include education, training, relevant experience, specialty, geography of work location, productivity, job responsibilities, or other applicable factors permissible by law. In addition to base compensation, this position may be eligible for performance-based incentive compensation, which may include productivity and quality bonuses. To apply please contact -Christine DePierro at christine.f.depierro@bilh.org.

Join Beth Israel Lahey Health Behavioral Services as a Psychiatrist in our Outpatient Clinic in Salem, MA.

What you will do:

Provide direct outpatient psychiatric care through comprehensive evaluations, evidence-based psychotherapy, and psychopharmacological management.

Key Responsibilities

- **Direct Patient Care:** Perform psychiatric evaluations, diagnose DSM mental disorders, and deliver individualized care plans.
- **Treatment & Safety:** Monitor medication responses/side effects, adjust treatments, and prioritize safety/harm-reduction at every visit.
- **Documentation:** Submit billing and progress notes within 48 hours of service.
- **Care Coordination:** Collaborate with multidisciplinary teams (therapists, nurse practitioners, social workers) and manage patient history.
- **Supervision & Leadership:** Participate in supervision with the Medical Director. Option to supervise NP students, residents, and medical students.
- **Compliance:** Adhere to HIPAA, DMH, MA Board of Registration in Medicine, and BILH BS regulations.

Qualifications

- **License:** Unrestricted MA Physician License, active MA/DEA controlled substance registrations.
- **Board Certification:** Board Certified in Psychiatry and Neurology.
- **Clinical Skills:** Expertise in DSM diagnostics, psychotherapy, and psychopharmacology.
- **Tech & Comm:** Proficient in standard office software (Windows/Word/Excel) with strong clinical writing and interpersonal skills.

Pay Range:

\$300,000.00 USD - \$370,000.00 USD

The pay range listed for this position is the annual base salary range the organization reasonably and in good faith expects to pay for this position at this time. Actual compensation may be determined based on several factors, that may include education, training, relevant experience, specialty, geography of work location, productivity, job responsibilities, or other applicable factors permissible by law. In addition to base compensation, this position may be eligible for performance-based incentive compensation, which may include productivity and quality bonuses. To apply please contact -Christine DePierro at christine.f.depierro@bilh.org.

An Invitation to Join the MPS Consultation-Liaison Psychiatry Committee

The Consultation-Liaison Psychiatry Committee brings together psychiatrists across Massachusetts committed to advancing the care of medically complex patients, strengthening interdisciplinary collaboration, and cultivating the next generation of C-L leaders. We provide a forum where clinicians share emerging practices, develop scholarly and educational initiatives, and support one another in building meaningful and sustainable careers.

We opened the 2026-2027 academic year in September with Drs. Marta Herschkopf (BIDMC) and Carrie Wu (DFCI), who spoke on ethics in C-L practice, including what distinguishes a psychiatry consult from an ethics consult, what the C-L psychiatrist's responsibilities are when ethical issues arise in a case, and how to pursue further ethics training. Dr. Wu brought a psycho-oncology perspective to the discussion.

The 2025-2026 academic year brought other highlights. Drs. Josh Leo (BIDMC), Polina Teslyar (BWH), Ilana Braun (DFCI), and Kaila Rudolph (BMC) reflected on what first drew them to C-L psychiatry and how they have built careers across clinical, academic, and leadership roles. Dr. Theodore Stern (MGH) joined us for a fireside chat on translating everyday consultations into scholarship. Dr. Danny Mendoza (BIDMC) led a two-part neuroimaging series built around teaching cases, with practical guidance on reviewing images before the radiology report and recognizing when structural pathology mimics primary psychiatric illness. Incoming and graduating C-L fellows offered candid reflections on why they decided to pursue C-L psychiatry fellowship, impactful moments in their training, the benefits of additional training, and where they see the field going.

The committee also shares submission guidance and a collaboration sign-up sheet for the ACLP Annual Meeting, helping members build multi-institutional teams across the state. Abstracts for the 2027 meeting are due in April, and we would be glad to help you find collaborators.

The committee meets virtually every two months. We welcome MPS members at all career stages who are interested in C-L psychiatry, including residents and fellows considering C-L careers and psychiatrists practicing outside major academic centers. To learn more about who we are and what we do, visit our committee page at psychiatry-mps.org/consultation-liaison-committee, where you will also find links to recordings from certain past sessions. To join the committee, please contact Mayuri Patel at mpatel@mms.org.

Best,

MPS C-L Psychiatry Committee

Katuska Ramirez, MD, Co-Chair (BIDMC); Damien Miran, MD, Co-Chair (DFCI); Sunita Singh, MD, Fellow Co-Chair (BWH C-L Psychiatry Fellow); Rayah Touma Sawaya, MD, MPH, Resident Co-Chair (BMC, PGY-4); Juan Correa Rubianes, MD, Resident Co-Chair (BMC, PGY-4)

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Emerson Health is a regional health system providing advanced healthcare to more than 300,000 people across 25 towns in Massachusetts. We make high-quality healthcare more accessible to those who live and work in our community at Emerson Hospital in Concord, health centers in Bedford, Groton, Sudbury, Westford, and Concord, and Urgent Care settings in Hudson, Littleton, and Maynard.

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ADDRESS SERVICE REQUESTED

MPS Calendar of Events

SEMPs/WMPs - Presidential Update	October 7 at 7:00 pm via Zoom	mpatel@mms.org
Council	October 13 at 5:30 pm via Zoom	dbrennan@mms.org
Nominating Committee	October 19 at 7:00 pm via Zoom	dbrennan@mms.org
Psychiatrist Reflection and Support Town Hall	October 21 at 7:00 pm via Zoom	dbrennan@mms.org
Membership Committee	October 22 at 12:00 pm via Zoom	mpatel@mms.org
CME Committee	October 26 at 7:00 pm via Zoom	dbrennan@mms.org
Retirement Committee	October 28 at 7:00 pm via Zoom	mpatel@mms.org