Assembly Rules Committee
Conference Call- Thursday, April 7, 2016
8:00 PM- 9:30 PM ET
Materials Included in this Packet

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ACTION PAPERS

1 Abellard: Enhancing the Retention of Resident Fellow Members (RFMs) Who Have Received APA Funding Following the End of their Terms

2 Batterson: Performance in Practice Certification by the American Psychiatric Association

3 Batterson: Standards for Inpatient Psychiatric Care

4 Catapano-Friedman: Providing Recordings of Individual Presentations from the APA Annual Meeting

5 Catapano-Friedman: Third Party Coverage of Medication Found to Be Beneficial to an Individual Patient

6 De Figueiredo: APA Position Statement on Mental Health Hotlines

7 De Figueiredo: Supporting the WACP Position Statement on Migrant Crisis Around the World

8 Dunn: Utilization of DSM-5 Terminology in APA Publications and Communications

9 Fuller: Improving Electronic Medical Record (EMR) – Information Technology (I.T.) Toolkit

10 Geller: Direct to Consumer Advertising

11 Hanson: Psychiatrist Involvement in Medical Euthanasia and Physician-assisted Suicide of the Non Terminally Ill

12 Hart: Improving the Efficacy of Prescription Drug Monitoring Programs

13 Hovav: Increasing the Opportunity for Involvement of Resident Fellow Members (RFMs) and Early Career Psychiatrists (ECPs) in the APA Assembly

14 Koh: A Psychiatric Response to Human Trafficking

15 Lee: Pharmacists Substituting Medications with Similar Mechanisms of Action

16 Matthews: Develop an APA White Paper on the Use of Patient Information Discovered in Targeted Internet or Social Media Searches

17 Mawhinney: Eliminate Out Of Pocket Cost Barriers to Care for Patients with Severe, Persistent and Recurrent Disabling Mental Disorders

18 McGee: Encouragement of Senior Psychiatrists to Maintain Active Membership in APA

19 McGee: Enhancing Ethical Knowledge of APA Members

20 Morrison: APA Takes a Neutral Stand on Physician Aid in Dying

21 Parish: Disapproval of the Detention of Central American Asylum Seeking Children and Families in Need of International Protection

22 Peele: Allow Deputies to Vote

23 Peele: Coding Suicidal Ideation

24 Peele: Exercise: Too Little, Too Much

25 Peele: Inclusion of Racism in ICD-10-CM and DSM 5

26 Peele: Increasing Members' Involvement in APA Policy

27 Plakun: Develop an APA Position Statement Regarding the Ethical Tensions Faced by Psychiatrists Serving as Third Party Utilization Management Reviewers under the Parity Law

28 Scasta: The Pathologizing of Same Sex and Transgender Orientations by Indonesian Psychiatrists

29 Scasta: US Joint Statement on Conversion Therapy

30 Shemo: APA Referendum Voting Procedure

31 Sonkiss: Mandatory Competency Testing for Senior Psychiatrists

32 Vivek: Eliminate Federal Parity Opt-Out

33 Vivek: Making Access to Treatment for Erectile Disorder Available Under Medicare

REPORT OF THE JOINT REFERENCE COMMITTEE

1 Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone With That Of Co-occurring Mental Illnesses

2 The Role of Psychiatrists in Assessing Driving Ability

3 Proposed Position Statement on Patient Access to Electronic Mental Health Records

4 Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System

5 Retire Position Statement: Position Statement on Adjudication of Youths as Adults in the Criminal Justice System

6 Retire Position Statement: Infectious Disease Epidemics Including H1N1

7 Revised Position Statement on Sexual Harassment

8 Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders

9 Retain Position Statement: Any Willing Physician

10 Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents

11 Proposed Position Statement: Integrated Care

12 Proposed Position Statement: Off-Label Treatments

13 Retire Position Statement: Patient Access to Treatments Prescribed by their Physicians

14 Proposed Position Statement: Call to Action: Accountability for Persons with Serious Mental Illness

15 Retire Position Statement: A Call to Action for the Chronic Mental Patient

16 Proposed Position Statement: College and University Mental Health

17 Retire Position Statement: College and University Mental Health

18 Retain Position Statement: Conflict of Interests for Clinical Practice and Research

19 Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness

REPORT FROM THE BYLAWS COMMITTEE

1 Ratification of the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Enhancing the Retention of Resident Fellow Members (RFMs) Who Have Received APA Funding Following the End of their Terms

WHEREAS:
The goal of the APA leadership in involving RFMs at every level of the organization's decision making is to foster their personal and professional development within the organization and to groom RFM into future leaders of the field.

Whereas the APA funds about $1,500,000 yearly to about 150 RFMs who are members of ACORF and the various APA Fellowships.

This funding allows these RFMs to attend various APA meetings, including the APA Annual Meeting, May Assembly Meeting, November Assembly Meeting, IPS, and the September Components Meeting.

A relatively small number of these RFMs remain active within the APA following the conclusion of their terms. Some even drop their APA memberships.

This may be considered an inefficient use of APA funds and a lost opportunity to APA's commitment to ensure the growth and sustainability of the APA as a membership organization to our future leaders.

BE IT RESOLVED:
That all RFMs selected or elected to APA funded position at the time of the application process commit to maintaining their APA membership for at least 5 years following the end of their term, make every effort to serve the organization at the local and national level, and provide mentorship to RFMs following the end of their term.

This agreement will be based on good faith and held to the highest standards.

That the APA develop an alumni network highlighting these members' achievements and continued involvement within the organization, provide contact information for appropriate networking, and enhance professional growth.

AUTHORS:
Jessica Abellard, M.D., RFM Representative, Area 3 (abellard-jessica@cooperhealth.edu)
Elie G. Aoun, M.D., ACORF Mentor
Lama Bazzi, M.D., APA Member
Sarit Hovav, M.D., RFM Representative, Area 4

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Resident Fellow Member Involvement, Membership, ECP, Networking

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Chief Membership & RFM-ECP Officer

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title:	Enhancing the Retention of Resident Fellow Members (RFMs) Who Have Received APA Funding Following the
Action Paper Author(s):	Jessica Abellard, M.D.,RFM Representative, Area 3
Phone/email:	abellard-jessica@cooperhealth.edu
APA Admin. Name:	-
Phone/email	-

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Performance in Practice Certification by the American Psychiatric Association

WHEREAS:
Whereas: Physician engagement in activities that change their care of patients in response to updates in medical knowledge has been well recognized.

Whereas: Performance in Practice (PIP) also known as Part 4 of Maintenance of Certification (MOC) was one attempt to document physician participation in these activities.

Whereas: The federal government has passed legislation that encourages physician documentation of their activities in PIP such that participation in MOC will qualify physicians for a reimbursement enhancement from Centers for Medicare and Medicaid (CMS).

Whereas: There is no clear mechanism to meet these requirements for the physician who is not board certified and roughly 25% of psychiatrists are in this category. Initial Board Certification for those not certified and not currently enrolled in a training program is now much more daunting because they have to do clinical skills work in a training program to be eligible to sit for an exam. Furthermore, most board certified psychiatrists who have lifetime certificates are not participating in MOC.

Whereas: Members of the APA would benefit from having access to the increased reimbursement by CMS programs and other insurers.

Whereas: New rules around physician participation in programs such as Metrics-based Incentive Payment System (MIPS) will be starting in 2019 and it will require such participation to avoid penalties in payments.

Whereas: The APA already offers PIP units that qualify for Part 4 MOC and is working towards a registry program that will also assist member participants in qualifying for MIPS.

BE IT RESOLVED:
The APA Division of Education along with the Council on Education and Lifelong Learning explore the possibility of the APA creating a program whereby the currently existing products that satisfy MOC requirements such as PIPs, Self Assessment CME and the safety course be packaged together and if required elements are met, the physician would receive a certificate recognizing participation in the program. The certificate could be used by the member to satisfy Part 4 of MOC if they are participating in MOC or used to prove participation in quality improvement for federal reimbursement if not participating in MOC.

AUTHOR:
James R. Batterson, M.D., Representative, Area 4 bbatterson@cmh.edu

ESTIMATED COST:
Author: $924
APA:

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Performance in Practice Certification, PIP, MOC

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Performance in Practice Certification by the American Psychiatric Association
Action Paper Author(s): James R. Batterson, M.D., Representative, Area 4
Phone/email: 816-898-0757/bbatterson@cmh.edu
APA Admin. Name:
Phone/email

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Research background information from ABPN and CMS on documentation requirements for quality assurance		770
2	Conference calls with Committee on Education and Lifelong Learning		154
3		-	-
	Total Staff Costs		924
		Total Author Estimate	**$924**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Standards for Inpatient Psychiatric Care

WHEREAS:
Whereas: Inpatient Psychiatric Care is generally regarded as the most intensive level of service provided to patients with active psychiatric illness.

Whereas: The expense of providing care at this level has been under great scrutiny by federal and state governments and insurance companies causing shortened lengths of stays and markedly fewer beds as well as a cut in the services provided to patients.

Whereas: Patients are often unable to make choices about where to receive care despite having insurance or financial means because of lack of beds and little knowledge about the quality of care provided by various inpatient facilities.

Whereas: Mental health crises are labor and time intensive to manage, requiring physicians, nurses, social workers, activity and occupational therapists among others. In addition to medication, patients benefit from individual and family therapy and a properly managed milieu.

Whereas: Some public and private hospitals have reduced or eliminated individual and family therapy and other services mentioned above.

Whereas: Psychiatrists who serve as medical directors of these institutions have no standards on which to argue for the maintenance of important treatment services as currently existing standards by other agencies are directed at safety and APA Practice Guidelines are directed at disease-specific treatment recommendations.

BE IT RESOLVED:
The APA Council on Healthcare Systems and Financing explore the APA setting standards of care for inpatient psychiatric hospitals. The mechanism to do this could be a practice guideline or a position statement. The Council would report back to the Assembly by the May 2017 Assembly meeting.

AUTHOR:
James R. Batterson, M.D., Representative, Area 4 bbatterson@cmh.edu

ESTIMATED COST:
Author: $924
APA:

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Inpatient, Inpatient Care, Psychiatric Care, Psychiatric Hospitals

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Standards for Inpatient Psychiatric Care
Action Paper Author(s): James R. Batterson, M.D., Representative, Area 4
Phone/email: 816-898-0757/bbatterson@cmh.edu
APA Admin. Name:
Phone/email

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Staff Research time on currently existing standards.		770
2	Conference call time with Council on Healthcare Systems and Financing		154
3		-	-
	Total Staff Costs		924
		Total Author Estimate	**$924**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Providing Recordings of Individual Presentations from the APA Annual Meeting

WHEREAS:
Whereas, APA members and other mental health professionals desire recordings of specific APA Annual Meeting sessions as an important means of enhancing their knowledge on a particular topic in order to better treat their patients; and

Whereas, at present, APA only makes recordings of Annual Meeting presentations available by requiring purchase of *Psychiatry On Demand*, a compendium of recordings of nearly all Annual Meeting sessions, at a very high cost (as of this writing, $1399), which strains or exceeds the financial means of many members, especially early career psychiatrists, while forcing them either to purchase a much larger package than what they desire or to forego obtaining any recordings whatsoever; and

Whereas, according to Learner's Digest International, the company that produces *Psychiatry on Demand*, the technology for marketing individual meeting sessions is readily available, and their production solely of a full meeting recording is in response to the preference specified to them by APA; and

Whereas, in years past APA did provide members with the option of purchasing individual annual meeting sessions, a salubrious and exquisitely unbroken arrangement;

BE IT RESOLVED:
That the APA Board of Trustees direct the appropriate component and/or staff department to require that any Annual Meeting recording vendors it engages make available for purchase both individual session recordings as well as recordings of the Meeting as a whole.

AUTHORS:
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Jonathan L. Weker, M.D., DLFAPA, APA member

ESTIMATED COST:
Author: Unknown, see estimate
APA:

ESTIMATED SAVINGS: Cannot be determined; analysis required to determine if this would result in additional costs or additional savings

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 1

KEY WORDS: Annual Meeting, Psychiatry on Demand

APA STRATEGIC PRIORITIES: Education

REVIEWED BY RELEVANT APA COMPONENT: Pending

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Providing Recordings of Individual Presentations from the APA Annual Meeting
Action Paper Author(s): Lisa Catapano-Friedman, M.D., DLFAPA, Represetative, Vermont Psychiatric Society
Phone/email: 802-223-2266/ jlweker@gmail.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Costs unknown. Analysis required to determine if this would result in additional costs or savings		-
2		-	-
3		-	-
Total Staff Costs			-

Total Author Estimate **$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Administration Estimate **$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Third Party Coverage of Medication Found to Be Beneficial to an Individual Patient

WHEREAS:
Whereas, many health insurance companies providing health insurance benefits limit their coverage of medications to those which are "evidenced-based," requiring clinicians to pursue prior authorization appeals for exceptions to this limit and frequently turning those appeals down for what they construe as lack of a sufficient research to support the requested medicine's use; and

Whereas, the research that underlies "evidenced-based" criteria for using medication involves population-based studies which base their conclusions on how a majority, but not every, member of the studied population responds to that medication; and

Whereas, in actual practice, some patients derive significant benefit from a specific medicine for which the research indicates that most members of the studied population do not benefit;

BE IT RESOLVED:
That the APA instruct its delegation to the American Medical Association House of Delegates to promulgate and promote legislation mandating that health insurance companies be required to provide coverage of a particular patient's ongoing costs for the purchase and use of any medication from which that patient has empirically experienced two months or more of continuous benefit with respect to a particular condition, regardless of the FDA's stated indications for that medication's use and regardless of whether or not any "evidence basis" for the use of that medicine to treat that condition has been determined. ~~Such mandated insurance coverage of the cost of medicines with empirically-determined clinical benefit would apply only if that patient had failed to benefit, at any time in the past, from trials of two or more medicines that were either approved for treatment of that condition by the FDA or whose use for treating that condition has been deemed to be "evidence based" by the insurer.~~
(Sentence struck out and included at the request of the authors.)

AUTHORS:
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Jonathan L. Weker, M.D., DLFAPA, APA member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: insurance, pharmacy benefits management (PBM), on-label, off-label, FDA

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: pending

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Third Party Coverage of Medication Found to Be Beneficial to an Individual Patient
Action Paper Author(s): Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Phone/email: 802-223-2266/jlweker@gmail.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

Title: APA Position Statement on Mental Health Hotlines

WHEREAS:

1. The APA has no position statement on mental health hotlines.

2. States have varying standards on mental health hotlines.

3. There have been several cases of calls made to mental health hotlines being referred to a voice mail in the VA System and similar routing to voice mail may happen in other settings.

4. Mental health hotlines are meant to produce an immediate response by a trained live operator at all times.

5. The lack of such immediate response by a trained live operator could result in attempted or successful suicide or homicide by the caller.

6. There is a critical need to provide a competent and prompt response to all calls and requests for help made by individuals who feel suicidal or homicidal or facing a serious mental health crisis.

7. Mental health hotlines in the United States and Canada should be answered by a live operator trained to answer calls made by individuals who feel suicidal or homicidal or facing a serious mental health crisis at all times during their operating hours and such calls should never be routed to a voice mail.

8. This is an issue that affects quality of care and patients' safety.

BE IT RESOLVED:

The APA Assembly requests the Council on Quality Care to develop a Position Statement presenting minimum uniform standards for mental health hotlines in the United States and Canada and to present such Position Statement to the Assembly during the November 2016 meeting for approval.

AUTHORS:
John M. de Figueiredo, M.D., ScD, DLFAPA, Representative, Connecticut Psychiatric Society
Harold M. Ginzburg, M.D., JD, MPH, DLFAPA, Representative, Oklahoma Psychiatric Physicians Assoc.
Manuel Pacheco, M.D., DFAPA, Deputy Representative, Area 1
Vincenzo Di Nicola, M.D., FAPA, Representative, Quebec and Eastern Canada District Branch
Eileen McGee, M.D., DFAPA, Representative, Ohio Psychiatric Physicians Association
Judy Glass, M.D., MAPA, Representative, Quebec and Eastern Canada District Branch
Dionne Hart, M.D., FAPA, Representative, Minnesota Psychiatric Society
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association

ESTIMATED COST:
Author: $308
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: Mental health hotlines Suicide

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Quality Care

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: APA Position Statement on Mental Health Hotlines
Action Paper Author(s): John M. de Figueiredo, M.D., ScD, DLFAPA, Representative, Connecticut Psychiatric Society
Phone/email: 203-233-0495/johndefig@sbcglobal.net
APA Admin. Name:
Phone/email

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Compilation of existing policies in the United States and Canada		308
2		-	-
3		-	-
Total Staff Costs			308
		Total Author Estimate	**$308**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Supporting the WACP Position Statement on Migrant Crisis Around the World

WHEREAS:

1. Massive migrations have taken place creating a major challenge to the Governments of the host countries

2. Such migrations have created a major demand for basic physical and mental health care as well as cultural understanding of complex personal and social issues

3. The long haul of the migration journey and its traumatic sequelae engender demoralization and mental health casualties among refugees and other migrants

4. Concrete and well-coordinated actions are needed with emphasis on positive use of clinical resources to attend to the needs of refugees and other migrants

5. The World Association of Cultural Psychiatry (WACP), an international organization of experts in cultural psychiatry, has approved a Position Statement on this issue

6. The APA does not have a Position Statement on refugees or migrant crisis

7. The Position Statement of the World Association of Cultural Psychiatry is consistent with the principles of the American Psychiatric Association

BE IT RESOLVED:

The Assembly of the American Psychiatric Association requests the President of the American Psychiatric Association to co-sign the Position Statement of the World Association of Cultural Psychiatry entitled "Migrant Crisis around the World" (copy attached) indicating, by virtue of being a co-signatory, that the American Psychiatric Association agrees with and supports that Position Statement.

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Author: $0
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ESTIMATED SAVINGS: $0

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ENDORSED BY: San Diego Psychiatric Society

KEY WORDS: Refugees Migrants Culture Demoralization Mental health

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Council on International Affairs

World Association of Cultural Psychiatry

Position Statement on the Migrant Crisis around the World

Subscribed by:

World Asociation of
Cultural Psychiatry

Grupo Latino Americano
de Estudios Transculturales

Universidad
de Guadalajara

O.P.D. Hospital Civil
de Guadalajara

Centro Universitario
de La Costa, UDG

Centro Universitario de
Ciencias de la Salud, UDG

Centro Universitario de
los Lagos, UDG

Puerto Vallarta, Jalisco, Mexico.

October 29th., 2015 – November 2nd., 2015.

Preamble

The World Association of Cultural Psychiatry (WACP) was founded to encourage international collaboration, friendship, scholarship, research and compassionate mental health care around the world. Sharing and exchanging best practices, and improving the safety and quality of mental health care as a priority,

emphasizing an objective focus on the diversity of cultures, legal systems, commissioning processes and wider political and social issues such as stigma, discrimination and prejudice against the mentally ill and their families, our organization has contributed to improvements in these areas, even though problems persist and our work will continue. Human resources and consistent support and funding from public and private agencies are required in order to make sure that the quality of care provided everywhere responds to expectations compatible with a profound respect for the dignity of all human groups and communities affected by mental illness or emotional ailments.

During the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life, general health care and mental health, in particular. Culture impacts practically all aspects of mental illness and, thus, culturally relevant care is needed for patients of diverse ethnic, racial, social and cultural backgrounds. From a social perspective, the world has witnessed rapid and significant changes magnified by political crises and information disseminated through a world media nourished by sophisticated technological advances. One of the realities resulting from these facts is that countries, regions and societies all over the world are becoming multi-ethnic and poly-cultural in nature. An undisputed evidence of this process is the massive presence of migration phenomena both within and between nations worldwide. The many implications (and consequences) of migrations in statistical, human and clinical terms urgently require in-depth examination of their precipitating factors, and multiple actions oriented to improving the cultural competence of health and mental health professionals. A resulting comprehensive medical and psychiatric

care would respect identities and beliefs, and wholly consider the ethnic, racial and cultural background of each and every immigrant patient.

The theme of the 4th. WACP Congress is appropriately titled **Global Challenges & Cultural Psychiatry:** Natural Disasters, Conflict, Insecurity, Migration and Spirituality. It takes place at a time of inexorable and dramatic intensification of violence and turmoil in different parts of the world, causing widespread destruction and increasing numbers of displaced people, immigrants and refugees. Internal and external migrations, pervasively growing in, for instance, Latin American countries and Latin America-North America fluxes, have recently reached dramatic, almost overwhelming levels in parts of the Middle-East, Asia and Africa, with practically millions of people displaced within their countries or continents, or forced to move mostly towards European countries. The World Migrant Crisis and its American and European versions are, thus, results of chronic socio-economic inequities and the intensification of political conflicts and religious wars. The mass movements of people generate great mental health risks among the immigrants, their enclaves in the receiving/host countries and the latter's overall social stability, resulting in a big volume of trauma-induced psychopathologies (depression, anxiety, psychoses and PTSD, among others).

This WACP Position Statement on the World's Migrant Crises is a resolution adopted by the Association Executive Board in the context of the 4th. World Congress of our organization. It aims at providing a forum for vivid discussions, open debates and progressive actions. It will include specific considerations about the situation in Europe, the Americas, Asia and Africa, intending to identify

common and distinctive factors, as well as making concrete suggestions and recommendations for action.

General Background

The United Nations High Commissioner for Refugees (UNHCR)[1] estimates in 59.5 million the number of people forcibly displaced worldwide in 2014. This figure includes Refugees, Asylum Seekers, Internally Displaced People (IDP) and Stateless People. War, conflict and political turbulence in many regions of the world have increased the number of displaced people fleeing complex emergencies and disasters. They often end up in marginal sections of urban areas or large camps under minimal living conditions. Developing countries host over 86% of the world's refugees, compared to 70% ten years ago.

Middle East-Europe

There were 19.5 million refugees worldwide at the end of 2014, 14.4 million under the mandate of UNHCR, around 2.9 million more than in 2013. In turn, 5.1 million Palestinian refugees are registered with the United Nations Relief and Works Agency (UNRWA). The Syrian civil war, complicated by the irruption of ISIS, presents, however, the most severe and dramatic picture. By the end of

2014, Syria had become the world's top source country of refugees, overtaking Afghanistan, which had held that position for more than three decades.

Today, on average, almost one out of every four refugees is Syrian, with 95 per cent located in surrounding countries. Last year, 51 % of refugees were children**,** the highest figure for this age group of refugees in more than 10 years.

In 2014, the country hosting the largest number of refugees was Turkey, with 1.59 million people, now reaching nearly 2 million. Lebanon, Jordan and Turkey, currently sheltering 3.6 million Syrian refugees, are reaching a breaking point and even experiencing food shortages, overwhelmed as international humanitarian funding is falling far short of the amount needed and some time promised. Many would rather attempt the dangerous journey to Europe rather than stay for years in impoverished, overcrowded refugee camps, where they can experience more violence, rape, diseases and even death.

About 38.2 million people were forcibly uprooted and displaced within their own country and are known as Internally Displaced People (IDP)**.** Continued fighting in Syria brought the number of IDP in that country to 7.6 million**.** As well, Iraq witnessed massive new internal displacement as a result of the Islamic State (or 'ISIS') offensive across multiple parts of the country.

Statelessness refers to the condition of an individual who is not considered a national by any state, although stateless people may sometimes also be refugees. Syria has more than 300,000 denationalized Kurds, Kuwait has 93,000 Bidoon (*bidoon jinsiya*)[2],

Furthermore, 1.66 million people submitted applications for asylum in 2014, the highest level ever recorded. With an estimated 274,700 asylum claims, the Russian Federation became the largest recipient of new individual applications in 2014, although as of September 2015, Germany has 256,000 formally registered refugees out of an estimated 800,000, predicted to reach 1 million by the end of the year. Similarly, Sweden with more than 190,000 asylum seekers just this year is the country with, proportionately, the largest number of immigrants per capita; more than 20,000 (12 %) of them are children and adolescents making the journey (mainly from the Middle East, but also from other distant countries such as Afghanistan and Somalia, without their parents or other responsible adults.[3] By contrast, in 2014, the USA received 121,200 refugees from the Middle East.

Thus, it is clear that, in 2015, Europe is struggling to cope with the large-scale influx of migrants making their way across the Mediterranean, the biggest since the aftermath of World War II[4] . This has sparked a crisis as countries struggle to cope with the influx, and has created divisions in the European Union (EU) over how best to deal with resettling people. Squalid conditions in makeshift refugee camps and heartbreaking scenes like the photograph of a drowned Syrian toddler, have contributed to bring Europe's current refugee crisis into the global spotlight. According to the UNHCR, more than 380,000 migrants and refugees have landed on Europe's southern shores so far this year, up from 216,000 arrivals in the whole of 2014. The voyage from Libya to Italy is longer and more hazardous. The migrants are fleeing persecution, poverty and conflicts that rage beyond the continent's borders. Not all manage to arrive safely: according to the International Organization for Migration (IOM)[5], more than 2,700 migrants are

reported to have died trying to make the crossing this year; altogether, 2,988 people have died in the Mediterranean in 2015.

With tensions running high, Europe's leaders remain divided on how best to respond to the crisis. A disproportionate burden is faced by some countries, particularly Greece and Italy. Germany has recently promised to accept about 1 million people over the next 12 months; other countries have begun to take a more humanitarian line, albeit slow and narrow in its implementation. On the other hand, in many cases the rhetoric has been profoundly xenophobic and racist, invoking as their justifying arguments the protection of religious identities or the security of the potential host communities. There have been references to an imminent "collapse of European civilization", or to a "swarm" of migrants advancing even beyond the coast of Western Europe. All of this happens in the midst of growing conservative political trends in the continent, and muddled policies with regards to the areas of war and conflict.

Latin America-North America

Throughout a period close to one century, migration from Latin American countries (particularly Mexico) to the United States (primarily) and Canada, has been a persistent social phenomenon. Initially, the motivating factor was the need of workers to build and establish railroads across North America and even expanding to communicate with "South of the border" countries; later, a strong agricultural development in the U.S. determined the hiring of people who, in addition to having a hard work ethics, were willing to receive a lower payment[6]. During the second half of the 20th. Century, economic and socio-political factors in

Mexico, Central and South America (such as unemployment, public budget deficits, government instability, social disorganization, family needs, civil wars, administrative corruption, etc.) have been the main reasons behind an increasing Hispanic migration. The main characteristic of Hispanic newcomers in the last five decades has been the so-called “undocumented migration”, the “illegal” migrants who, nevertheless, remain in the US for many years, work in many, mostly low-paying areas (primarily agriculture) and remain marginalized and discriminated against. Throughout the last 15 to 20 years, Hispanics or Latinos have consistently constituted just over half of the foreign-born population in the U.S. According to recent census figures, there are 54 million Hispanics living in the country, 17 % of the total population and the largest ethnic minority in the country. Projections for 2050 (104 million) and 2060 (128 million) confirm a pattern of consistent growth.

Mexicans are the largest subgroup (33 million in 2013, 63 % of the total Hispanic population). More than 11 million (28 % of all U.S. immigrants) are immigrants proper according to 2013 statistics[7] Other Latino groups include Cuban/Caribbeans, Puerto Ricans, Central Americans (the largest subgroup coming from El Salvador) and South Americans (the largest subgroup coming from Colombia). Between 2000 and 2010, the Puerto Rican subgroup grew 36 %, Cubans, 44 % (a number of them escaping from Cuba by boat) and others, 22 %. Of note, the elderly Latino sub-population is currently one of the largest segments among the “baby-boomers”.

The most common features of the Hispanic population in the U.S. are lower income, lower educational level, significant unemployment, the second largest number (after African Americans) of people in jail, and the most numerous

households. More importantly, from a socio-cultural vantage point, the pace and level of assimilation to the so-called "American lifestyle" (culture in its many forms, economic and civic life) is the slowest among Mexicans and other Latin Americans. This trend persists even though immigrants who arrived in the past 25 years have assimilated faster than their counterparts of a century ago, according to a report by the conservative Manhattan Institute for Policy Research[8].

Adding to the unstable and unpredictable realities, there were 662, 483 apprehensions in 2013 by the U.S. Customs and Border Protection, and the U.S. Immigration and Custom Enforcement, two agencies responsible for the identification and removal of "inadmissible noncitizens". Sixty-four percent of all apprehensions (420, 789) were reported by the Border Patrol in 2013, up from 364,768 in 2012, and about 98 % of those apprehensions (414,397) occurred along the Southwest border. Additionally, 35 % or 229,698 persons were subjects of "administrative arrests" in 2013. The leading countries of nationality (93 %) of those apprehended were Mexico (64 %), Guatemala, Honduras and El Salvador. Furthermore, 648,783 individuals in 2012, and 616,792 in 2013, were deported [9].

In short, Latino immigration to North America is a massive picture that has been present in the world scene for over a century. In spite of high economic costs (payments to the so called *coyotes*, usually gang members that supposedly conduct the immigrants across the border) and dramatic reports of violence at different points of the long migration journey (e.g., rapes, sexual commerce, extortions even on the top of trains carrying the migrants; or total neglect, hunger and even assassinations) this crisis, perhaps due to its longevity, does not seem to attract the public attention the way the current wave of Middle East migrations

does. It is there to be examined, however. Its extremely significant impact (both in numbers and in severity) on the life of the immigrants themselves and on the citizens of the host countries is undeniable. The cultural and clinical costs of this phenomenon cannot be demeaned or neglected.

Almost as a footnote, other migration-related facts are also seen in Latin America. For instance, the Dominican Republic has an estimated 900,000 to 1.2 million undocumented individuals of Haitian origin, many of whom are stateless or at risk of statelessness.

Asia and the Pacific Region

Only twenty Asian countries have followed the 1951 Refugee Convention and its 1967 protocol, while the whole region is home to 7.7 million people, more than half of whom are refugees,1.9 million internally displaced (IDPs), and 1.4 million, stateless persons. The majority of the refugees originate from Afghanistan and Myanmar. The Afghan refugee situation is dramatically protracted. Up to 96 per cent of them are living in Iran and Pakistan, which have generously hosted them for over three decades.

The Myanmar situation is no less delicated. For several decades now, people from different ethnic groups have been fleeing to avoid conflict and violence. Currently, an estimated 500,000 refugees are in zones of neighboring countries such as Karen and Karenni in Thailand, Chins in Malaysia, Rohingyas in Bangladesh and in large urban centers. There are over 400,000 IDPs in Myanmar, more than half of the population of the Kachin and Rakhine states. This includes

over 140,000 people displaced during inter-communal violence two years ago, many of whom have undetermined citizenship status.

Sixty-three percent of the 3.5 million refugees live outside camps, mainly in urban environments where they are basically unprotected, exposed and vulnerable to all kinds of stressors. Those living in camps have limited freedom of movement, many lack documentation and risk detention and deportation. Detention practices and other forms of restrictive asylum policies continue to spread, limiting the refugees' access to basic services or to the labor market; the consequences are predictable: they become victims of exploitation and abuse, with women and adolescent girls particularly vulnerable to the actions of sexual predators.

In view of this situation, many refugees and their families are risking their lives to cross the sea in search of safety and protection. UNHCR has documented this irregular departures particularly in the Bay of Bengal at the Bangladesh-Myanmar border area.

Africa

Massive new displacements caused by conflict, violence and human rights abuses are likely to continue to affect many African countries in 2015. Although the projected numbers of people of concern are expected to decrease slightly (from 15.1 million in 2014 to 14.9 million this year), due to repatriation, resettlement and other durable solutions, many problematic areas remain. The

scale of the displacement caused by the upheaval inside the Central African Republic (CAR) (611,000 displaced), South Sudan (1.5 million in 2013, 200,000 in 2014)), and Yemen (85,000) is likely to continue in the years ahead. A renewed fighting in the Democratic Republic of Congo that displaced 1 million people, brought the total number of IDP in that country to 2.8 million. [10]

In recent years, some core values of the traditionally laudable protection system in several African countries have been challenged, including difficulties for the access of Human Rights advocates to people in need of international protection. In Southern Africa, an increase in mixed migratory movements has also led to growing hostility towards refugees, putting pressure on asylum and protection space.

A significant proportion of Mali's population - 267,000 people - remains displaced internally and externally. The insurgency in the federal states of Adamawa, Borneo and Kobe in north-eastern Nigeria has provoked the displacement of a large number of people, forcing more than 650,000 to flee their homes within the country, and an estimated 70,000 to take refuge across the borders with Cameroon, Chad and Niger.

In this complex context, organizations such as the UNHCR have continuously worked to alleviate this collective suffering. The subscribers recognize efforts such as those in the last five or six years, for the implementation of a comprehensive durable strategy for the Angolan refugee situation, a Tripartite Agreement for the repatriation of Somali refugees, re-establishment of peace and security throughout Ivory Coast and other countries in Western Africa, and a Regional Return and Reintegration Strategy for the Sahel

and the Government's Accelerated Strategy for northern Mali.[10] Improvement of conditions in return areas throughout the continent and consistent work towards a community-based approach that fosters social cohesion, must be complemented by concrete protective measures of the health, mental health and socio-cultural values of the affected populations.

WACP Calls for Action

- We call on all European Governments to respect, uphold and administer the UNITED NATIONS REFUGEE CONVENTION (1951) with fairness and promptness, to act with humanity and compassion and to not let the evil of Europe's past history taint or threaten to repeat itself. European Governments with influence in the regions of conflict and wars (in th Middle East, Asia and Africa), and with permanent positions at the UN Security Council, must intensify their efforts to resolve these conflicts, assuage their consequences and bring about an end to the migration crisis.

- We extend this call to the U.S.A. Government (Executive Branch and Congress) to join others in reaching the same objectives as well as, particularly, to adopt and reinforce policies aimed at establishing more practical, flexible and humane rules and proceedings regarding the management of the Hispanic waves of immigrants from Mexico, Central and South America, their treatment by bureaucratic personnel and offices and social agencies in different regions and States.

- We call on all Governments of countries in the receiving end of immigrants (particularly Europe and the U.S.A.) to act with promptness and fairness in

assessing, screening and deciding on the legal status of migrants. Prompt decisions on refugee and asylum status must be done with humanity and dignity. The host populations must be reassured, their fears and concerns addressed, and their leaders encouraged to become actively involved in assisting with constructive re-settlement programmes.

- We call for all basic health care to be provided to migrants, with a clear emphasis on the immediacy of physical care, e.g., injuries from violence, war, rape, malnutrition, fractures, pregnancy and childbirth, basic immunizations, chronic medical conditions, etc., as well as emotional and psychological care (effects of torture, violence, rapes, deaths, traumatic stress, etc.). WACP can act as a reservoir for cultural understanding and recognition of the importance of cultural influences on life and mental health.

- We call for respect to and protection of individual cultural, religious and spiritual dignity, valuable features revered by most people, after the long haul of the migration journey and its traumatic sequelae. Paying attention to the acculturative processes and providing safeguard and protection to avoid or prevent coercion and fear-inducing procedures, behaviors or maneuvers are key components of the immigrants' survival and the strengthening of their own resilience.

- The WACP will actively work towards the organization of international meetings on the subject of the World Migrant Crisis and its different expressions in several continents. The purposes of such events would be to bring together government officials, politicians, advocates, media,

communities, health and mental health professionals, clinicians, social organizations and researchers in the field, engaging them all in the formulation of concrete and well coordinated actions, with emphasis on positive use of clinical resources and cultural factors in the management and recovery of mental health affected by the traumatic experiences of migration. The collaboration of other organizations with strong political and international impact (UN, EU, OAS, WHO, WPA, EPA, APA, etc.) should be actively pursued for the materialization of all these objectives.

Sergio J. Villaseñor-Bayardo	**Renato D. Alarcon**	**Hans Rohlof**
WACP President	**WACP Secretary**	**WACP Treasurer**

Additional points

Refugee Convention. *Under international law,* ***THE UNITED NATIONS REFUGEE CONVENTION, 1951,*** *refugees must not be forced back to the countries they have fled, a principle which forbids the rendering of a true victim of persecution to his or her persecutor. Host governments are primarily responsible for protecting refugees and most states fulfill their obligations to do so. Others, however, avoid their responsibility by pointing to a lack of resources, the country being full in its capacity to host more immigrants, threats to national security, fears of domestic political de-stabilization, or the arrival of even greater numbers of refugees.*

A note on terminology. *The BBC uses the term migrant to refer to all people on the move who have yet to complete the legal process of claiming asylum. This group includes people fleeing war-torn countries such as Syria, who are likely to be granted refugee status, as well as people like those from Latin America to the U.S. or Canada who are seeking jobs and better lives and who governments are likely to rule as "economic migrants."*

References

[1] UNHCR: UN Refugee Agency UK. http://www.unhcr.org.uk

[2] Refugees International. http://www.refintl.org

[3] Sweden Immigration Authority. www.migrationverket.se

[4] Europe Migrant Crisis. http://www.bbc.co.uk/news

[5] International Organization for Migration. http://unitedkingdom.iom.int

[6] Durand J, Massey DS, Charvet F. *Soc Sci Quart* 2000; 81: 1-15

[7] Migration Policy Institute, Spotlight, February 26, 2015.

[8] Manhattan Institute for Policy Research. September 2015 Report on immigrants' acculturation.

[9] U.S. DHS' Office of Immigration Statistics, 2013 Report.

[10] http:www.unhcr.org/pages/4a02d7fd6,html

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Supporting the WACP Position Statement on Migrant Crisis Around the World
Action Paper Author(s): John M. de Figueiredo, M.D., ScD, DLFAPA, Representative, Connecticut Psychiatric Society
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APA Admin. Name:
Phone/email

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Utilization of DSM-5 Terminology in APA Publications & Communications

WHEREAS:
Whereas: The American Psychiatric Association has expended considerable financial, intellectual, and member resources on DSM-5 to further refine psychiatric diagnoses.

Whereas: In some cases entire diagnostic categories were discarded. For example, separate diagnostic labels of Autistic Disorder, Asperger's Disorder, and PDD-NOS were replaced by one umbrella term "Autism Spectrum Disorder."

In another case, the diagnoses of "Substance Abuse & Substance Dependence" were replaced by the "Substance Use Disorders." The "abuse category" was eliminated from the proposed structure because of the lack of data to support an intermediate state between drug use and drug addiction.[1] In addition, the authors of this paper feel the term "Substance Abuse" implied a parallel to criminal actions such as "Domestic Abuse" and could be interpreted to mean that individuals who carried this diagnosis should be dealt with by the criminal justice system

Whereas: The February 2016, APA Free Course of the Month: **Choosing the Right Treatment for Substance Use Disorders**, did not even use the DSM-5 terminology in its educational objectives! For example, the objective that and individual taking the course would learn to "Recognize clinical signs and symptoms of **abuse** of sedative-hypnotic or stimulant medications." Or the participant would be able to "Describe the problem of opioid **abuse** among chronic pain patients and be aware of screening tools to reduce likelihood of abuse."

Whereas: The lead article in a recent issue of Psychiatric News (Volume 50, Number 23, December 4, 2015, P.1) began with the headline: "CEOs Meet to Discuss Ways to Foster Workplace Mental Health," followed by "Leaders of major corporations related personal experiences with mental illness and **substance abuse** are major drivers of health care costs for businesses and corporations."

BE IT RESOLVED:
That the American Psychiatric Association will make every effort to see that every program, publication, communication, etc. utilizes up-to-date-language that reflects DSM-5 with particular emphasis on the Autism Spectrum Disorders and the Substance Use Disorders.

That the American Psychiatric Association will give a report back to the Assembly beginning at the May, 2017 meeting and annually thereafter until the problem is deemed resolved.

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[1] Addiction. Author's (Charles O'Brien) manuscript available in PMC 2013 Oct 30.
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Addiction. 2011 May; 106(5): 10.1111/j.1360-0443.2010.03144.x.
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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $00.00

ESTIMATED REVENUE GENERATED: $00.00

ENDORSED BY: Ohio Psychiatric Physicians Association

KEY WORDS: DSM-5, Autism, Substance Use Disorders

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Utilization of DSM-5 Terminology in APA Publications & Communications
Action Paper Author(s): Jonathan E. Dunn, M.D., PhD, Representative, Ohio Psychiatric Physicians Association
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

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Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Improving Electronic Medical Record (EMR) – Information Technology (I.T.) Toolkit

WHEREAS:

1) Whereas, the combination of three (3) forces has resulted in clinicians being required to spend large amounts of time entering data into EMR systems.

   The three forces (perfect storm) are:

   a) Regulatory driven measures i.e. (meaningful use) and (required preventative measures).

   b) Large for Profit Computer Software Companies trying to make money and sister companies that sell hardware, consulting and I.T. support.

   c) Health System Administrators who want the "most advanced" system that is available. A system that mandates physician compliance, improves efficiency, measures and improves outcomes, and ensures that they will meet regulatory body's requirements.

2) Whereas excessive data input, and printouts that contain redundant and "boilerplated" information which result in evaluations and progress notes that are difficult to read, especially to find the meaningful information.

3) Whereas, common sense printouts are absent from these records (i.e. running medication history and history of hospitalization). Usually these records are unable to be modified to assist clinicians without exorbitant costs.

4) Whereas, time studies have indicated that three to five additional hours are required to complete these records in an average days work.

5) Whereas, A.M.A. data shows concern about this issue as always the #1 or #2 concern driving physician dissatisfaction.

6) Whereas, previous attempts to modify EHR Systems (to make them more "user friendly") by individuals or professional organizations have been ineffective and frustrating. (Reactive attempts to change large systems with great momentum like EMR have usually failed unless forced legally or legislatively.)

BE IT RESOLVED:
That the APA will take decisive action to improve the efficiency and utility of Electronic Medical Records for Psychiatrists (and therefore most physicians in other specialties).

This proposal the "I.T. Toolkit" will result in improved data entry, improved reports, i.e. progress notes, and a system to provide feedback to administrators and software companies (better updates or modifications of software systems).

The APA will explore three areas for potential action:

1) Increasing competition directly.
2) Developing specific and practical templates for Data Input.
3) Developing a National quality rating scale for EMR Companies and Health System Administrators.

The issue should be referred to the Assembly Executive Committee and the Board of Trustees for further discussion of these three issues and possible action including:

An ad hoc committee of the Area IV Council be formed to develop a standardized progress note that can be "pasted" into the narrative section of EMR's. This committee could be expanded to an Assembly Committee, a Task Force, or appropriate Component if felt advisable by the AEC or the Board.

The APA will develop an Application in collaboration with an existing software (EHR) company which would make record keeping more "user friendly".

AUTHOR:
William Fuller, M.D., Representative, South Dakota Psychiatric Association

ESTIMATED COST:
Author: $1,267
APA:

ESTIMATED SAVINGS: $7,500 - $75,000, per "enrolled" psychiatrist

ESTIMATED REVENUE GENERATED: $1,000,000 - $1,000,000

ENDORSED BY:

KEY WORDS: I.T. Toolkit, EMR, Health System Administrators National Quality Rating Scale

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT: Steve Daviss, MD, Chair, APA Committee on Mental Health Information Technology, Nathan Tatro, APA, EMR Information Technology

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Improving Electronic Medical Record (EMR) - Information Technology (I.T.) Toolkit
Action Paper Author(s): William C. Fuller, MD
Phone/email: 605-360-8509/fullerwc@goldenwest.net
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	6	-
Number of Staff	1	-
Number of Non-Staff	-	-
Total	**7**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$518	$518
Meeting 2	-	-	-	-	518	518
Total Travel Budget		-	-	-	1,036	1,036

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Staff Ad Hoc Meetings (2)		231
2		-	-
3		-	-
	Total Staff Costs		231

Total Author Estimate	**$1,267**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**-**	**-**	**-**	**-**	**-**

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		**-**

Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Direct to Consumer Advertising

WHEREAS:

Direct to consumer advertising of medications for the treatment of psychiatric disorders (in fact all prescription medication) is legal in the United States and New Zealand, but illegal in the rest of the world;

Direct to consumer advertising of medications for the treatment of psychiatric disorders is expanding from print and television to online marketing;

There is considerable evidence that direct to consumer advertising of psychotropic medication harms more individuals than it benefits;

There is substantial evidence that direct to consumer advertising of psychotropic medication benefits pharmaceutical companies through greater sales of medications without medical indications;

There is little evidence that direct to consumer advertising of medications used to treat psychiatric disorders provides information in a fashion that increases informed decision making by patients;

There is considerable evidence that direct to consumer advertising impacts physicians' prescribing of psychotropic medication through patients' requests for specific medications by brand name;

There is some evidence that direct to consumer advertising of psychotropic medication biases individuals against non-pharmacologic treatment, such as psychotherapies and psychosocial treatments;

It is well known that non-psychiatric medications have the potential to negatively impact an individual's mental status, and so medications that are not medically indicated should be avoided;

It is well known that medication interactions can produce undesirable effects (such as increased blood levels of another medication, decreased effectiveness of a medication, or additional side effects), and so medications that are not medically indicated should be avoided;

The current position statement of the APA on Direct to Consumer advertising, an adoption of AMA policy (see attachment A), is no longer meaningful as the AMA has repudiated its former position statement indicating the AMA favors a ban on direct to consumer advertising—see attached.

The Assembly has twice before (November 2014 and November 2015) rejected the APA's maintaining its current position statement on direct to consumer advertising.

Time is of the essence, since without action, the APA will find itself in the unworkable situation of endorsing an AMA Position Statement as its own Position Statement while the AMA has jettisoned the very same Position Statement.

BE IT RESOLVED:

1. The American Psychiatric Association shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010.
2. The American Psychiatric Association shall adopt the Position Statement on Direct to Consumer Advertising, 2016.
3. The Speaker shall report out this Action Paper to the Board of Trustees (BOT) for action by the Board of Trustees at the next BOT meeting.

AUTHORS:
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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: $5,000.00 from new memberships

ENDORSED BY: Area 1, Area 7, Colorado Psychiatric Society

KEY WORDS: Direct to consumer advertising

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

References

Richard L. Kravitz, Ronald M. Epstein, Mitchell D. Feldman, et al. **Influence of Patients' Requests for Direct-to-Consumer Advertised Antidepressants. A Randomized Controlled Trial.***JAMA.*2005;293(16):1995-2002. doi:10.1001/jama.293.16.1995.

Jeffrey R. Lacasse. **Consumer Advertising of Psychiatric Medications Biases the Puhlic Against Nonpharmacological Treatment.** Ethical Human Psychology and Psychiatry,2005:7 (3):175-180.

Matthew H. Hollan. **Direct to consumer advertising. A haphazard approach to health promotion.***JAMA.*2005;293(16):2030-2033. doi:10.1001/jama.293.16.2030.

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Robert A. Bell, Laramine D. Taylor, Richard L. Kravitz**. Do antidepressant advertisements educate consumers and promote communication between patients with depression and their physicians**? Patient Education and Counseling 2010: 81(2): 245-250.

Steven S. Sharfstein**. Big Pharma and American Psychiatry**. Journal of Nervous & Mental Disease 2008:196(4):265-266.doi:10.1097/NMD.0b013e31816a4380

Adam E. Block. **Costs and benefits of direct-to-consumer advertising**. Pharamcoeconomics 2007: 25(6):511-521.

Julian De Freitas, Brian A. Falls, Omar S. Haque et.al. **Recognizing misleading pharmaceutical marketing online**. Journal of the American Academy of Psychiatry and the Law 2014: 42(2): 219-225,

POSTION STATEMENT ON NEXT PAGE

Position Statement

American Psychiatric Association

DIRECT TO CONSUMER ADVERTISING

Background

Direct to consumer advertising of medications does not provide information in a fashion that increases informed decision making by patients. Direct to consumer advertising impacts physicians prescribing of medication through patients' requests for specific medications by brand name. Direct to consumer advertising of psychotropic medication biases individuals against non-pharmacologic treatment, such as psychotherapies and psychosocial treatments. Non-psychiatric medications can negatively impact an individual's mental status so medications that are not medically indicated should be avoided. Direct to consumer advertising of psychotropic medication harms more individuals than it benefits.

Position

The American Psychiatric Association opposes any direct to consumer advertising of medications for the purpose of treating psychiatric disorders. The American Psychiatric Association does not support direct to consumer advertising of any prescription medications.

Attachment

Nov. 17, 2015

AMA Calls for Ban on Direct to Consumer Advertising of Prescription Drugs and Medical Devices

For immediate release:
Nov. 17, 2015

ATLANTA –Responding to the billions of advertising dollars being spent to promote prescription products, physicians at the Interim Meeting of the American Medical Association (AMA) today adopted new policy aimed at driving solutions to make prescription drugs more affordable.

Physicians cited concerns that a growing proliferation of ads is driving demand for expensive treatments despite the clinical effectiveness of less costly alternatives.

"Today's vote in support of an advertising ban reflects concerns among physicians about the negative impact of commercially-driven promotions, and the role that marketing costs play in fueling escalating drug prices," said AMA Board Chair-elect Patrice A. Harris, M.D., M.A. "Direct-to-consumer advertising also inflates demand for new and more expensive drugs, even when these drugs may not be appropriate."

The United States and New Zealand are the only two countries in the world that allow direct-to-consumer advertising of prescription drugs. Advertising dollars spent by drug makers have increased by 30 percent in the last two years to $4.5 billion, according to the market research firm Kantar Media.

New AMA policy also calls for convening a physician task force and launching an advocacy campaign to promote prescription drug affordability by demanding choice and competition in the pharmaceutical industry, and greater transparency in prescription drug prices and costs.

"Physicians strive to provide the best possible care to their patients, but increases in drug prices can impact the ability of physicians to offer their patients the best drug treatments," said Dr. Harris. "Patient care can be compromised and delayed when prescription drugs are unaffordable and subject to coverage limitations by the patient's health plan. In a worst-case scenario, patients forego necessary treatments when drugs are too expensive."

New AMA policy responds to deepened concerns that anticompetitive behavior in a consolidated pharmaceutical marketplace has the potential to increase drug prices. The AMA will encourage actions by federal regulators to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

The AMA will also monitor pharmaceutical company mergers and acquisitions, as well as the impact of such actions on drug prices. Patent reform is a key area for encouraging greater market-based competition and new AMA policy will support an appropriate balance between incentives for innovation

on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

Last month, the Kaiser Family Foundation released a report saying that a high cost of prescription drugs remains the public's top health care priority. In the past few years, prices on generic and brand-name prescription drugs have steadily risen and experienced a 4.7 percent spike in 2015, according to the Altarum Institute Center for Sustainable Health Spending.

The AMA's new policy recognizes that the promotion of transparency in prescription drug pricing and costs will help patients, physicians and other stakeholders understand how drug manufacturers set prices. If there is greater understanding of the factors that contribute to prescription drug pricing, including the research, development, manufacturing, marketing and advertising costs borne by pharmaceutical companies, then the marketplace can react appropriately.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Direct to Consumer Advertising
Action Paper Author(s): Jeffrey Geller, M.D., MPH, Representative, American Association of Community Psychiatrists
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APA Admin. Name:
Phone/email

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Psychiatrist Involvement in Medical Euthanasia and Physician-assisted Suicide of the Non-Terminally Ill

WHEREAS:

Whereas, Belgium and the Netherlands have expanded access to non-terminal conditions that are considered "insufferable" and "untreatable." This opened the door to physician-assisted suicide and active euthanasia being provided to non-terminally ill people with psychiatric conditions. Often their own treating psychiatrists and psychiatric facilities are administering the lethal injection or providing lethal prescriptions to self-administer. Alternative clinics have been established to give voluntary euthanasia even when treating psychiatrists disagree.

Whereas, in Canada, the Supreme Court held in *Carter v Canada* that all citizens of that country have a constitutional right to medically assisted death if the individual has "a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual." In February 2016, a committee of the Canadian Parliament recommended that medically assisted death be made available to people with mental illness.

Whereas, current and emerging laws in the U.S. are limited to the terminally-ill, but legislators and advocacy groups are exploring possible expansion to allow access by the non-terminally ill, including people with mental illness under the principles of parity and the ADA law.

Whereas, the American Psychiatric Association must articulate its position on psychiatrist participation in the euthanasia of non-terminally ill people with psychiatric conditions in the interest of protecting the vulnerability of our patients and maximize their well-being.

Whereas, the phrase 'terminally ill' refers to an individual who is medically qualified for aid-in-dying in states where this practice is legal, and 'non-terminally ill' includes individuals not qualified for aid-in-dying, as well as physically healthy individuals who are not diagnosed with a particular medical condition,

Whereas, several countries, including The Netherlands, Belgium, and Canada have extended legal physician-assisted suicide to include the non-terminally ill, with "untreatable" and "insufferable" conditions, resulting in a growing number of non-terminal mentally ill patients being euthanized in those countries, some by their own treating psychiatrists, some within a psychiatric treatment facility,

Whereas, multiple factors, both clinical and non-clinical, may lead to an assertion that a condition is "untreatable."

Whereas, mental suffering may be due to treatable, undiagnosed psychiatric conditions and, among physicians, psychiatrists are particularly qualified to evaluate suicidal thoughts and behavior independent of diagnosis, psychiatric or otherwise,

Whereas, a fundamental and critical ethos of psychiatrists is to *prevent* suicide, to help patients find alternative paths through suffering to a better future, and to even find meaning in suffering that cannot be fully ameliorated,

Whereas, the profession of psychiatry has a duty to promote access to treatment and education regarding the efficacy and availability of that treatment,

BE IT RESOLVED:
That the Board of Trustees of the American Psychiatric Association adopt the following position statement:

"The American Psychiatric Association holds that a psychiatrist should not deliberately prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death."

AUTHORS:
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Leslie Hartley Gise, M.D., Representative
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Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Madelyn Hicks, M.D., APA Member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: Euthanasia, aid-in-dying, death with dignity, assisted suicide, mental suffering, stigma, vulnerable patients, discrimination, patient advocacy, suicide prevention

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Psychiatry and Law, Council on Geriatric Psychiatry

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Psychiatrist Involvement in the Medical Euthanasia and Physician-assisted Suicide of the Non-Terminally Ill
Action Paper Author(s): Annette Hanson, M.D., Representative, Maryland Psychiatric Society
Phone/email: 410-724-3149/annette.hanson@maryland.gov (Hanson); 410-494-4411/mkomrad@aol.com (Komrad)
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Improving the Efficacy of Prescription Drug Monitoring Programs

WHEREAS:
According to the Center for Disease Control and Prevention (CDC), an estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses receive an opioid prescription,

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose. In 2014 alone, there were 19,000 deaths related to opioid pain medication in the United States,

Prescribing and sale of opioids has quadrupled since 1999 and according to the DEA, from 1998 to 2006, the number of methadone prescriptions increased by 700 percent,

The risks of opioid pain medication increase dramatically when used in combination with other frequently-prescribed medications including benzodiazepines,

Methadone carries more risks than other opioids because it tends to build up in the body and can disrupt a person's breathing or heart rhythm. The CDC showed that while methadone accounts for only 2 percent of painkiller prescriptions in the United States, methadone is involved in more than 30 percent of all prescription painkiller deaths. In deaths involving only a single painkiller, methadone accounted for four out of every ten deaths,

Prescription drug monitoring programs (PDMPs) are statewide electronic databases, currently, in 49 states, the District of Columbia and U.S. territory Guam have legislation authorizing the creation and operation of a PDMP accessible to health care practitioners, pharmacists, regulatory boards, and law enforcement agencies,

PDMPs are proactive in safeguarding public health and safety while supporting the legitimate use of controlled substances, and therefore do not infringe on the legitimate prescribing of a controlled substance by a practitioner acting in good faith and in the course of a professional practice,

PDMPs are used by providers to obtain vital clinical data, ensuring that prescribed controlled substances are taken as directed, and do not risk imminent harm secondary to serious, adverse drug interactions. And absent full prescription data, treatment providers prescribe medications without vital clinical data placing their patients at risk of diversion of controlled medications, continued addiction, overdose, and death,

Federal regulations such as 42 CFR Part 2 (2.1) states: "Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be

disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section," undermining the utility of PDMPs while running counter to concept of substance use disorders as legitimate, medical conditions of concern to a patient's treating physicians,

BE IT RESOLVED:
The American Psychiatric Association lobby Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, and appropriate state and federal agencies to require inclusion of methadone prescriptions in all Prescription Monitoring Programs in an effort to decrease the risk of serious drug interactions, overdose, and death.

AUTHORS:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society (dionnehart@charter.net)
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ESTIMATED COST:
Author: $2,886
APA:

ESTIMATED SAVINGS: $0.00

ESTIMATED REVENUE GENERATED: $0.00

ENDORSED BY: Minnesota Psychiatric Society

KEY WORDS: Prescription, Opioids, Safety

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry

Council's Comments:
Smita,
I think the VA has been added. At least in Washington State the Rx's I write are showing up on our PDMP.
Andy

I like Andy's last comment about a single national PDMP (and might add that the VA be added to that reporting). However as Elie points out this may need to be approached on a state level. Can the AP make a resolution that this happens at a state level, or is that too much of the national organization interfering with state goals?
Smita Das, MD, PhD, MPH

I also agree with Andy's comments. This needs some careful editing. Also as Elie noted, this has to be directed to APA District Branches since it has to be addressed at the state level. John Runner

I love what the AP is addressing, it is a very important issue that we, as a country need to address given the scope of the opioid epidemic.

My concerns is that while the Recommendation of this AP makes a lot of sense (and excluding methadone from those databases puts patients at risk and limits how effective the databases are), unfortunately, PMPs are vastly dependent on specific state legislatures, and some states do not even have a PMP (Missouri for example out of concern for privacy), so I am not sure SAMHSA and the DHS have any authority pushing for such changes, rather, it would require state by state lobbying that is typically better done by state medical and psychiatric associations and district branches.

I agree, adding "other appropriate agencies", will give the board more room and flexibility acting on this action paper. Ideally, if we are going to take action on this and spend lobbying money, I would love for the APA to invest in making the databases federal so that you can see what a patient has filled in other states too. This is a major issue for small states, or cities close to state borders, for example, here in RI, I would say that half of my patients live in Massachusetts and fill their prescriptions in Mass, making the PMP ineffectual, the same is true in cities like Philadelphia or Chicago, where patients who are trying to obtain large amounts of prescribed controlled substances while evading the PMP will travel to NJ or IN respectively.
Best
Elie
Elie G. Aoun MD.
Psychiatry resident

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Improving the Efficacy of Prescription Drug Monitoring Programs
Action Paper Author(s): Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
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Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	1	-
Number of Staff	1	-
Number of Non-Staff	-	-
Total	**2**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	2	$850	$1,220	$200	$0	$2,270
Meeting 2	-	-	-	-	-	-
Total Travel Budget		850	1,220	200	-	2,270

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Preparing materials to lobby appropriate agencies		308
2	Preparing talking points for DBs		308
3		-	-
Total Staff Costs			616
		Total Author Estimate	**$2,886**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**-**	**-**	**-**	**-**	**-**

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			**-**
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Increasing the Opportunity for Involvement of Resident Fellow Members (RFMs) and Early Career Psychiatrists (ECPs) in the APA Assembly

WHEREAS:
RFM and ECP involvement in the Assembly ensures that psychiatry and the APA has strong future leadership.

A majority of RFMs and ECPs in the country are not aware that they have the opportunity to be a part of the Area Council, that a Council exists, and for many, that the Assembly exists.

Currently, it is not feasible to create a listserv for a specific group at the APA, and given the inability to tailor the listserv to individual communications

The Assembly Committee of Resident Fellow Members (ACORF) and the Assembly Committee of ECPs cannot have a listserv to communicate with District Branch RFMs/ECPs, Executive Directors of District Branches, and Residency Training Directors.

Given the current inability to tailor communications distributed through the APA to a specific Committee's preference, access to the database is tightly controlled. There is also no defined organizational structure for communications that would allow identification of the appropriate person who could filter and approve messages to be sent out to the list or to sub-lists.

Attempting to advertise as an Area RFM or Area ECP on open positions in the Area Council and Assembly has been inconsistent due to a breakdown of communication on a variety of levels outside the Council (level of the Executive Directors, District Branch RFMs/ECPs) due to varying degrees of participation.

Advertising opportunities for RFMs and ECPs should be made as simple as possible, with as few barriers as possible, so that the APA can be promoted as a fair and welcoming organization that looks to engage its young members.

Engagement of younger members can enhance member retention and improve leadership capability, which translates into future financial and organizational benefits for the association.

ECPs are specifically a group whose membership declines with time, and engaging this member early in their career can help keep them informed on the issues, develop a sense of responsibility to general member issues, help them with networking opportunities, and stimulate their interest in varying issues. This will ultimately lead to retention of membership though and beyond the ECP membership level.

BE IT RESOLVED:
That a description of Area RFM Rep/Dep Rep and Area ECP Rep/Dep be posted and clearly articulated on the APA website and the RFM handbook.

That the Area ECP Rep/Dep Rep position be advertised in the Member Benefit area of the website (in addition to other areas within the website), so as to promote engagement of the member in the organization as a benefit to the ECP member, which will ultimately boost membership.

That the basic application for Area RFM Rep/Dep Rep and Area ECP Rep/Dep Rep would be available for download on the APA website.

That the Membership and Elections Committee consider creating a uniform application for all Area RFM and one for ECP Rep and Dep Rep positions in the case that specific Areas have specific requirements outside the standard basics; and also to ensure that the implementation of future elections for these positions are more transparent, done in sensible timeframes, and that obstacles involved in applying are minimized.

That the APA use the existing listserv of Program Directors to target new faculty members that are recent graduates, so that information can be further distributed to more ECPs.

That the Chief-Resident listserv be used as a way to spread information to about-to-become ECPs on opportunities for Area ECP Rep/Dep Rep positions.

AUTHORS:
Sarit Hovav, M.D., RFM Representative, Area 4 anisarit@gmail.com
Lara Cox, M.D., APA Member
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Matt McDougall, M.D., APA Member
Justin Schoen, M.D., APA Member

ESTIMATED COST:
Author: $424
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: unable to determine at this time

ENDORSED BY: Nebraska Psychiatric Society, Assembly Committee of Resident-Fellow Members

KEY WORDS: Fairness and equality in voting, opportunity, RFM, ECP; communication; member benefits; diversity

APA STRATEGIC PRIORITIES: Diversity

REVIEWED BY RELEVANT APA COMPONENT: none

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title:	Increasing the Opportunity for Involvement of Resident Fellow Members (RFMs) and Early Career
Action Paper Author(s):	Sarit Hovav, M.D., RFM Representative, Area 4
Phone/email:	818-331-0233; anisarit@gmail.com
APA Admin. Name:	-
Phone/email	-

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	1	-
Number of Non-Staff	-	-
Total	**1**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:	
1	Create Basic Applications	231
2	Upload applications to website	39
3	Update website with information on roles of RFM Reps and ECP Reps	154
Total Staff Costs		424
	Total Author Estimate	**$424**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: A Psychiatric Response to Human Trafficking

WHEREAS:

The US Department of Health and Human Services has acknowledged human trafficking as the second largest and fastest growing criminal industry, and the International Labor Organization estimates that 20.9 million people are trafficked annually; and

Up to 95% of women who have been trafficked reported physical or sexual violence. Moreover, there are high rates of mental health diagnoses in this population with studies indicating that some trafficked populations have rates of PTSD as high as 77% and rates of depression as high as 76%; and

Studies indicate that 28-87.8% of human trafficking victims have been seen by a medical provider while in captivity; and

The needs of human trafficking populations are unique and complex as it can be difficult to differentiate between trafficking survivors and willing participants in the sex and labor industries, survivors are stigmatized and have sustained repeated (often daily) sexual and physical trauma and have often developed strong bonds with their traffickers; and

There is minimal scientific literature in regards to the education of psychiatrists regarding trafficking and the treatment of the needs of trafficking survivors; and

Healthcare societies across the country have issued position statements that human trafficking is a health issue including the American Public Health Association, American Academy of Pediatrics, American College of Obstetrics and Gynecologists, American Medical Association, American Women's Medical Association, American Nurses Association, American Psychological Association, and Emergency Nurses Association; and

The American Psychiatric Association has a commitment to improving access and quality of mental health services to individuals that need them.

BE IT RESOLVED:

That the American Psychiatric Association write a position statement acknowledging human trafficking as a public health issue which impacts the mental health of its victims and advocating for improved research and education surrounding issues of identifying victims and treating their mental health needs.

AUTHORS:
Steve Koh, M.D., ECP Representative, Area 6
Rachel Robitz, M.D., APA Member
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Lawrence Malak, M.D., ECP Deputy Representative, Area 6
Eraka Bath, M.D., APA Member
Kimberly Gordon, M.D., APA Member
Roya Ijadi-Maghsoodi, M.D., APA Member
Mariam Garuba, M.D., APA Member
Amy Gajaria, M.D., APA Member

ESTIMATED COST:
Author: $1,540
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: San Diego Psychiatric Society

KEY WORDS: Trauma, Clinical Practice, Human Trafficking

APA STRATEGIC PRIORITIES: Education, Diversity

CURRENTLY IN REVIEW BY RELEVANT APA COMPONENTS:
Council of Psychiatry and the Law
Council of Minority Mental Health and Health Disparities
Council of Children, Adolescents and their Families
Caucus of Women Psychiatrists

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: A Psychiatric Response to Human Trafficking
Action Paper Author(s): Steve Koh, M.D., ECP Representative, Area 6
Phone/email: shkoh77@yahoo.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Staff research, administrative support, advocacy, coordination of conference calls		1,540
2		-	-
3		-	-
	Total Staff Costs		1,540
		Total Author Estimate	**$1,540**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Pharmacists Substituting Medications with Similar Mechanisms of Action

WHEREAS:

1. The American Psychiatric Association[1] opposes the practice of therapeutic interchange of psychoactive medication, including the interchangeability of generic and brand medications, without the express consent of the prescribing psychiatrist, AND

2. In 2013, Arkansas legislature passed an Act[2] enabling prescribers to "authorize the pharmacist to substitute a *therapeutically equivalent* drug", AND

3. The Act modified the definition of "therapeutically equivalent," striking out the requirement for pharmaceutical equivalence and, instead, allowing for drug products "from the same *therapeutic class*", AND

4. The Act defined "therapeutic class" as "a group of similar drug products that have the same or similar mechanisms of action and are used to treat a specific condition", AND

5. The Act specified that the "pharmacist shall send notice of the substitution to the prescriber in writing or by electronic communication within twenty-four (24) hours AFTER the drug is dispensed to the patient".

Similar to the concept of "generic acceptable" authorization, this Act enables prescribers in Arkansas to authorize pharmacists to substitute medications with similar mechanisms of action, with dosages determined by the pharmacist, and with notification to *(and not necessarily in consultation with)* the prescriber AFTER the drug has already been dispensed. Amongst other concerns, this practice is not consistent with the doctrine of Informed Consent.

BE IT RESOLVED:
That the Joint Reference Committee refer this Action Paper to an appropriate APA Council to update the APA's 2009 "Position Statement on Medication Substitutions," incorporating such considerations as "therapeutic class" and/or "mechanisms of action," and to present the draft Position Statement to the Assembly in May, 2017.

[1] APA 2009 Position Statement on Medication Substitutions
http://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2009-Medication-Substitutions.pdf
[2] ftp://www.arkleg.state.ar.us/acts/2013/Public/ACT274.pdf

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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: none directly

ESTIMATED REVENUE GENERATED: none directly

ENDORSED BY: Executive Council, Arkansas Psychiatric Society, Area 3 Council, Area 5 Council

KEY WORDS: scope of practice, medication substitution, mechanism of action, therapeutic equivalence, pharmaceutical equivalence, pharmacist

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Pharmacists Substituting Medications with Similar Mechanisms of Action
Action Paper Author(s): Eugene Lee, M.D., FAPA, Representative, Arkansas Psychiatric Society
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Develop an APA White Paper on the Use of Patient Information Discovered in Targeted Internet or Social Media Searches

WHEREAS:
Patient targeted internet and social media searches (sometimes referred to as "patient targeted Googling") is when a psychiatrist searches online (to include Facebook, Spokeo, Twitter, Zillow, Whitepages.com, LinkedIn, YouTube, Mugshots.com, and other similar sites) for patient specific information;

Through this kind of review of the internet and social media the psychiatrist may learn about current and prior addresses, telephone numbers, educational history, work history, legal history, publications, blog posts, photos, videos, family information, and much more about their patient, some of which may be incorrect or gossip;

There may be NO ethical issue with the collection of information from the internet and social media as it is publically available, and could potentially help with the assessment of patient , including their safety and the safety of the public;

OR there may be ethical concerns that using information from the internet and social media may damage the psychotherapeutic relationship by breaking unspoken privacy boundaries. It may reduce the patient's feelings trust if not disclosed but then discovered by the patient. It may also be the result of unconscious motivators on the part of the psychiatrist, and potentially be a HIPPA violation;

The APA has an ethics opinion on "patient targeted Googling," and the opinion notes that it "should only be done in the interests of promoting patient care and wellbeing." However, it does not provide clear guidance on when (if) to use it when there is concern for violence risk – to member(s) of society or the psychiatrist. In the extreme, could a psychiatrist be held liable for failing to check the internet and social media in a person endorsing homicidal ideation who acts on that threat?

Nor does the APA ethics opinion discuss if different types of psychiatric practitioners should have different ways to proceed (e.g. a psychiatrist who sees patients just released from jail vs. a psychoanalyst with a long term relationship). More detailed APA guidance is needed on when and how to use the internet and social media clinically, and on how to precede once information about that patient from social media sources has been obtained including what documentation, if any, should be put in the chart;

BE IT RESOLVED:
That the APA assist the Ethics committee in developing a detailed white paper on patient targeted internet and social media searches to provide guidance on when (if) and how to use the internet and social media clinically, and disseminate the position statement to its members. In doing so (per request of the Ethics Committee) that the APA ask the Council on Communications to first lay out *what* types of technology are out there and are being used for patient targeted internet and social media

searches, and *how* these various types of technology are being used for such searches. Finally, that the Ethics Committee develop a white paper, and include at least two resident and /or early career psychiatrist consultants to assist in developing this white paper, as there may be generational differences in the thinking and approach to patient targeted internet and social media searches.

AUTHORS:
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Amela Blekic, M.D., Representative, Oregon Psychiatric Physicians Association
Megan Brown, M.D., APA Member
Neisha D'Souza, M.D., APA Member
Clara Ruiz, M.D., APA Member
Joshua Sonkiss, M.D., ECP Representative, Area 7
Craig Zarling, M.D., Representative, Area 7

ESTIMATED COST:
Author: $9,808 – Includes cost of two resident and/or early career consultants to attend one meeting of the Ethics Committee and staff costs of coordinating related meetings and production of document.
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Area 7 Council

KEY WORDS: Patient care, ethics.

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT (with attached comments as appropriate):

Committee on Mental Health Information Technology
Below is the summary of feedback from the committee's call last week.
Re the "Patient Targeted…Access to Patient Information via Targeted Internet or Social Media Searches":

- The title itself is unclear in its wording, but it also calls the proposed product a "White Paper," whereas "Action Paper" is in its title. This needs to be clarified, especially in light of the comments from the CMHIT. For example, one member suggested that this topic should be a white paper instead of an Action Paper because it's a highly complex and evolving topic. A good summary review of the literature would be more helpful than an Action Paper, per se. (Author: Title changed.)
- Another member chimed-in and suggested that the authors refer to either the AAMC or the AMA's guidelines/statements on guidelines for social media for physicians. (Author: Links to AMA and Federation of State Medical Boards statements were added to references, and a link

to an article from AAMC about the importance of developing guidelines was added, but I could not locate guidelines from them.)

- Finally, another member suggested that no matter how much guidance the APA produces on "Googling," that it might be a better idea to develop a position about patient identifying information in social media, in general, and how it might impact the patient-physician relationship.

I hope this is helpful. So, the topic is clearly of interest, though I was not on the call to clarify the whole action paper/white paper confusion that is obvious from the first comment. As to the second bullet, the last time I looked at the AMA's guidelines, they were not very helpful (such as maintaining separate professional and personal persona, which is mostly not even possible with Facebook, though you can effectively keep your people separate via privacy filters, etc).

The title needs some wordsmithing for clarity, and you'll probably want to identify a component in the Resolved to carry out the execution of the white paper. Grayson Norquist for Council on Quality suggested the Ethics Committee. I agree that they would be the best component to use. BTW, I note that in their opinion attached to your paper, they did not even address the issue of informing your patient that you found information on them on the internet. I believe this is important, in the same way that if a friend or family member of the patient provided you information, you would likely find a way to discuss that with your patient. (Author: Added comment to the "whereas" section.)

Personally, the only times I look on Facebook, etc, for patient-generated material is when they present to the ED, typically on an emergency petition basis, because they threatened to kill themselves on Facebook, or something similar. For an outpatient, if they know you are looking, then they may use that as a quasi-public channel for meta-communications with you, which is probably not what you'd want to encourage.

=Steve Daviss

Ethics Committee

The Committee agrees that this is an important topic, but also feels that it is difficult to address such a broad issue without more specificity, particularly because ethics questions are always so fact-specific. Therefore, the Committee suggests that in your "Be It Resolved" clause, you ask APA's Council on Communications to first lay out *what* types of technology are out there and are being used for patient targeted internet and social media searches, and *how* these various types of technology are being used for such searches. Then, (and this should all be included in the "Be It Resolved" clause), the Ethics Committee would develop parameters/guidelines to help psychiatrists consider the ethical issues involved with these various technologies in these scenarios. (Author: Added their request to the "be it resolved" clause.)

Committee on Psychiatry and the Law

#1 – The irony embedded in this action paper is that the authors' concern about psychiatrists being sued for failing to Google potentially violent patients will only come to fruition if such behavior reflects the standard of care. And one step in that direction would be for APA to develop a position statement on when psychiatrists should do it, as the authors are suggesting. Sometimes it's best to let sleeping dogs lie. That's what I'd do here.
#2 - #6 – Agrees with the above.

References

- American Medical Association, Opinion 9.124 – Profesionalism in the Use of Social Media (2010) http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9124.page
- Ashby GA, O'Brian A, Bowman D, Hooper C, Stevens T, Lousada E. Should Psychiatrists 'Google' their patients? BJPsych Bulletin 2015 39:278-83.
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- Federation of State Medical Boards, Model policy guidelines for the appropriate use of social media and social networking in medical practice, http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pub-social-media-guidelines.pdf
- Kisberg K. Spotlight: When Googling a patient raises ethical questions. https://www.aamc.org/newsroom/reporter/may2015/431966/googling-patient.html
- Mathy RM, Kerr DL, Haydin BM. Methodological rigor and ethical considerations in Internet-mediated research. PsychotherTheory Res Pract Training 2003;40:77–85.
- Styra R. The Internet's impact on the practice of psychiatry. Can J Psychiatry 2004;49:5–11.

Ethics Committee opinion on patient "googling", which is also available online at: http://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/Opinions-of-the-Ethics-Committee.pdf

A.1.h

Question: We have learned that our psychiatry residents routinely "google" their patients. On one recent occasion the resident discovered that an inpatient was on a most wanted list in another state for arson despite having denied a history of illegal behavior. Is it ethical to do a google search of your patient's name? What is the ethical response to learning through a google search that your patient is wanted by the police?

Answer: "Googling" a patient is not, in and of itself, unethical. First and foremost, the —googling of a patient should only be done in the interests of promoting patient care and wellbeing and never to satisfy the curiosity or other needs of the psychiatrist. Also important to consider is how such information will influence treatment, and how the clinician will ultimately use this information. The psychiatrist should ask him or herself these questions before resorting to a Google search. A clinician who routinely assumes information that cannot be verified as fact and directs treatment based on such information may be at risk for practicing incompetently. It is prudent to identify the source of information that is entered into a medical record.

The standard of practice for learning about a patient's medical condition is through face-to-face interviews, and this information may be supplemented by collateral information, e.g., medical records or family members. Refusal or inability by patients to provide important historical information is not uncommon; in this circumstance collateral data may assume an important role. —Googling a patient in such a scenario may provide useful information. However, information obtained this way, such as on a My Space website, may not be current or accurate, especially for clinical purposes. Similarly, newspaper articles may not be reliable. Information such as birth records and sex offender registration is more likely to be trustworthy. Whenever information is obtained through —googling, it is important to corroborate it. Reporting requirements vary state to state; those that supersede confidentiality regulations or laws are generally relevant to public safety. Every psychiatrist should become familiar with their State reporting laws. (2010)

Rev: 3/23/16

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Develop an APA White Paper on the Use of Patient Information Discovered in Targeted Internet or Social
Action Paper Author(s): Annette M. Matthews, M.D., Representative, Oregon Psychiatric Association
Phone/email: (503) 220-8262 x57003 / Annette.Matthews@va.gov
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	2	$1,275	$1,830	$200	$444	$3,749
Meeting 2	2	1,275	1,830	200	444	3,749
Total Travel Budget		2,550	3,660	400	888	7,498

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Coordinate e-mails and telephone conference calls.		2,310
2		-	-
3		-	-
Total Staff Costs			2,310
		Total Author Estimate	**$9,808**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**-**	**-**	**-**	**-**	**-**

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			**-**
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Eliminate Out Of Pocket Cost Barriers to Care for Patients with Severe, Persistent and Recurrent Disabling Mental Disorders

WHEREAS:
Whereas:
Mental disorders account for 20-40% of the Burden of Disease worldwide and mental disorders are treatable with significant reduction of pain, suffering, disability collateral damage to loved ones and economic impact to society when science based treatment is applied in a timely and appropriate manner, and;

Whereas:
Having access to insurance is not the same as access to health care and the phenomenon of increasing out of pocket costs for patients is creating a significant barrier to care with delayed, disrupted and deferred treatment resulting in increased severity of illness, disability and cost of care due to the requirement for higher intensity of care (e.g. ER, acute hospital, co-occuring medical illness and cost shifting) and; Ref. *CDC "Tracking Trends in HealthCare" March 2011.

Whereas:
Health care related personal debt is once again rising due to out of pocket costs contributing to an increase in personal bankruptcies, and;

Whereas:
CMS has recognized that with increasing out of pocket costs, greater medical costs, impairment and disabliity result from delayed and deferred adherence to appointments or prescribed medication regimens, particularly in patients with severe, persistent disorders, and;

Whereas:
It is recognized that over 50% of severe disabling mental disorders have onset in childhood or adolescence calling for early effective treatment of these disorders.

Whereas:
The public health impact and cost to society of undertreated or untreated, severe persistent and recurrent disabling mental disorders is similar to the impact of severe, persistent and recurrent medical disorders, and;

Whereas:
In May 2012 The Assembly passed Action Paper #12 C "Access to Care for Patients with Severe, Persistent Mental Illness And Disabling Recurrent Disorders" addressing this issue but it did not request a Position Statement. * See references

BE IT RESOLVED:
1. That APA will develop a Position Statement through the Council on Health Care Systems and Financing, asserting that Care Managing Entities, public and private, should waive or minimize co-pays, deductibles and share of costs for patients with severe, persistent and recurrent disabling mental disorders including child, adolescent and adult patient populations, (this is based on development of a Position Statement) and;

2. That the APA will advocate through legislative and regulatory lobbying and state legislative outreach, and;

3. That the APA, through its AMA delegation, advocate for a similar resolution for all patients with severe, persistent and recurrent disabling illness.

AUTHOR:
Joseph Mawhinney, M.D., DLFAPA, Representative, Area 6

ESTIMATED COST:
Author: $1,320
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

KEY WORDS: Out of pocket costs, Barriers to care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT:

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AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Eliminate Out of Pocket Cost Barriers to Care for Patients with Severe, Persistent and Recurrent Disabling
Action Paper Author(s): Joseph Mawhinney, M.D., Representative, Area 6
Phone/email: drmawhinney@sbcglobal.net
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	1	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**1**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$610	$100	$148	$858
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	610	100	148	858

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	take minutes of meeting		462
2		-	-
3		-	-
Total Staff Costs			462
		Total Author Estimate	**$1,320**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

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Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Encouragement of Senior Psychiatrists to Maintain Active Membership in APA

WHEREAS:
Whereas: Many older psychiatrists express frustration with the requirements by various entities to mandate their use of electronic medical records. This is also a huge financial burden for members in smaller practices.

Whereas: Costs for many older psychiatrists who continue in individual or small group practices often make it difficult for them to continue to maintain professional memberships in organizations such as APA. These psychiatrists often ask to change their membership status to INACTIVE or resign from the APA completely.

Whereas: Those of us who are making calls to members on the "drop-list" often hear the main reason for dropping membership is due to the cost. This is especially true for our senior members who start to reduce the number of patients that they continue to see. Losing our more senior members due to this reason is a loss to the APA of a valuable resource, and of dues revenue.

Whereas: It has been said that 70% of American psychiatrists in practice are age 55 or over.

BE IT RESOLVED:
The APA Membership Division looks back over their records for the last 5 years and determines:

1. The percentage of psychiatrists over the age of 55 who resign, fail to renew membership, or request Inactive Status

2. The percentage of psychiatrists who reach Life status who do not continue to renew membership until their 11th year of Life status, either by attrition or by death

3. How the loss of these members' dues revenues currently impacts the functioning of the APA and whether it would be worth changing the structure of the dues formula to charging Life Members in years 1-3 to two-thirds of dues and 4-6 to one third of dues and making the 7th year on as free membership. This would almost certainly be useful in maintaining more senior members as it would mean 4 less years of dues that need to be paid. Continuing their membership would generate more income when they continue to participate in APA meetings as qualified members, rather than not participating.

AUTHORS:
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Sarit Hovav M.D., RFM Representative, Area 4
Jon Dunn, M.D., Representative, Ohio Psychiatric Physicians Association

ESTIMATED COST:
Author: $3,080
APA:

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Life Members, Dues

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Encouragement of Senior Psychiatrists to Maintain Active Membership in APA
Action Paper Author(s): Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Looking at the last 5 years membership records to extract data needed to see percentage of those over 55 who dropped membership		1,540
2	Looking at the last 5 years membership records to see what percentage of life members continue to life member 11		1,540
3		-	-
	Total Staff Costs		3,080
		Total Author Estimate	**$3,080**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**-**	**-**	**-**	**-**	**-**

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		**-**
		Total Administration Estimate	**$0**

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May 13-15, 2016

ACTION PAPER

TITLE: Enhancing Ethical Knowledge of APA Members

WHEREAS:
Whereas: The American Psychiatric Association is proud of its long history upholding the highest ethical standards in the performance of the practice of psychiatry, as evidenced in part by our explicit stance against torture.

Whereas: The American Academy of Child and Adolescent Psychiatry requires since 2008 attestation to the performance of 1 credit of continuing education in psychiatry with an ethical focus every 2 years in order to renew membership.

Whereas: Several of the educational activities during the Annual Meeting of the APA could already be labeled as dealing with ethics in practice.

BE IT RESOLVED:
The American Psychiatric Association makes its support of the importance of ethics by emulating the AACAP and requiring that 1 credit of continuing education in psychiatry with an ethical focus be required every 2 years. This would be monitored just by attesting to it on your renewal form.

The APA offers several different options endorsed to confer such credit at its Annual Meeting each year.

The APA develops an educational activity that can be performed online for credit with an ethical focus and that this activity be offered for free to members as one of the monthly free courses offered online and that this course be updated at least every 2 years.

AUTHORS:
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Mark S. Komrad M.D., Representative, Southern Psychiatric Association
John M. de Figueiredo M.D., Representative, Connecticut Psychiatric Society
Sarit Hovav M.D., RFM Representative, Area 4
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ESTIMATED COST:
Author: $308
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY:

KEY WORDS: Membership, Ethics Education

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENTS:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Enhancing Ethical Knowledge of APA Members
Action Paper Author(s): Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Phone/email: eileen@themcgees.net/ 440-478-4934
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Changing the form to pay dues yearly		77
2	Posting a course on the web		231
3		-	-
	Total Staff Costs		308

Total Author Estimate	**$308**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-

Total Administration Estimate	**$0**

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Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: APA Takes a Neutral Stand on Physician Aid in Dying

WHEREAS:

1. **Definition.** Physician aid in dying (sometimes termed physician-assisted suicide or death with dignity) refers to a process by which a physician can prescribe, and a mentally capable adult with a terminal illness and less than six months to live can self-administer, aid-in-dying medication provided that specific requirements are met (see below).[1]

2. **U.S. Experience to Date.** Physician aid in dying is authorized in five states through either a ballot referendum (Oregon[2] - 1994 ballot with implementation in 1997; Washington[3] – 2008 ballot & implementation), the legislative process (Vermont[4] – 2013 passage and implementation; California[5] – 2015 passage with implementation likely in 2016), or court decision (Montana[6] - 2009).

3. **Consideration in Other States.** Many other states, including Colorado, Connecticut, New York, New Jersey, Maryland, Minnesota, and Nebraska are considering similar legislation.

4. **Protections for Patients and Providers.** All the states with regulations controlling the processes surrounding physician aid in dying have a similar core set of protections for patients and healthcare providers, including
    a. The Patient
        i. must be an adult
        ii. must have a terminal illness likely to lead to death within six months
        iii. must be mentally capable of making informed healthcare decisions
        iv. must be capable of self-administering the aid-in-dying medication
        v. must initiate the process and make multiple requests
        vi. may rescind the request at any time and decide whether and when to self-administer the medication

    b. The Attending Physician
        i. may elect to participate or not
        ii. must determine that the patient meets all qualifications and eligibility criteria

[1] President Renée Binder, MD column on physician aid in dying: http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.1a1
[2] Oregon Statute: https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx
[3] Washington Death with Dignity Act: http://app.leg.wa.gov/rcw/default.aspx?cite=70.245
[4] Vermont Patient Choice and Control at End of Life Act: http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf
[5] California End-of-Life Option Act: https://legiscan.com/CA/text/ABX215/2015
[6] Montana Court Ruling: http://aclumontana.org/wp-content/uploads/2013/10/baxteropinion.pdf

iii. must determine that the patient has the capacity to make medical decisions and is not suffering from a condition that may cause impaired judgment; if the physician is unable to determine that the patient has mental capacity, the Attending Physician must refer the patient to a mental health professional for a mental health assessment.
iv. must inform the patient of end-of-life care alternatives

c. A Consulting Physician, who may elect not to participate, must medically confirm the patient's terminal illness, prognosis and capacity, or if the consulting physician is unable to determine the patient's mental capacity, refer the patient to a mental health professional for a mental health assessment.

d. A Psychiatrist or Psychologist, who may elect not to participate, must determine that the patient has the capacity to make medical decisions and is not suffering from a condition causing impaired judgment.

e. All health care providers. No person can be subjected to civil/criminal liability or professional disciplinary action for good faith compliance with the statute, and good faith actions are not considered neglect.

5. **Clinical Criteria.** Academic healthcare organizations in Oregon, Washington and elsewhere have developed clinical criteria to ensure that the process addresses the needs of all parties and prioritizes quality of care and professionalism.[7,8,9]

6. **Extensive Data Documenting Processes**. States that already have physician aid in dying, particularly Oregon and Washington, have collected extensive data documenting how the process has worked.[10,11]

7. **No Evidence of Abuse**. After more than 30 years of combined experience in the four states that have physician aid in dying, there is no evidence of abuse of or coercion of individuals who have not wanted aid in dying. Disability Rights Oregon, the state's Protection & Advocacy (P&A) System for 37 years, ". . . has still not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act."[12]

8. **The Ability of Attending and Consulting Physicians to Determine Need for Mental Health Evaluation**. Within our existing medical standard of care, attending physicians routinely evaluate a patient's capacity to make informed healthcare decisions, including end-of-life decisions such as whether to voluntarily stop intake of fluid and nutrition or to accept or remove

---

[7] The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals. https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf
[8] Implementing a Death with Dignity Program at a Comprehensive Cancer Center. . http://www.nejm.org/doi/full/10.1056/NEJMsa1213398#t=articleTop
[9] J Palliative Medicine Guidelines. http://online.liebertpub.com/doi/pdf/10.1089/jpm.2015.0092
[10] Oregon Data: https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx
[11] Washington Data: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct
[12] Disability Rights Oregon. https://droregon.org/

a feeding tube. Attending physicians are experts in determining mental capacity and informed consent and are in the best position to determine if a patient needs additional evaluation by a mental health professional.

9. **Previous *Amicus* Briefs Opposed Physician Aid in Dying Despite the Absence of an APA Policy.** In 1996 the APA, the American Medical Association (AMA), and several other groups filed *amicus* briefs in two important cases before the U.S. Supreme Court**,** arguing against the right to physician aid in dying.[13] The APA filed its brief without an official policy on physician aid in dying, resulting in an unclear position for the past 20 years.

10. **AMA Policy Opposes Physician Aid in Dying.** In 1996 the AMA developed an updated policy strongly opposed to physician aid in dying, and has not changed it since.[14]

11. **California Medical Association (CMA) Position**. The CMA recently changed its position from opposing physician aid in dying to a neutral position, stating that "The decision to participate in the End of Life Option Act is a very personal one between a doctor and their [sic] patient, which is why CMA has removed policy that outright objects to physicians aiding terminally ill patients in end of life options. We believe it is up to the individual physician and their [sic] patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage."[15]

12. **Survey of Psychiatrists in Maryland.** A recent survey of psychiatrists in two Maryland counties showed that 74% wanted their professional society to either support or take a neutral position regarding physician aid-in-dying legislation.[16]

13. **Physicians Protected.** Physicians who participate in physician aid-in-dying processes in those states where it is authorized are protected if they operate in good faith under the regulations.

BE IT RESOLVED:

The APA takes a "neutral" stand on physician aid in dying, that is, the APA believes that the decision to participate in physician aid in dying is a personal one that is best left to a physician and his/her patient with a terminal illness.

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[13] Amicus briefs filed in Vacco v. Quill and Washington v. Glucksberg: http://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/amicus-briefs

[14] AMA Code of Medical Ethics. Opinion 2.211. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page?

[15] California Medical Association Changes Position: http://www.cmanet.org/news/detail/?article=cma-changes-stance-on-physician-aid-in-dying

[16] The Suburban Maryland Psychiatric Society, a Chapter of the Washington Psychiatric Society, recently surveyed its members' positions on a bill before the Maryland legislature to allow aid in dying. The results: 50% thought SMPS should support the bill, 24% thought SMPS should take a neutral stand, and 26% opposed the bill.

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Molly Strauss, M.D., DLFAPA, APA Member
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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: physician aid in dying, physician-assisted suicide, death with dignity

APA STRATEGIC PRIORITIES:

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: APA Takes a Neutral Stand on Physician Aid in Dying
Action Paper Author(s): Elizabeth Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

Description:		
1	-	-
2	-	-
3	-	-
Total Staff Costs		-
	Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Disapproval of the Detention of Central American Asylum Seeking Children and Families in Need of International Protection

WHEREAS:
Whereas, asylum seeking children and families from Central America are placed in detention centers upon arrival in the United States.

Whereas, the vast majority of these children and families are fleeing from extreme violence in their country of origin and many have been traumatized in their homeland, during their perilous journey, and during their period of detention.

Whereas, the containment centers run by for-profit prison companies are filled with traumatized strangers; separate detainees from family in the US; and impede healthy child development.

Whereas, the uncertainty of their future; fear of being returned to a place of violence and retaliation, and the daily exposure to others who are extremely distressed places children and mothers in a highly stressful environment in which many experience re-traumatization.

Whereas, adverse childhood experiences (ACE) have been linked to serious physical and emotional illnesses in adults and to many of the leading causes of death in adults and the effects of ACEs are cumulative.

Whereas, repetitive, chronic trauma may negatively affect the developing brain and this is especially true when the trauma occurs within the care giving system.

Whereas, in the detention centers there have been reports of detainees experiencing posttraumatic stress disorder, depression, and suicidal ideation with mental health needs being inadequately addressed.

Whereas, the APA is an organization that advocates for those in need of mental health services, supports the prevention of mental illness, and opposes discrimination in those in need of care,

BE IT RESOLVED:
That the APA develop a position statement that the APA does not approve of the detention or deportation of asylum seeking children in need of international protection and advocates for the appropriate mental health services for these children and families.

AUTHORS:
Brooke Parish, M.D., Representative, Psychiatric Medical Association of New Mexico
Lane Leckman, M.D., APA Member
Mary DeLuca, M.D., APA Member

Carol Larroque, M.D., APA Member

ESTIMATED COST:
Author: $154
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: (Area Chapter of APA) Psychiatric Medical Association of New Mexico and Area 7

KEY WORDS: Repetitive Trauma, Adverse Childhood Experiences, Child Development

STRATEGIC PRIORITIES:

REVEIWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Disapproval of the Detention of Central American Asylum Seeking Children and Families in Need of
Action Paper Author(s): Brooke Parish, M.D., Representative, Psychiatric Medical Association of New Mexico
Phone/email: parish_brooke@yahoo.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Adminstrative costs related to accomplishing the paper		154
2		-	-
3		-	-
Total Staff Costs			154
		Total Author Estimate	**$154**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Allow Deputies to Vote

WHEREAS:
1. There are duly-elected Members of the Assembly who are allowed to speak, but not to vote: Seven Deputy Representatives of the Minorities, seven Deputy Representatives of ECPs, and seven Deputy Representatives of RFMs.

2. The number of APA Members that an Assembly Member represents is quite variable. Some speak for less than a hundred, others speak for over five thousand [AACAP Liaison]. Having the deputies' vote doesn't alter that variability meaningfully.

3. One of the rationales to having deputies of the ECP psychiatrists and RFM psychiatrists not vote is that they are "overwhelmed" at the complexity of the Assembly process and need a year to get seasoned. They are no more "overwhelmed" than many a representative joining the Assembly for the first time and having a vote immediately. [Actually, the RFM and ECP Deputy's learning curve is probably superior to most coming into the Assembly.]

4. There is no evidence that allowing these leaders of their constituencies to vote would be detrimental to the APA. None.

6. This Action Paper has no costs implications because it only allows Deputies who are otherwise attending the Assembly to vote.

7. It is unseemly for the Assembly not to allow the leaders of their constituencies to vote. The Assembly should have a climate of equality and openness.

BE IT RESOLVED:
1. That the Assembly allows its elected Deputies to vote.

2. Refer to the Assembly Procedures Committee to change the procedures to where the Assembly allows its Deputies to vote.

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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society, January, 2011

KEY WORDS: Deputies, a climate of equality, respect for the members

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Allow Deputies to Vote
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Costs would be within meetings already acheduled. No change in deputy status other than can vote.		-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Coding Suicidal Ideation

WHEREAS:

1) Suicidal ideation is common and an important focus of psychiatric care;

2) Suicide is the 8th leading cause of death in the US;

3) DSM-5 has suicidal ideation in only four of its criteria sets: Major Depressive Disorder, Bipolar I Disorder, Bipolar II Disorder, and Depressive Episodes with Short-Acting Hypomania. Yet suicidal ideation is seen in almost all psychiatric conditions, and is very common in some, such as OCD [>50%] and Dissociative Identity Disorder [>70%]. Even DSM-5's Suicidal Behavior Disorder excludes suicidal ideation if there have been no suicidal acts;

4) Treating patients with suicidal ideation must include addressing the ideation in addition to whatever other symptoms the patient has. Managing this condition requires one to consider this symptom on its own, not limit one's thinking to the syndrome of which they might be part -- and sometimes it is not part of a syndrome;

5) The rest of medicine has Suicidal Ideation as a symptom with code R45.851 in ICD-10-CM;

6) Despite this importance of suicidal ideation, the APA is not urging its identification as to nomenclature and coding;

7) For both clinical and research reasons, it is desirable that Suicidal Ideation be fully recognized by clinicians;

8) See attached "Syndromal Issues with Suicidal Ideation."

BE IT RESOLVED:
That the APA urge use of "Suicidal ideation - R45.851" whenever it is present in order to increase the focus on this symptom;

That the next edition of the DSM list "Suicidal ideation - R45.851."

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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Pennsylvania Psychiatric Society

KEY WORDS: suicidal ideation, DSM-5, coding

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT: Sent to Assembly DSM component.

Attachment:

Syndrome Issues with Suicidal Ideation

DSM-5's focus on syndromes, rather than symptoms, has two major problems relative to suicidal ideation:

1] Placing suicidal ideation inside three syndromes -- major depressive disorder, bipolar disorder, and borderline personality disorder -- but not in other some other major disorders where suicidal ideation is very prominent, such as PTSD, OCD, and DID, is misleading. Suicidal ideation is a major clinical issue outside those three disorder. Furthermore, with 25% of all suicides being associated with people who are legally intoxicated, it would seem important that suicidal ideation be noted in people with alcoholism.

2] Burying suicidal ideation in the three disorders supra makes it difficult to draw conclusions as to cause or treatment of suicidal ideation. Those disorders have large number potential symptoms. Major depression has 170 different possible combinations of symptoms [much larger number of possible combinations if one includes specifiers] and Borderline personality disorder has 256 possible combinations. Bipolar I with both manic and depressive episodes has an astronomic number of possible symptoms. Using borderline personality disorder as an example, how is a clinician to apply the results of a study on borderline personality disorder when that disorder comes in 256 varieties? How would the clinician know whether a study on borderline is relevant to her borderline patient with suicidal ideation when only about a fifth of the 256 possibilities have suicidal ideation?

Two NIMH Directors and others have said that psychiatry has advanced little in recent decades, and they have indicated that the DSMs may be the problem. I am suggesting more specifically that DSMs syndromal approach may be the problem.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Coding Suicide Ideation
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Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	AP will be part of meetings already scheduled.		-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Exercise: Too Little, Too Much

WHEREAS:
1] One of the most important behaviors as to mortality and morbidity is physical exercise. It would be difficult to name a DSM-5 condition that contributes to more mortality than lack of physical exercise. Tobacco use is the main contender.

2] "Lack of physical exercise" is listed in ICD-10-CM with code Z72.3.

3] It would be desirable to have a word for lack of physical exercise and definition of such. Addressing overeating, for example, has benefitted from having a medical term, "obesity," and having a way of measuring obesity, BMI.

4] Lack of physical exercise, Z72.3, while available to all of medicine, is not listed in DSM-5.

5] "Exercise addiction" is a mental condition that can lead to significant morbidity and mortality.

6] Exercise addiction is not listed in DSM-5.

7] "Exercise addiction" may not be the ideal term for those whose exercising is pathological.

BE IT RESOLVED:
1] That the Assembly establish a component of volunteers, appointed by the Speaker [can include non-Assembly APA Members], to propose to the Assembly by November, 2016:

a] a term and definition for lack of exercise.
b] a term and definition for too much exercise

2] That these volunteers use their own resources to meet electronically and prepare their proposals, that APA Headquarter resources not be used, except to the degree APA staff may want to attend.

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ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society, 2016

KEY WORDS: Exercise

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Exercise: Too Little, Too Much
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Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Discussion of this Action Paper will occur during meetings already scheduled.		-
2		-	-
3		-	-
Total Staff Costs			-

Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Inclusion of Racism in ICD-10-CM and DSM 5

WHEREAS:
1) APA's Strategic Priorities include eliminating health inequities based on bias, prejudice, xenophobia, and racism;

2) The APA adopted the Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health in July 2006 (1);

3) The 2006 APA Resolution defined racism as a set of beliefs and practices that (1):

- assume genetic differences between various groups;
- result in systemic social, economic, and political advantage of one group over another;

4) Racism is multifactorial and may be a symptom or learned behavior in an individual without psychopathology, and it may be a manifestation of narcissistic disturbance or a delusional process in others (1,2,3);

5) Acknowledged and unacknowledged bias and racial discrimination are known factors leading to mental health disparities and inequities;

6) Racial and ethnic bias in clinicians may result in misdiagnosis, denial of treatment, ineffective treatment, and poor clinical outcomes;

7) Some patients with learned racist beliefs, behavior, and mental health disorders may respond positively to mental health treatment (4);

8) Racially motivated violence has trans-generational psychological consequences for both perpetrators and victims and their families and communities;

9) Widespread media coverage of racially motivated violence increases the risk of copycat incidents (5); and

10) ICD-10-CM currently includes Z codes as factors influencing health status, e.g., "social exclusion and rejection" (Z60.4) and "target of (perceived) adverse discrimination and persecution" (Z60.5), but does not include a code for racism;

BE IT RESOLVED:
1) That the APA will request the adoption of a new Z-code Z60.8, "the object of racism" for ICD-10-CM;

2) That the APA will appoint a DSM Study Group to study the spectrum of racism as a symptom and learned behavior sometimes manifesting as mass hysteria, and as a mental health disorder characterized by pathological bias, narcissistic disturbance, and a variant of a delusional disorder;

3) That this Study Group will include psychiatrists, forensic psychiatrists, psychoanalysts, psychologists, legal experts, and other mental health clinicians to examine the potential societal impact that the use racism as a mental health disorder will have on criminal defense efforts, i.e., potential exoneration for criminals found not guilty by reason of insanity;

4) That the APA will consider the appropriate placement(s) of racism for inclusion in DSM 5 and future versions of DSM;

5) That the APA will request federal funding to study the neuroscience of race-based aggression including the study of aggressors and the objects of aggression;

6) That the APA will support enhanced member and public education about racial discrimination, race-based violence and race-based homicides through guidelines for residency training, continuing medical education programs, and media outreach.

AUTHORS:
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Veronica Slootsky, M.D., APA Member

ESTIMATED COST:
Author: $5,110
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society, Black Psychiatrists

KEY WORDS: Diagnosis, DSM 5, ICD-10-CM, Racism, Discrimination, Health Inequities

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Inclusion of Racism in ICD-10 and DSM-5
Action Paper Author(s): Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	10	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**10**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	10	$2,975	$2,135	$0	$0	$5,110
Meeting 2	-	-	-	-	-	-
Total Travel Budget		2,975	2,135	-	-	5,110

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$5,110**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Increasing Members' Involvement in APA Policy

WHEREAS:
1. To the degree practical, the APA should facilitate Members involvement in policy decisions.

2. While usually deciding on policy is not a "yes" or "no" decision, at times, the APA has to decide on a policy which is "yes" or "no." For example, whether to support legislation before Congress, legislation which is not within APA's reach to amend.

3. Through electronic communicating, it is practical to have Members express their opinion rapidly.

BE IT RESOLVED:
That the Assembly Executive Committee explore the feasibility of having APA Members vote on an issue facing the APA through electronic voting and report back to the Assembly at the November, 2016, meeting.

AUTHORS:
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Elizabeth Morrison, M.D., DFAPA, Representative, Washington Psychiatric Society
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Natalie Velasquez, M.D., APA Member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society, 2016

KEY WORDS: Members Voting, Democracy

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Sent to Assembly Committee on Procedures

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Increasing Members' Involvement in APA Policy
Action Paper Author(s): Roger Peele, M.D., DFLAPA, Representative, Washington Psychiatric Society
Phone/email: RogerPeele@aol.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Will be discussed at meetings already scheduled.		-
2		-	-
3		-	-
Total Staff Costs			-

Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Develop an APA Position Statement Regarding the Ethical Tensions Faced by Psychiatrists Serving as Third Party Utilization Management Reviewers under the Parity Law

WHEREAS:
Whereas the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or parity law) requires that treatment for mental and substance use disorders be covered without quantitative or non-quantitative limitations that are more stringent than those applied for medical and surgical care;

Whereas implementation of the parity law is incomplete, but case law will eventually establish clarity about which mental health and substance use disorder utilization management limitations are clearly outside of the requirements of the parity law;

Whereas in late 2015 the APA Ethics Committee answered questions put to it by the authors of this action paper (based on the assumptions that medical necessity is not an issue and that the utilization management review [UR] standards are known to be out of compliance with the terms of the parity law): "*In our [the Ethics Committee] opinion, the questions posed can be distilled into one; does the [non-treating] psychiatrist working as a managed care or utilization reviewer owe primary obligation to the patient or to the plan?*";

Whereas the Ethics Committee answered this question in a way that is concisely captured in the following statement from their report (full report is attached): "*In our opinion, the psychiatrist managed care or utilization reviewer owes his primary obligation to the managed care company and a secondary one to the patient*.";

Whereas this Ethics Committee response suggests that the "primary obligation" to the managed care company allows the managed care psychiatrist to apply such theoretically parity violating utilization review standards to the patient's care, with only "secondary" ethical concern about the needs and rights of the patient under parity;

Whereas the Ethical Annotations for Psychiatry state in multiple sections that a psychiatrist has an ethical obligation to patients in general and to the public at large;

Whereas the December 2015 APA Commentary on Ethics in Practice, available on the APA web site (attached), states in Topic 3.4.1 on "*Working within organized systems of care*," which explicitly includes psychiatrists who "*work for third party payors,"* that *"In these systems, other values often compete with the interests of the individual patient. The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care cannot wholly ignore the needs of patients.*";

Whereas the Ethics Committee stance can be read as suggesting there is an ethical hierarchy in which business needs (i.e., application of UR standards known to be outside the parity law) are primary and

professional needs are secondary, while the Commentary on Ethics in Practice suggests there is an ongoing tension between competing business and professional interests so that ethical concerns require the balancing of these competing interests by the utilization review psychiatrist in every case;

Whereas respected psychiatrist ethicists Paul Appelbaum, Steven Sharfstein, and Laura Roberts, when consulted about this issue via email, telephone and/or personal contact, shared the concern that the Ethics Committee opinion seemed potentially inconsistent with the Commentary on Ethics in Practice (e.g., as Laura Roberts said in a personal communication, "Professionalism trumps business, not the other way around.");

Whereas a 75 minute conference call including the first author of this action paper, Ezra Griffith, Ethics Committee Chair, and Rebecca Brendel, lead author of the Commentary on Ethics in Practice, led to agreement that [1] the 2015 Commentary on Ethics in Practice represents the official ethical position of the APA, [2] it was the intent of the Ethics Committee in its response to be fully consistent with the Commentary on Ethics in Practice, and [3] that use of the terms "primary" and "secondary" could be misleading to readers of the opinion who were not part of the Ethics Committee discussions of the matter, as the committee did not intend to imply a hierarchy of importance.;

BE IT RESOLVED:
1. That the Board of Trustees shall create a committee to develop a position statement regarding the ethical tensions faced by psychiatrists serving as managed care utilization reviewers, or as managed care medical directors developing utilization review management standards.

2. The committee shall include members of the Council on Healthcare Systems and Finance, the Committee on Managed Care, and psychiatrist ethicists familiar with the 2015 Commentary on Ethics in Practice.

3. The position statement shall define and elaborate the ethical tensions, described in the 2015 APA Commentary on Ethics in Practice under Topic 3.4.1, that are encountered by psychiatrist utilization management reviewers and managed care medical directors, with special regard to the implications of the parity law on these tensions.

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ESTIMATED COST:
Author: $3,850
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Parity, Ethics, Utilization Review

APA STRATEGIC PRIORITES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Not at this time.

AMERICAN PSYCHIATRIC ASSOCIATION

APA Commentary on Ethics in Practice

December 2015

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Ad Hoc Work Group on Revising the Ethics Annotations

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Robert Weinstock, MD

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Laura Roberts, MD

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Section 1. Introduction

Ethical conduct by psychiatrists requires more than mere knowledge of ethics principles. It also requires that psychiatrists consistently apply that knowledge in their day-to-day professional activities. This assures that ethically sound judgment is exercised and the actions that follow fall within accepted ethical bounds. Important to the ethical practice of psychiatry are the abilities: 1) to recognize ethical aspects of a professional situation; 2) to reflect on one's role, motives, potential "blind spots", and competing or conflicting interests; 3) to seek out, critically appraise, and make use of additional knowledge and valuable resources, e.g., clinical, ethical, or legal information; 4) to systematically evaluate the ethical aspects of a professional situation and identify possible courses of action; and 5) to create appropriate safeguards in an ethically complex situation. Moreover, obtaining additional data, seeking appropriate consultation or supervision, maintaining clear professional boundaries, and separating roles that may pose conflicts are all actions that can help ensure ethical decision-making and minimize the likelihood of ethical breaches.

This document is intended to assist psychiatrists in understanding and applying the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry to their practice.

Uses of this document

This document is written for psychiatrists who serve in many roles. It may be of particular value to individual psychiatric practitioners in their clinical activities. It may also be helpful to teachers and academic psychiatrists as they convey expectations regarding ethical conduct to the next generation of physicians.

This document is intended to aid in understanding the complexity of psychiatric ethics and how they apply in different situations. It is not a "rule book" but rather a tool. It is not intended to cover all ethically important situations and novel ethical questions that psychiatrists may encounter in the course of their careers. It is not intended for the resolution of courtroom disputes, which apply legal rather than clinical standards and values, nor is it intended to undermine ethical practitioners serving in communities where scarce mental health resources call for flexibility. Furthermore, it cannot fully capture all of the circumstances that alter the ethical nature of a particular decision or action.

This document emphasizes the importance of ethical skills as well as knowledge of ethical principles and their application to psychiatric practice; however, it is only as good as the integrity and judgment of those who use it.

Section 2. Ethical principles in the professional practices of psychiatrists

By focusing on:

- The ethical basis of the physician-patient relationship;
- Ethically important practices in psychiatric care;
- The ethical basis of relationships with colleagues; and
- Other ethically important topics in psychiatric practice,

this document highlights ethical principles that find expression in the professional practice of psychiatrists in their various roles and activities. Knowledge of ethical principles will allow psychiatrists to respond to complex and novel situations with an understanding of their ethical implications and to make ethically-sound decisions.

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Section 3. Practice Domains

3.1: The ethical and professional basis of the physician-patient relationship

Topic 3.1.1 *The physician-patient relationship*

The physician-patient relationship is the cornerstone of psychiatric practice, and its goal is to promote patient health and well-being, embodying the key ethical considerations of respect for persons, fairness, and beneficence. Patients often lack medical expertise and sometimes struggle with symptoms that adversely affect their autonomous decision-making; the psychiatrist is responsible for rendering medical care in the patients' best interest while respecting the patient's goals and autonomy.

The physician-patient relationship is a collaborative endeavor between two autonomous individuals who establish the professional relationship for the benefit of the patient. Every effort should be made to have the relationship begin by mutual consent. Psychiatrists should be cautious in interactions with persons who are not (or not yet) patients to avoid rendering input, advice, or other suggestions that might lead to the assumption or expectation that a treatment relationship has begun. These early conversations can occur over the phone or through other media. Especially as new consultative roles are emerging for psychiatrists, psychiatrists should ensure clarity of role for themselves, colleagues, and patients in a given system or treatment of a patient to ensure the highest standard of care. The relationship may include a child's parent or guardian, next of kin, an adult's legally recognized substitute decision-maker, or anyone a competent patient invites to participate. For patients lacking competency, psychiatrists should still consider requests to include persons important to the patient in the treatment in consultation with the patient's substitute decision maker. The relationship may continue for as long as an illness persists or until a patient either transfers his or her care to another clinician or chooses to end treatment. Because psychiatric patients share sensitive and intimate details of their lives with the psychiatrist, psychiatric patients may be especially vulnerable to undue influences and the psychiatrist should be sensitive and careful that his/her conduct does not physically, sexually, psychologically, spiritually or financially exploit or harm the patient.

There may be times when the physician-patient relationship is difficult and when the therapeutic alliance erodes. The psychiatrist should try to find ways to improve the relationship by working with the patient jointly to establish parameters that would enable treatment to continue; sometimes a consultant can be helpful. If the relationship cannot be repaired, or the parties cannot abide by the conditions agreed upon, the physician may transfer the patient's care to another clinician, or the patient may terminate the psychiatrist. In either case, the psychiatrist should cooperate with the patient's request to release files and/ or share information with contemporaneous and subsequent treating physicians.

Topic 3.1.2 *Professionally competent care*

Professional competence is the ability to apply clinical knowledge and to provide care within the accepted standards of clinical practice, which includes providing appropriate expertise as well as adequate time and attention to meet each patient's needs responsibly. Professionally competent care at times may involve the consideration and use of innovative treatments, consulting with other physicians, and practicing only within one's field of expertise.

In a rapidly evolving and diverse field such as psychiatry, competent practice is influenced by advances in a variety of disciplines, including the behavioral, social, and biological sciences, and by religion, and the complex social and economic contexts of practice. Obtaining and

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maintaining knowledge and skills sufficient for competent professional practice requires attention throughout a psychiatrist's career.

Psychiatrists should maintain professional competence through continuing education, supervision, and/or consultation. Psychiatrists should practice within the bounds of their competence as reflected in their training, education, and professional experience, all of which is kept current through continuous education and practice. Psychiatrists should make referrals or delegate care only to persons who, based on their training and experience, are in the psychiatrists' reasoned judgment, competent to deliver the necessary treatment.

Topic 3.1.3 *Dual agency and overlapping roles*

By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients. The terms "dual agency," "dual roles," "overlapping roles," and "double agency" refer to these competing obligations. Psychiatrists may have competing duties to an institution (e.g., employers, the judicial system, or the military) and to an individual patient, or to two patients or two institutions.

The treating psychiatrist has a primary, but not absolute, obligation to the patient. Wherever possible, the treating psychiatrist should strive to eliminate potentially compromising dual roles by attending to the separation of their work as clinicians from their role as institutional or administrative representatives. However, as the medical system becomes increasingly complex, it is critical for psychiatrists to recognize that not all competing obligations may be resolved. Psychiatrists should remain committed to prioritizing patient interests as treating physicians, expecting that they will find themselves in the position of having to reconcile these interests against other competing commitments and obligations.

Psychiatrists should inform patients about the potential for competing obligations within the treatment or other non-clinical evaluation, such as a forensic evaluation. At a minimum, the psychiatrist should inform the person being treated as a patient or evaluated for another purpose of the purpose of the clinical encounter or evaluation, the limits on confidentiality of the treatment/ examination, and the parameters of the relationship between the physician and the patient or evaluee. (e.g., who requested the examination/evaluation, whether an ongoing relationship will occur, and, if so, the parameters/expectation of that relationship).

Treating psychiatrists should carefully reflect on the situation when asked to serve as a forensic expert or witness on behalf of a patient under their care. There are many considerations, including the loss of confidentiality between doctor and patient, the potential for the psychiatrist to provide testimony that is adverse to the patient upon cross examination, and the ability of the treatment relationship to continue after the psychiatrist has testified, perhaps having said some things that, while honest, were not to the patient's liking. The central principle in the psychiatrist's decision about whether to testify and/or serve as an expert for the patient is the patient's overall interest and wellbeing. At a minimum, psychiatrists should carefully address with patients that there is a balance that must include weighing the risks and benefits of testifying and not testifying. (For example, if a psychiatrist does not testify, a patient may have no realistic chance of securing deserved disability benefits.) Psychiatrists should be sure to include a candid discussion of the potential risks of unintended outcomes, the lack of scientific precision in the legal process, and the potential for an adverse decision.

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3.2: Central ethical and professional practices in psychiatric care

Topic 3.2.1 *Confidentiality*

Medical confidentiality is the physician's obligation to his or her patient not to reveal the patient's personal or health information without that patient's explicit, informed permission. This obligation is an ethical duty distinct from the legal duty to protect patient privacy.

Patients should be informed of the limits on confidentiality at the beginning of the physician-patient relationship and again as necessary and/or relevant. Disclosures, even with informed consent, should be limited to the requirements of the situation, particularly when legal privacy rules provide a lower standard of protection than ethics require. Progress notes should record only the information necessary for good continuity of patient care.

There are legally imposed limits on confidentiality. For example, most states impose some obligation to warn or protect intended victims or report threats to authorities when there is a reasonable probability that a patient may carry out the threat to harm him- or herself or another person. All states impose a duty to report child abuse and most require reporting of elder abuse. In addition, a rapidly growing number of states require physicians to check prescription monitoring databases to promote patient safety and to avoid duplicate prescriptions and polypharmacy by multiple providers. Because the specific requirements of each state's law vary, psychiatrists should know the legal limits on confidentiality in the jurisdiction(s) in which they practice.

The advent and expansion of the use of electronic medical records and the increasing use of care coordinators and integration of medical care present challenges to traditional notions of patient confidentiality. The need to share information and coordinate care to benefit the patient must be weighed against the patient's need for confidentiality. Where electronic records are concerned, many hospitals inform patients of how the records will be used upon admission or upon use of the hospital system and patients sign a notice that they have been informed.

The psychiatrist should exercise caution to include in notes that may be available to others only the information that would be necessary for evaluation and treatment of the patient's condition. In addition, as part of their routine practice, psychiatrists may inform patients about the types of information that are included in the record, how the information in the record could be shared with others (with and without consent), and/or patient options for amending the record.

Topic 3.2.2 *Honesty and integrity*

Patients seeking psychiatric care have the fundamental expectation of honesty from their psychiatrists. Honesty includes both ensuring that information provided is truthful and that information is not withheld from the patient. Psychiatrists should strive to provide complete information to patients about their health and all aspects of their care, unless there are strong contravening cultural factors or overriding therapeutic factors such as risk of harm to the patient or others that would make full disclosure medically harmful. Limiting the sharing of information with the patient should be the exception rather than the rule in respect of the value of honesty in the therapeutic relationship. Decisions not to share information with a patient should be thoughtfully considered and justified after a careful process of analysis. Psychiatrists may consider the value of deliberation with treatment teams, supervisors, and/or colleagues in coming to decisions to withhold clinical information from patients in recognition that decisions not to share information may fundamentally affect the patient's dignity.

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In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between the psychiatrist and the patient and should be avoided. Sharing information with any patient, including children, should occur in clinically and developmentally appropriate terms and settings.

During the course of patient care, psychiatrists are often asked to communicate with other individuals and agencies. Psychiatrists should not provide third parties with more information than is needed under the circumstances and they should stick to the facts. Releasing inaccurate or misleading clinical information to insurers, employers, or other third-party entities is a specific example of dishonesty and may constitute fraud.

Topic 3.2.3 *Non-participation in fraud*

As stated in the above section, psychiatrists should uphold their ethical duty to honesty and integrity. Fraud is an action that is intended to deceive, and ordinarily arises in the context of behavior that seeks to secure unfair or unlawful gain. Psychiatrists should be aware that fraudulent actions, in addition to being unethical, may also trigger legal sanctions. (Moreover, because honest dealings with patients are fundamental to the physician-patient relationship, any act of deception or misrepresentation with a patient has the potential to compromise the psychiatrist's ability to provide competent care.)

Psychiatrists communicate with numerous agencies and individuals during patient treatment. They are responsible for the usual physician contact with funding and reimbursement agencies, families, employers, and other third parties. However, because of their expertise in human behavior, psychiatrists are often asked, formally and informally, for information justifying or excusing patient actions. These requests offer numerous opportunities for ethical missteps. While each unique situation may have particular circumstances affecting the ethical analysis of a psychiatrist's conduct, psychiatrists should be particularly aware of their ethical responsibilities to honesty and integrity even in situations that occur for the benefit of the patient.
Specific examples of fraud in psychiatric practice include making false or intentionally misleading statements to patients, falsifying medical records, research, or reports, submitting false bills or claims for service, lying about credentials or qualifications, supporting inappropriate exemptions from work or school, providing unnecessary treatment, taking credit for another's work, and writing a prescription for a patient in a family member's name. These are some examples of actions that are not ethically acceptable in the practice of psychiatry. Some may also be legally actionable.

Topic 3.2.4 *Informed Consent*

Psychiatrists should recognize the importance of informed consent for assessment or treatment as an essential means to recognition of and respect for the patient's autonomy and personhood. Informed consent is an ongoing process that involves disclosing information important to the patient and/or decision-maker, ensuring the patient/decision-maker has the capacity to make treatment decisions, and avoiding coercive influences. Typical elements of disclosure include an accurate description of the diagnosis and the proposed treatment, its potential risks and benefits, any relevant alternatives, including no treatment at all, and the relative risks and benefits of each option. Psychiatrists should honor the specific and enduring values of their patients and, in general, not condition a patient's ongoing treatment on a patient's acceptance of specific treatment recommendations. It is the exception rather than the rule that a psychiatrist

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would terminate a treatment relationship due to a patient's refusal of a specific recommendation, and generally limited to compelling circumstances in which such refusal involves actual, threatened, or heightened risk of harm to the patient or others. Psychiatrists must balance the ethical principles of patient autonomy with their professional obligations of providing effective – or at least non-harmful – care. Therefore, psychiatrists may ethically refuse to provide or insist on withholding certain treatments to or from a patient when those treatments would be harmful to the patient or contrary to an established and rational therapeutic plan, even if the patient demands those interventions.

Topic 3.2.5 *Involuntary psychiatric treatment*

Involuntary psychiatric treatment is on occasion needed to ensure the safety of the public or the care and protection of patients. The legal doctrines of police power and of *parens patriae* (i.e., the state as parent) have provided the customary rationale for involuntary treatment. Involuntary treatment may involve interventions such as psychiatric hospitalization, court-ordered outpatient treatment, and/or treatment with psychiatric medications.

Enforced treatment contains an inherent ethical tension among several values: respecting the individual's autonomy, providing care for that individual, and protecting the community. To exercise this coercion while balancing these competing values calls for great sensitivity on the part of the psychiatrist. When involuntary treatment is imposed, it should ensure the least restrictive clinically appropriate alternative and, to the extent possible, respect the informed consent process and the patient's decision-making capacity. Several specific issues requiring particular ethical attention include the commitment of children by parents or guardians, and patients committed to outpatient treatment in the community.

Topic 3.2.6 *Therapeutic boundary keeping*

Therapeutic boundaries are the professional limits on the conduct of the relationship between psychiatrists and their patients. They are required to ensure that the psychiatrist does not take advantage of a patient and to ensure that there is no appearance of impropriety in the psychiatrist-patient relationship. Psychiatrists must never exploit or otherwise take advantage of their patients, must avoid patient interactions that are aimed at gratifying the psychiatrist's needs and impulses, and must not use their position to influence the patient in a manner that may undermine or threaten treatment goals. The concept of "beneficence" holds that all interaction with a patient should be for the benefit of the patient and the concept of "non-maleficence" holds that interactions that could potentially cause harm or misunderstanding should be avoided. However, the psychiatrist should show compassion towards, interest in, and kindness to patients.

Sexual behavior with patients is unethical. Further, even the possibility of future sexual or romantic relationship may contaminate current clinical treatment. Therefore, sexual activity not only with current, but also with former patients is unethical. Likewise, any occasion in which the physician interacts with a current or former patient in a way that may be a prelude to a more intimate relationship should be avoided.

While sexual contact is the most obvious form of unethical behavior, other non-sexual behaviors may also undermine the therapeutic relationship and cause harm to the patient. For example, psychiatrists should be aware that business transactions and relationships with patients as well as non-sexual social relationships may negatively affect the therapeutic relationship. Because of

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the diverse array of treatments and treatment settings, it is impossible to create unambiguous rules of conduct for all areas of clinical practice. However, psychiatrists must maintain awareness that their behavior should be directed toward the patient's therapeutic benefit, and behavior that is likely to conflict with that goal should be avoided.

Finally, rules guiding professional behavior are context sensitive. Because of this contextual element, it is important to distinguish boundary violations from boundary crossings. Boundary violations are transgressions that are immediately harmful, are likely to cause future harm or are exploitive of the patient, and as such, are always unethical. Boundary crossings are deviations from customary behavior that do not harm the patient and that on occasion may facilitate the therapeutic process. However, because of their potential to erode the therapeutic relationship, especially in the context of long-term psychotherapy, boundary crossings should be undertaken in treatment only in an intentional manner and when the benefits clearly outweigh the risks. (For instance, the appropriateness of accepting a small gift from a patient should be evaluated in light of the cultural and community context and the therapeutic impact. Likewise, a hug may be appropriate in certain circumstances as sign of respect for the culture of the patient or of compassion and support.) The psychiatrist must evaluate the situation and ensure that his or her conduct is not misconstrued and is in the best interest of the patient. Psychiatrists are encouraged to seek peer or other professional consultation in these matters, especially when they are in doubt about what course of action to take or refrain from.

Topic 3.2.7 *Ethical philanthropy and political advocacy in psychiatry*

Across all fields of medicine, organizational fundraising must be conducted with sensitivity so as not to exploit the relationship of trust that the physician has with the patient. Psychiatrists should consider whether the therapeutic relationship would encourage the patient to donate when he or she otherwise would not but the inherent conflict of interest must also take into account patients' competent decisions and their right to act as citizens. To be ethically acceptable, fundraising in psychiatry must be based in trust and honesty and in the fulfillment of goals of shared importance to the organization and the donor. Most importantly, philanthropic activities must be non-exploitative. Individual psychiatrists must not approach their patients for funds or initiate identification of specific patients for their institutions to solicit, as this may adversely affect the therapeutic relationship and cannot sufficiently safeguard the patient from exploitation.

While psychiatrists are expected to participate in activities contributing to the improvement of the community and public health, care should be exercised when the psychiatrist enters political discussions with the patient. In that context, there is potential for invading and exploiting the treatment relationship, especially when patients are asked to support political causes. Psychiatrists should refrain from attempting to influence the patient's political views, although they may promote the patient's civic engagement. Psychiatrists should exercise thoughtfulness in their interactions with patients regarding political issues, including the materials they provide or make available.

3.3: The ethical and professional basis of the relationship with colleagues

Topic 3.3.1 *Seeking professional consultation*

Psychiatrists treat challenging illnesses, and psychiatric illnesses are influenced by complex social and cultural contexts, co-morbid conditions, and discrimination. Because of this complexity, psychiatrists should carefully consider the need for consultation with colleagues and/or

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supervisors, especially when patients are not doing well. Professional competence entails recognizing the limits of one's clinical skills. Consultation in the analysis of ethical dilemmas is also sound practice.

If psychiatrists receive referrals for conditions that are outside their area of particular expertise and more specialized psychiatrists are available, they should consider making a referral to the more experienced clinician. Consideration of such a referral may include consultation with the specialist. Psychiatrists should exercise care in working on teams with and delegating responsibility to non-physicians to assure patients receive sound care.

Psychiatrists should agree to patient requests for consultation (or to the requests of family/guardian for minor or incompetent patients) and are free to accept or reject the consultant's opinions. Psychiatrists may suggest, but should not dictate, a choice among consultants. If psychiatrists disapprove of the professional qualifications of the consultant, or have a difference of opinion with the findings that cannot be resolved with the patient, they may withdraw from the case after suitable attention to the patient's ability to find needed care from another provider.

Topic 3.3.2 *Relations with non-psychiatrists on multidisciplinary teams*

The treatment of patients often occurs on multidisciplinary teams. Psychiatrists are regularly asked to assume a collaborative role with other mental health clinicians on such a team, and such collaboration can produce an ethical tension regarding the extent of responsibility of the psychiatrist for treatment decisions. When collaboration occurs between independent practitioners (as in split psychotherapy/psychopharmacology treatment), psychiatrists should coordinate care with their colleagues and should be aware that they are assuming shared responsibility for the overall treatment but are still solely responsible for the medical aspects of treatment. The psychiatrist and the collaborating clinician must communicate to their common patient the unique roles of each.

Given that there are times where the number of psychiatrists available is insufficient to meet the needs of the population, the psychiatrist should be willing to consult with and for non-medical or medical non-psychiatric providers when necessary.

Topic 3.3.3 *Responsibilities in teaching and in supervising psychiatrists-in-training*

As teachers and supervisors, psychiatrists must model not only clinical expertise but also a high standard of professional ethics. They must foster a positive, respectful learning environment, mindful of the asymmetry in power between themselves and their trainees, with a resulting responsibility on teachers (for example, avoidance of sexual involvement with trainees).

Topic 3.3.4 *Responding to the unethical conduct of colleagues*

All psychiatrists have an obligation to recognize and address the unethical behavior of colleagues, including a variety of behaviors that violate professional standards, such as exploitation of a patient, dishonesty or fraudulent professional activities, or behavior that intentionally demeans or humiliates patients or colleagues/supervisees. In some instances reporting is also mandated by law. Options for addressing behavior may include seeking advice from supervisors, engaging in consultation with the individual, or reporting behavior to the appropriate authorities (including Ethics Committees of District Branches of the American Psychiatric Association).

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Topic 3.3.5 *Responding to impaired colleagues*

Impairment among psychiatrists may arise from physical-, mental-, or substance use-related disorders. Such impairment may compromise professional competence and pose a serious threat to patient welfare. An impaired psychiatrist who does not seek help and correct the problem fails the community of psychiatrists, its standards, and his or her patients. Patients may not recognize an impairment or, if they do, be reluctant to report it.

A psychiatrist who is concerned about an impaired colleague's ability to care for patients safely may attempt to counsel or encourage the impaired colleague to seek treatment and to refrain from patient care. However, if the impaired psychiatrist does not respond to a collegial approach, the psychiatrist has an obligation to address the problem through appropriate channels such as the state's impaired physician program, the state medical board, the chief of the service, the hospital medical staff procedures, or other available route (e.g. a District Branch wellness committee).

3.4: Other ethically important topics in psychiatric practice

Topic 3.4.1 *Working within organized systems of care*

While psychiatrists enjoy professional autonomy in their practice, an increasing number of psychiatrists nonetheless work within at least one system of care, such as a hospital, group practice, multispecialty group practice, accountable care organization, government system, military system, or work for third-party payors. These systems have increased complexity but can create opportunities for improved patient care through innovation, clinical research, integration of health care, collegiality and peer relationships. However, they also create potential for conflict between the primacy of the individual patient and the legal, business and political interests of the care system of which the psychiatrist should be aware and monitor.

In increasingly complex systems of care, treating psychiatrists will encounter situations in which the primacy of individual patient care competes with other compelling interests and obligations. Psychiatrists in any system of care, whether or not they are providing clinical care to individual patients, maintain responsibility to patient interests and commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally. Care systems may employ a variety of cost containing measures, including prospectively, concurrently, or retrospectively reviewing treatment, emphasizing preventive or primary care services, requiring specific approvals for specialty procedures or referral, promoting the use of treatment guidelines, or creating economies of scale to streamline care within large systems. In these systems, other values often compete with the interests of the individual patient. The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care cannot wholly ignore the needs of patients. Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside of the system when the patient's psychiatric or medical well-being requires it.

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Topic 3.4.2 *Clinically innovative practices*

Clinical decision-making without established research evidence to guide practice requires informed clinical judgments drawing on the best available research, adherence to the ethical principles of beneficence and non-maleficence, and sound theoretical reasoning. When usual treatments have failed, psychiatrists may offer non-standard or novel interventions using a shared decision-making approach grounded in the patient's informed consent and a thorough discussion of risks, benefits, and alternatives to the innovative treatment. Since innovative practice sometimes leads to important scientific advances, it should not be categorically discouraged; however, because it may prove ineffective or even harmful, psychiatrists should proceed with caution in their use of clinical innovation. When considering use of clinical innovation, psychiatrists should consider first consulting colleagues and exploring other resources to ensure that careful thought has been given to possible alternatives as well as to the safest and most effective use of innovative interventions.

Topic 3.4.3 *Psychiatric issues in end-of-life care.*

Psychiatrists can have a critical role to play in end-of-life discussions because of their experience in dealing with sensitive and difficult discussions with patients. Psychiatrists can also identify and treat common psychiatric and neuropsychiatric symptoms at the end of life. Finally, psychiatrists may be well-positioned to address the psychological suffering that accompanies the potential stigmatization and marginalization of those nearing the end of life.

Appropriate approaches to end-of-life care often combine treatment-specific information with values histories. Such approaches allow physicians to balance information regarding end-of-life care with accurate knowledge of patient preferences. Patients must be provided sufficient information for making decisions and their wishes documented and reassessed over time. Ongoing discussions with caregivers can be an invaluable source of information. Use of the full range of tools for improving end-of-life care — including advance directives, treatment vignettes, and values histories — can begin to overcome the barriers to treatment faced by persons requiring end-of-life care.

Where there is doubt regarding the authenticity or stability of decisions, psychiatrists may contribute specialized expertise in focused capacity assessments. In addition, specific assurances that patients will not be abandoned can mitigate feelings of hopelessness. Information on the likely course of an illness and means for managing symptoms can also bring hope. Improved communication is critical for addressing common feelings of dread and despair, identifying and treating depression, addressing medication side effects or related neuropsychiatric symptoms, and supporting families in dealing with psychosocial stressors. Psychiatrists, like all physicians, should be truthful with patients about their diagnoses and prognosis and must have the requisite compassion and skill to thoughtfully and sensitively foster dialogue with patients who are seriously ill and suffering from a terminal illness.

Topic 3.4.4 *Relations with the Pharmaceutical and Other Industries*

New psychopharmacologic medications, medical devices, and innovations in genetics and biotechnology are increasingly important elements of modern psychiatric practice. Psychiatrists may interact with industry in many ways, including presenting at industry sponsored lectures and appearing in industry sponsored publications and advertisements,

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accepting and distributing sample products, recommending patients for industry sponsored clinical trials, and accepting personal or office gifts or corporate donations from industry. Psychiatrists should recognize that industry has obligations beyond patient welfare, including primary obligations to shareholders that psychiatrists do not share.

All psychiatrists should be aware of the potential conflicts that interactions with industry pose between business objectives and the psychiatrist's clinical or research responsibilities. Although the mere appearance or existence of a conflict of interest does not by itself imply wrongdoing, the failure to recognize and actively address such conflicts does compromise professional integrity and threatens the independence of the psychiatrist's judgment. For example, receiving gifts from industry may cause the psychiatrist to favor one medication over another.

At a minimum, psychiatrists should disclose their affiliations, relationships, and financial involvement with Industry to their patients in clinical settings and to audiences in professional presentations, even if they believe they are inconsequential.

Addressing conflicts of interest should be guided by three principles: the primacy of patient welfare, the independence of the psychiatrist's judgment, and disclosure. The guiding principle should be that the patient's interest rises above that of the psychiatrist or Industry. In each clinical decision the psychiatrist makes, he must be able to justify why that decision was in the best interest of the patient.

Topic 3.4.5 *Ethical issues in small communities*

Patients in small or underserved communities may encounter greater barriers to care because of limited health care resources, including the absence of specialty and subspecialty expertise and fewer health services. In small and/or remote communities, psychiatrists may effectively function as generalists across a broad range of clinical areas in psychiatry rather than specialists in a particular area of psychiatry. In an underserved context, if a patient care situation falls outside a psychiatrist's usual scope of practice, he or she may justifiably provide care if the psychiatrist has closely-related training and experience, if the psychiatrist possesses the most readily available relevant expertise, and if the patient's clinical needs warrant evaluation and intervention (e.g., because of severity and/or urgency). Psychiatrists who choose to extend the scope of their practice in such a manner incur an obligation to expand their expertise in appropriate ways by supervision, consultation, formal courses or other means of education.

Topic 3.4.6 *Professional Use of the Internet and Communication Technology*

Innovations in internet and communications technology over the past several decades have the potential to improve access to, delivery of, and quality of psychiatric care. However, these advances may also pose potential challenges to sound and ethical practice. While each type of technology and situation requires a case-by-case analysis, psychiatrists should be aware of potential ethical challenges in its use before using the technology in providing patient care. Psychiatrists are responsible for obtaining sufficient knowledge about the technologies they employ to respect patient confidentiality and deliver competent care. Psychiatrists must be aware of their responsibility to maintain professional boundaries in their internet activities – both in respecting their patients and in establishing separation between personal and professional internet and social media presence. Before using electronic communications or other technologies in the care of patients, psychiatrists should inform patients of the parameters of this technology use, including appropriate use (e.g. administrative vs. clinical), expectations, and emergency contact procedures.

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Topic 3.4.7 *Public Statements*

For some in our profession, psychiatry can extend beyond the physician-patient relationship into the broader domain of public attention: in administration, politics, the courtroom, the media, and the internet. Psychiatrists need to sustain and nurture the ethical integrity of the profession when in the public eye. A psychiatrist may render a professional opinion about an individual after an appropriate clinical examination and accompanying waiver of confidentiality and should not do so unless the examination and waiver have occurred. When a personal examination has not been performed and when a psychiatrist is asked for a professional opinion about a person in light of public attention, a general discussion of relevant psychiatric topics — rather than offering opinions about that specific person — is the best means of facilitating public education. In some circumstances, such as academic scholarship about figures of historical importance, exploration of psychiatric issues (e.g. diagnostic conclusions) may be reasonable provided that it has a sufficient evidence base and is subject to peer review and academic scrutiny based on relevant standards of scholarship. When, without any personal examination, the psychiatrist renders a clinical opinion about a historical figure,, these limitations must be clearly acknowledged. Moreover, labeling public figures cavalierly with psychiatric conditions, based on limited or indirect clinical knowledge is not consistent with this approach and undermines public trust in the profession of psychiatry. Psychiatrists should also exercise caution when asked to provide the profile of or otherwise comment on the kind of person who might have committed a crime by clearly and publicly identifying the inherent uncertainty in profiling and the necessity of considering additional information as it becomes available.

Topic 3.4.8 *Civil disobedience*

Civil disobedience is the nonviolent and principled refusal to obey the dictates of government. It may occur when a psychiatrist's ethical obligation to a patient conflicts with the law, for example when the state's request for patient information seems to the psychiatrist to jeopardize the patient's well-being. Psychiatrists should clearly state their ethical obligation in such cases, pursuing options within the law until they have been exhausted. Psychiatrists may subsequently agree to comply with the mandate or not. While physicians have an ethical responsibility to respect the law, it is conceivable that a practitioner could violate the law without violating professional ethics. If psychiatrists refuse to comply with the law, however, they should be aware of the legal consequences of their action and consider obtaining legal counsel.

Topic 3.4.9 *Execution*

Psychiatrists should not participate in a legally authorized execution and may not assume roles that lead them to facilitate, implement, develop or monitor any techniques involved in execution. When a condemned prisoner has been declared incompetent to be executed, psychiatrists should not treat the prisoner for the *sole* purpose of restoring competence unless a commutation order is issued before treatment begins. However, the psychiatrist may treat the incompetent prisoner, as any other patient, to relieve suffering.

Topic 3.4.10 *Psychiatrist participation in interrogations*

Psychiatrists providing medical care to individual detainees in military, criminal or civilian settings may face conflict between their primary obligation to their patients and obligations to the institution such as ensuring safety. Treating psychiatrists who become aware that the detainee may pose a significant threat of harm to him/herself or to others are not precluded from

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ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to any psychiatrist relationship. As in any other setting, psychiatrists should safeguard the confidentiality of patient information, understanding that there may be legal or ethical requirements to disclose information. In these settings, the record may be the property of the institution and psychiatrists should be aware that non-clinical entities may have access. Psychiatrists should inform patients in these settings that information disclosed in treatment may not be confidential and of the specific limits on confidentiality.

Psychiatrists should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of detainees on behalf of military or civilian agencies or law enforcement authorities.

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Question:
Can a psychiatrist who is serving as a managed care or insurance utilization reviewer (who does not have a direct relationship with the patient) ethically limit access to care in ways known to be in violation of parity? Here it is assumed the issue is not medical necessity, but whether the insurance company or manage-care company chooses to cover the benefit in question. (Examples: a reviewer refuses to authorize residential treatment because it is not a covered benefit--and a court has hypothetically determined that it is inconsistent with the parity law to exclude residential benefits, or a reviewer refuses to support treatment for a personality disorder, despite these being major disorders that carry a significant risk of suicide, complicate the treatment of other comorbid disorders, have a practice guideline, and several recognized evidence based treatments. Please note these examples are offered for clarity, but are not the only instances about which I am inquiring.)

Response:
In our opinion, the questions posed can be distilled into one; does the psychiatrist working as a managed care or utilization reviewer owe primary obligation to the patient or to the plan? To be clear, in this situation, the psychiatrist is a non-treating psychiatrist. The Opinions of the APA ethics code are best interpreted as meaning that for a treating psychiatrist in a managed care setting, patient welfare is primary. Similarly, for forensic psychiatrists in most contexts, patient care is not primary, and their primary duties instead are to promote justice and answer questions honestly.

A managed care or utilization reviewer is not a treating psychiatrist. Managed care is designed to cut costs, reduce premiums, and possibly increase profits. The reviewer is hired by the company to assess whether the care meets the criteria the plan has established. The reviewer cannot authorize benefits that are not covered by the plan. The patient who purchased the insurance should have been supplied the coverage by the plan. In our opinion, the psychiatrist managed care or utilization reviewer owes his primary obligation to the managed care company and a secondary one to the patient. In this context, it is a reasonable expectation that the reviewer will stay within the guidelines established by the company.

With regard to violations of parity laws as described in your question, it is not the ethics responsibility of the reviewing psychiatrist to determine whether the plan is meeting parity law requirements. Presumably, that would be outside his employment and obligations. If the plan is not following parity requirements, then others, including the patient or the treating psychiatrist, may take some action against the plan. The primary duty of the reviewing psychiatrist in this situation is to evaluate whether the requested treatment is warranted and covered by the plan. It would be unethical for the psychiatrist to deny care that was in fact covered by the plan. Nevertheless, some may wish to argue that the reviewer may be seen as obligated to advocate for change in the managed care plan. That is a laudable goal, but not one that can be mandated for those psychiatrists who are reticent about engaging in political advocacy.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Develop an APA Position Statement Regarding the Ethical Tensions Faced by Psychiatrists
Action Paper Author(s): Eric Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry
Phone/email: 413-931-5208/ eric.plakun@austinriggs.net
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Overseeing position statement process & work of committee which is assumed to function by conf call/email by member volunteers		3,850
2		-	-
3		-	-
	Total Staff Costs		3,850
		Total Author Estimate	**$3,850**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: The Pathologizing of Same Sex and Transgender Orientations by Indonesian Psychiatrists

WHEREAS:
Whereas: The leading Indonesian psychiatric association, Perhimpunan Dokter Spesialis Kedokteran Jiwa Indonesia – the Indonesian Mind Specialist Medical Doctors Association – has classified homosexuality, bisexuality, and transgenderism as mental disorders which the association asserts can be cured through proper treatment.

Whereas: The Indonesian psychiatric association asserts that LGBT (Lesbian, Gay, Bisexual, and Transgendered) orientations are triggered by external factors, such as the influence of a person's social environment, and therefore can be healed through psychiatric treatment,

Whereas: In December 2013 the Board of Trustees issued a comprehensive position statement on sexual orientation, stating that the American Psychiatric Association believes that the causes of sexual orientation (whether homosexual or heterosexual) are not known at this time and likely are multifactorial including biological and behavioral roots which may vary between different individuals and may even vary over time,

Whereas: It is the position of the American Psychiatric Association that no credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective that sexual orientation needs to be changed,

Whereas: The American Psychiatric Association believes that efforts to change same-sex orientation represents a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change.

Whereas: Societal stigma of LGBT orientations in Indonesia, driven in part by religious proscriptions, is profound. (For example homosexual behavior can be punished by 100 lashes in the Indonesia's northwestern province of Aceh based on Islamic Sharia Law),

Whereas: Science should be independent of religious perspective,

Whereas: The pathologizing of LGBT people by Indonesian psychiatrists represents a substantial and unethical risk of harm to LGBT people in Indonesia;

BE IT RESOLVED:
That the Assembly request that the President of the American Psychiatric Association write a letter to the leaders of the Indonesian psychiatric association expressing the APA's opposition to the view that same sex and transgendered orientations represent psychiatric pathology; noting that it is the opinion of the American Psychiatric Association (which represents 36,000 psychiatrists and is the largest psychiatric organization in the world), that there is no evidence to support the position that homosexuality or transgendered expression represents evidence of a mental disorder *per se*; nor, that such expressions

need to be changed; nor, that there is any scientific evidence that Psychiatry can, or has any role, in making such changes.

AUTHORS:
David L. Scasta, M.D., DLFAPA, Representative, Association of LGBTQ Psychiatrists
(scastadavid@msn.com)
James R. Batterson, M.D., DFAPA, DFAACAP, Representative Area 4
Eric Yarborough, M.D., APA Member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $ 0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: Lesbian, Gay, Bisexual, Transgendered, Conversion Therapy

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
Insufficient time to be reviewed by the Council on Minority Mental Health and Health Disparities because the news of the position by the Indonesian psychiatrists was published shortly before the deadline for this action paper. The requested letter is consistent with current, published APA positions.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: The Pathologizing of Same Sex and Transgendered Orientations by Indonsian Psychiatrists
Action Paper Author(s): David L. Scasta, M.D., DLFAPA, Association of LGBTQ Psychiatrists
Phone/email: 609-279-9330 / scastadavid@msn.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	The action paper calls on the APA president to write a letter to Indonesian psychiatrists in the normal course of duty as an APA president		-
2	No costs are anticipated.		-
3		-	-
	Total Staff Costs		-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: US Joint Statement on Conversion Therapy

WHEREAS:
Whereas: In December of 1998, the Board of Trustees issued a position statement that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality *per se* is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation,

Whereas: In December 2013 the Board of Trustees issued a position statement that the American Psychiatric Association believes that the causes of sexual orientation (whether homosexual or heterosexual) are not known at this time and likely are multifactorial including biological and behavioral roots which may vary between different individuals and may even vary over time. The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed,

Whereas: The World Psychiatric Association has taken the position that gender identity is not seen as pathological *and "the provision of any intervention proposed to' treat' something that is not a disorder is wholly unethical, "*

Whereas: The American Academy of Nursing, the American Counseling Association, the American Medical Student Association, the American Psychoanalytic Association, AGLP The Association of LGBTQ Psychiatrists, the Association of Lesbian, Gay, Bisexual, Transgender Issues in Counseling, the Clinical Social Work Association, GMLA: the Health Professionals Advancing LGBT Equality, and the World Professional Association for Transgender Health have signed on to the US Joint Statement on Conversion Therapy; and the Woodhull Freedom Foundation and PFLAG International have endorsed the US Joint Statement on Conversion Therapy.

BE IT RESOLVED:
That the American Psychiatric Association sign on as a signatory to the US Joint Statement on Conversion Therapy which cautions mental health professionals that conversion or change therapies for Lesbian, Gay, Bisexual and Transgendered patients are unethical and embody a risk of harm to those patients.

AUTHORS:
David L. Scasta, M.D., DLFAPA, Representative, Association of LGBTQ Psychiatrists
(scastadavid@msn.com)
James R. Batterson, M.D., DFAPA, DFAACAP, Representative, Area 4
Eric Yarborough, M.D., APA Member

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY:

KEY WORDS: Lesbian, Gay, Bisexual, Transgendered, Conversion Therapy

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT (with attached comments as appropriate):

Discussions were followed by Ranna Parikh, M.D., Director of Diversity and Health Equality; Kristen Kroeger, M.D., Chief of Policy, Programs and Partnerships; and Matthew Sturm, Director of Legislative & Regulatory Policy. No written comments were offered; no major objections were raised. The Action Paper is to be referred to the Council on Minority Mental Health and Health Disparities on passage.

Joint Statement on Conversion Therapy in the U.S.

This statement is a framework for values and action to address issues raised by conversion therapy (also known as reorientation therapy, sexual orientation change efforts, ex-gay therapy, or reparative therapy). This statement expresses a shared commitment of two core principles of ethical mental health services: 1) facilitate individual self-determination and 2) do no harm.

The ethical principle of self-determination requires that each individual is seen as a whole person supported in their right to explore, define, articulate, and live out their own identity. For this reason, it is essential for clinicians to acknowledge the broad spectrum of sexual orientations and gender identities/expressions. In order to do so, it is necessary to have an equal understanding of and respect for sexual and gender minorities as well as the religious, spiritual, and other ideological values of individuals, families, and communities.

To ensure all healthcare providers do no harm, it is essential to recognize that a person is not mentally ill or developmentally delayed because they experience same-sex attractions or a nontraditional gender identity or expression. The focus of treatment must not be to convert an individual's sexual orientation or gender identity/expression. The signatories share a commitment to protecting the public from the harms of conversion therapy.

There is no intention in this statement to deny those with conflicted feelings around sexuality or gender identity from seeking qualified and appropriate help. Nothing in this statement is intended to preclude ethical research relative to gender identity or sexual orientation.

Background

Historically, research findings and clinical expertise have found that variations in sexual orientation and gender identity are within the normal range of human development, and that conversion therapy or other efforts to make sexual orientation or gender identity/expression conform to specific standards and expectations are not effective, are not appropriate therapeutic practices, are not ethical, and are harmful.[1, 2, 3] Many professional associations already have position statements relative to Lesbian, Gay, Bisexual, Transgender, Questioning, of Gender NonConforming (LGBTQ/GNC) health and/or the ineffectiveness of efforts to change sexual orientation and/or the potential harms of conversion therapy for sexual orientation.[4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15]

Goals and Objectives

Given the harm associated with conversion therapy efforts, other affirmative behavioral, psychological, and emotional health interventions are recommended for individual or family distress associated with sexual orientation and gender identity/expression. We commit ourselves to ensure that:

- The public is informed about the research on conversion therapy and the risks thereof;
- Healthcare professionals are made aware of the ethical issues relating to conversion therapy;
- New and existing healthcare providers are appropriately trained to competently deal with requests for conversion therapy and to provide appropriate support to clients in distress over their sexual orientation and/or gender identity/expression;

- Healthcare professionals from various disciplines work together to promote the public interest in addressing conversion therapy.

Roles and Responsibilities

This statement does not define a list of actions which every organization will carry out. It sets out a framework for how organizations will respond to the issue in areas where they have responsibilities.

- Each organization will review its codes of ethical conduct for members and consider the need for the creation of specific amendments to those codes;
- Professional associations will ensure their members have access to the latest information regarding the ineffectiveness and harms of conversion therapy;
- Professional associations will endeavor to make continuing professional development events available to further providers' understanding and cultural competence in working with lesbian, gay, bisexual, transgender, questioning and gender nonconforming (LGBTQ/GNC) clients;
- Organizations will work together to create a shared information resource on the ineffectiveness and harms of conversion therapy to help and support both members of the public and professionals, including sets of Frequently Asked Questions (FAQs);
- Those with a responsibility for clinical and academic training will work to ensure that such programs provide mental and behavioral health providers with a sufficient degree of cultural competence to work effectively with LGBTQ/GNC clients;
- Clinicians who are not sufficiently trained around issues of sexual orientation and/or gender identity/expression will make every effort to seek appropriate training or consultation or to connect patients with clinicians and agencies who are trained to provide appropriate clinical care;
- Auditing and accrediting organizations will review their current guidelines and policies for individual practitioners and training organizations to assess the need for more specific standards to demonstrate awareness of and compliance with policies regarding conversion therapy.
-

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of people of all gender identities, gender expressions, and sexual orientations, including lesbian, gay, bisexual, transgender, questioning, and gender nonconforming people of all ages; to adopt appropriate and supportive therapies; and to provide current, targeted and accurate resources and information for all patients and their families. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ/GNC people.

Review

The undersigned organizations will review the statement 12 months after publication.

Mutual Understanding

This memorandum is signed in recognition of a shared professional responsibility to improve the support and help available to those at risk from conversion therapy.

Notes

1. http://www.psychotherapy.org.uk/UKCP_Documents/policy/MoU-conversiontherapy.pdf
2. http://store.samhsa.gov/product/Ending-Conversion-Therapy-Supporting-and-Affirming-LGBTQ-Youth/All-New-Products/SMA15-4928
3. http://www.paho.org/hq/index.php?option=com_content&view=article&id=6803%3A2012-therapies-change-sexual-orientation-lack-medical-justification-threaten-health&catid=740%3Anews-press-releases&Itemid=1926&lang=en
4. http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page?
5. http://www.apa.org/about/policy/sexual-orientation.aspx
6. http://www.socialworkers.org/diversity/new/documents/hria_pro_18315_soce_june_2015.pdf
7. http://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2013-homosexuality.pdf
8. http://www.guideline.gov/content.aspx?id=38417#Section420
9. http://www.aamft.org/iMIS15/AAMFT/Content/about_aamft/position_on_couples.aspx
10. http://annals.org/article.aspx?articleid=2292051
11. http://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy
12. http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender
13. http://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_LGBTQ.pdf
14. http://www.cswe.org/File.aspx?id=85010
15. http://www.wpanet.org/detail.php?section_id=7&content_id=1807

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: US Joint Statement on Conversion Theapy
Action Paper Author(s): David L. Scasta, M.D., DLFAPA, Representative, Association of LGBTQ Psychiatrists
Phone/email: 609-279-9330/scastadavid@msn.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	12	-
Number of Staff	-	-
Number of Non-Staff	14	-
Total	**26**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	No cost, the Council will address the AP under its usual business		-
2		-	-
3		-	-
Total Staff Costs			-

Total Author Estimate **$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-

Total Administration Estimate **$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: APA Referendum Voting Procedure

WHEREAS:

Whereas: The referendum process is a critical component in maintaining the American Psychiatric Association as a member driven organization and allows the membership to determine the need for even major structural or policy changes in the organization, similar to the purpose of the amendment process in the U. S. Constitution.

Whereas: The referendum process is currently operationalized by attaching the referendum for membership voting to the APA national officer election ballot.

Whereas: The election of officers occurs by a simple majority of those eligible members who choose to vote, while the passing of a referendum requires a majority of at least 40 percent of all eligible voters.

Whereas: Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only 15 percent voting in the 2016 election. Therefore, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011. In distinction, in the 2016 officer election, a candidate for office could have won with the votes of 8 percent of eligible voters.

Whereas: A referendum to change the voting percentage requirement would, itself, have to go through the above-referenced process which has clearly been shown to not be functional for establishing the predominant will of the membership in regard to proposals.

Whereas: There is a stipulation in the American Psychiatric Association bylaws, Section 8.4, which states that referenda are "to be voted on in the next annual ballot." It does not specifically stipulate that this "annual ballot" refers to, or only to, the national election ballot. Thus, a referendum ballot could be included with the dues statement mailing. Alternatively, the Assembly could request that the Board of Trustees, as per Section 1.2 of the bylaws, pass an amendment to the bylaws stipulating that referenda may be distributed for voting members in a yearly mailing, both paper and electronic, which includes the dues statement and/or solicitation for contributions (from non-dues paying but voting members).

Whereas: The cost of attaching referendum voting ballots to the dues notice process should not be inherently more expensive than the current practice of attaching them to the officers election ballot, beyond that of establishing the transition.

Whereas: Virtually identical action papers as originally amended by Reference Committee 5 have been unanimously approved by the Assembly on three separate occasions at three separate Assembly meetings. At its last unanimous approval, the Assembly speaker pointedly asked if, in addition to no negative vote, were there any abstentions. None were voiced.

Whereas: At the request of Reference Committee 5 to the authors after its unanimous approval at the November 2013 Assembly meeting this action paper was referred to the Assembly Executive Committee with the charge to "address feasible implementation of this action paper." Obviously, such implementation has not occurred.

Whereas: A former objection to this paper was based on the concern that it was in violation of a provision in the Washington, D. C. code. This issue was explored and found not to be relevant as this proposal does not change the percentage of eligible voters required to pass a referendum.

Whereas: This action paper has apparently become a benchmark demonstrating whether the APA is to be a membership driven organization.

BE IT RESOLVED:

1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues exempt status. Additionally, those voting members not getting a dues statement currently will need to be included in the mailing. It is suggested that a referendum ballot could, for the non-dues paying but voting eligible members, be attached to the yearly contribution solicitation which could go out at the same time as the dues statement, which also contains a contribution solicitation. A similar attachment should occur for electronic options.

2. That a separate envelope be provided for return of a referendum ballot, as opposed to the dues or contribution envelope, to allow for voter confidentiality. Again, a similar link should be provided to allow voter confidentiality with electronic options.

3. That it is the will and intent of the Assembly that this action paper, now reaffirmed for a fourth time, be passed on for implementation by the JRC to the Board of Trustees.

AUTHOR:
John P. D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia
jshemomd@hotmail.com

ESTIMATED COST:
Author: $35,000 (This is the cost estimate from the APA from a previous iteration of this paper.)
APA:

ESTIMATED SAVINGS: Not relevant for this paper.

ESIMATED REVENUE GENERATED: Not relevant for this paper.

ENDORSED BY: Psychiatric Society of Virginia, Area 5 Council

KEY WORDS: APA referendum, membership driven governance.

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT COMPONENT: Has been submitted to the By-Laws Committee and the Elections Committee.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: APA Referendum Voting Procedure
Action Paper Author(s): John P.D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia
Phone/email: (434) 984-6777 - jshemomd@hotmail.com or shemojohn@pabrcrc.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	I accept prior APA staff estimate of $35,000 total cost. Work should be doable by existing committee in the course of their ongoing work.	35,035	
2		-	-
3		-	-
	Total Staff Costs		35,035
		Total Author Estimate	**$35,035**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		-
		Total Administration Estimate	**$0**

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Mandatory Competency Testing for Senior Psychiatrists

WHEREAS:

There is a national movement to develop state and federal regulations to mandate competency testing for physicians over a certain age, and some hospitals and health systems have already begun requiring mandatory competency evaluation for senior physicians;

The American Medical Association resolved in 2015 to develop competency guidelines for older physicians;

The American Medical Association provides senior members with information and support to assist in navigating mandatory competency testing;

Research has not clearly established that competency testing for senior physicians measurably improves patient safety or health outcomes;

Research has not clearly shown that competency testing for senior physicians serves any purpose beyond that already served by maintenance of board certification;

Mandatory competency testing may impose financial burdens on senior physicians, expose them to discrimination in employment, diminish public trust in their ability to practice medicine, and violate state and federal anti-discrimination statutes;

The risks and burdens of mandatory competency testing may encourage senior physicians to retire earlier, depriving the public of access to the most experienced doctors and depriving medicine of its wisest practitioners;

Mandatory competency testing may disproportionately affect psychiatry because psychiatrists often retire later than other medical specialists;

BE IT RESOLVED:

1. The Council on Medical Education and Lifelong Learning

    A. Identify the best interests of psychiatrists who may be subject to mandatory competency testing.

    B. Consider developing informational and support resources for members who face mandatory competency testing, similar to the information and support the AMA provides its members but more specific to psychiatrists.

2. The Delegation to the American Medical Association collaborate with the AMA to ensure psychiatrists' best interests are represented in AMA activities that are related to mandatory competency testing.

3. The Council on Advocacy and Government Relations

A. Advocate the interests of psychiatrists as proposals for state and federal regulations related to mandatory competency testing of physicians are being considered.

B. Collaborate with the American Medical Association to ensure the interests of psychiatrists are represented in current and future guidelines for physicians competency testing.

AUTHORS:
Joshua Sonkiss, M.D., ECP Representative, Area 7
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ESTIMATED COST:
Author: $3,080
APA:

ESTIMATED SAVINGS: None.

ESTIMATED REVENUE GENERATED: None.

ENDORSED BY: Colorado Psychiatric Society

KEY WORDS: competency, capacity, testing, senior, discrimination

APA STRATEGIC GOAL: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

SUBMITTED TO:
Council on Education and Lifelong Learning
Council on Advocacy and Government Relations

REFERENCES
http://associationsnow.com/2015/06/ama-report-calls-age-based-competency-testing-doctors/

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Mandatory Competency Testing for Senior Psychiatrists
Action Paper Author(s): Joshua Sonkiss, M.D., ECP Representative, Area 7
Phone/email: -
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	Identifying the best interests of psychiatrists who may be subject to mandatory competency testing & potential development of informational support & resources		1,155
2	CAGR advocate & collaborate w/AMA to ensure interests of psychiatrists are represented in current & future guidelines		1,925
3		-	-
	Total Staff Costs		3,080
		Total Author Estimate	**$3,080**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**-**	**-**	**-**	**-**	**-**

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
	Total Staff Costs		**-**
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER

TITLE: Eliminate Federal Parity Opt-Out

WHEREAS:

Whereas, untreated and undertreated mental illness is a major cause of disability and recidivism, as well as lost hours of work, absenteeism and distress.

Whereas, there are no second class citizens with respect to the need for treatment of mental illness.

Whereas, both New York State and federal law provide for parity, requiring that psychiatric disorders be treated equally to other disorders.

Whereas, Section 2722(a) of the federal Public Health Service Act permits self-funded, nonfederal governmental health plans to "opt-out" of parity by filing written notice of their intent to elect the opt-out, to the disadvantage and hardship of plan participants and their families.

Whereas, if a health plan is experiencing financial hardship, the federal parity law already includes a cost exemption for plans that demonstrate that parity compliance will result in increased costs of at least two percent in the first year or at least one percent in any subsequent plan year.

BE IT RESOLVED:
That the American Psychiatric Association lobby for elimination of the federal "opt-out" provisions so that self-funded, nonfederal governmental health plans are no longer permitted to opt-out of parity, ensuring that all health insurance plans are subject to the same parity requirements.

AUTHORS:
Seeth Vivek, M.D., Representative, Area 2
Jeffrey Borenstein, M.D., Deputy Representative, Area 2

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Parity, mental health treatment, health plan, opt-out

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Eliminate Federal Parity Opt-Out
Action Paper Author(s): Seeth Vivek, M.D., Representative, Area 2
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APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Author Estimate	**$0**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Item 2016A1 12
Reference Committee
Assembly
May 13-15, 2016

ACTION PAPER
Final*

TITLE: Making Access to Treatment for Erectile Disorder Available Under Medicare

WHEREAS:
Whereas Erectile Disorder (302.72 [F52.21]) is included as a psychiatric disorder under the DSM5 when the dysfunction is not better explained by a nonsexual mental disorder, severe relationship distress, other significant stressor, the effect of a substance/medication or another medical condition and that access to a full array of evidenced based treatments are not available under Medicare.

Whereas there is an increasing likelihood of Erectile Disorder with advancing age. (By age 70, 67% of men experience some degree of Erectile Disorder.)

Whereas those with diabetes mellitus, hypertension, multiple sclerosis and many other medically diagnosed illnesses have a higher probability of experiencing Erectile Disorder than age matched controls.

Whereas treatment of prostate cancer whether by surgery and/ or radiation therapy and/ or hormone therapy as well as those undergoing bladder, rectal and other surgeries have a high probability of experiencing Erectile Disorder.

Whereas those treated for prostate surgery and other cancers or for diagnoses requiring bladder, rectal and other surgeries are highly likely to be insured by Medicare.

Whereas, due to Congressional prohibition, Medicare does not pay for PDE5 inhibitors, the penile pump, injectable medications, etc. but does pay for costly corrective surgery.

Whereas psychiatrists are aware that the consequences of Erectile Disorder may be depression, anxiety, diminished self-worth and quality of life, as well as significantly impacting the relation between the patient and his partner

Whereas the FEHB does include payment for PDE5 inhibitors, etc. (Representatives who oppose such coverage assert that the federal government should not have taxpayers paying for 'lifestyle' treatments. However, the federal government does pay for such care for its employees including Members of Congress.)

BE IT RESOLVED:
That the APA seek to collaborate with other medical societies, including the American Urological Assoc., AMA, etc., as well as organizations devoted to advocacy for those with illness which may result in Erectile Disorder to assure access to a full range of evidence based pharmaceutical, mechanical and surgical treatment options for dealing with Erectile Disorder in a cost effective manner.

That the Council on Advocacy and Government Relations and the Council on Healthcare Systems and Financing advocate, along with other professional societies and advocacy groups, for legislation to allow access to the full array of medications, mechanical therapies, and other treatments for Erectile Disorder which are currently excluded from coverage under Medicare.

AUTHORS:
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Barry B. Perlman, M.D., APA Member
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Deborah Cross, M.D., Representative, American Group Psychotherapy Association

ESTIMATED COST:
Author: $1,155 per annum
APA:

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY:

KEY WORDS: Medicare, Erectile Disorder, insurance benefits, human sexuality

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2016 Action Paper Budget Estimate

Action Paper Title: Making Access to Treatment for Erectile Disorder Available Under Medicare
Action Paper Author(s): Seeth Vivek, M.D., Representative, Area 2
Phone/email: seethvivek@aol.com
APA Admin. Name: -
Phone/email -

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

Travel Budget:	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1	staff to advocate for Medicare coverage for treatment of erectile disorder		1,155
2		-	-
3		-	-
Total Staff Costs			1,155
		Total Author Estimate	**$1,155**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	-	$0	$0	$0	$0	$0
Meeting 2	-	-	-	-	-	-
Total Travel Budget		-	-	-	-	-

Non-Staff Costs:

LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**

Staff Costs:

	Description:		
1		-	-
2		-	-
3		-	-
Total Staff Costs			-
		Total Administration Estimate	**$0**

Rvsd. Jan. 2016

Joint Reference Committee
Report to Assembly
May 2016

The Joint Reference Committee (JRC) refers the following actions to the Assembly for consideration. Click on Item Number to view item.

Item 4.B.1 Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses (JRCOCT158.A.1; JRCJAN168.A.2)

Will the Assembly approve the proposed Position Statement: *Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.2 Proposed Position Statement: Role of Psychiatrists in Assessing Driving Ability (JRCOCT158.E.1; JRCJAN158.E.2; ASMMAY154.B.8; JRCJAN168.E.1)

Will the Assembly approve the proposed Position Statement on the *Role of Psychiatrists in Assessing Driving Ability* and if approved, forward it to the Board of Trustees for consideration?

The Council noted that input was received from the Council on Psychiatry and Law in the development of the statement and that the statement is consistent with the AMA guidelines on assessing driving ability?

Item 4.B.3 Proposed Position Statement: Patient Access to Electronic Mental Health Records (JRCOCT158.J.2)

Will the Assembly approve the proposed Position Statement: *Patient Access to Electronic Mental Health Records* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.4 Proposed Position Statement: Trial and Sentencing of Juveniles in the Criminal Justice System (JRCOCT158.J.3)

Will the Assembly approve the proposed Position Statement: *Trial and Sentencing of Juveniles in the Criminal Justice System* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.5 Retire Position Statement: 2005 Adjudication of Youth as Adults in the Criminal Justice System (JRCOCT158.J.4)

Will the Assembly retire the 2005 Position Statement: *Adjudication of Youth as Adults in the Criminal Justice System* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The 2005 Position Statement: *Adjudication of Youth as Adults in the Criminal Justice System* has been replaced by the proposed Position Statement: *Trial and Sentencing of Juveniles in the Criminal Justice System.*

Item 4.B.6 Retire Position Statement: Infectious Disease Epidemics Including H1N1 (JRCOCT158.L.2)

Will the Assembly retire the Position Statement: *Infectious Disease Epidemics Including H1N1* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The position statement is out of date as H1N1 is no longer an issue.

Item 4.B.7 Revised 2007 Position Statement: Sexual Harassment (JRCJUL158.J.2; ASMNOV154.B.9; JRCJAN166.15)

Will the Assembly approve the revised Position Statement: *Sexual Harassment* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The Joint Reference Committee revised the position so that the title and content were in parallel.

Item 4.B.8 Proposed Position Statement: Equitable Access to Quality Medical Care for Substance Related Disorders (JRCJAN168.A.1)

Will the Assembly approve the proposed Position Statement: *Equitable Access to Quality Medical Care for Substance Related Disorders*, and if approved, forward it to the Board of Trustees for consideration?

N.B. The JRC made a minor revision to the proposed position statement.

Item 4.B.9 Retain Position Statement: Any Willing Physician (JRCJAN168.B.1)

Will the Assembly retain the Position Statement: *Any Willing Physician* and if retained, forward it to the Board of Trustees for consideration?

Rationale: Council members agreed that the intent of the statement is applicable to current issues concerning workforce and scope of practice.

Item 4.B.10 Revised Position Statement: Psychiatric Hospitalization of Children and Adolescents (JRCJAN168.C.1)

Will the Assembly approve the revised Position Statement: *Psychiatric Hospitalization of Children and Adolescents* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The statement was revised as it was out of date, included inaccurate statements and did not highlight current concerns in the field. The Council has integrated the feedback and recommendations from the JRC into this version of the document.

Item 4.B.11 Proposed Position Statement: Integrated Care (JRCJAN168.G.1)

Will the Assembly approve the proposed Position Statement: *Integrated Care* and if approved, forward it to the Board of Trustees for consideration?

Input on this position statement was provided by the Council on Psychosomatic Medicine, the Council on Healthcare Systems and Financing and its Work Group on Integrated Care.

Item 4.B.12 Proposed Position Statement on Off-Label Treatments (JRCJAN168.G.2)

Will the Assembly approve the proposed Position Statement: *Off-Label Treatments* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.13 Retire Position Statement: Patient Access to Treatments Prescribed by Their Physicians (2007) (JRCJAN168.G.3)

If the proposed Position Statement: *Off-Label Treatments* is approved by the Assembly (see item 4.B.12), will the Assembly retire the Position Statement: *Patient Access to Treatments Prescribed by Their Physicians* and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.14 Proposed Position Statement: The Call to Action: Accountability for Persons with Serious Mental Illness (JRCJAN168.G.4)
Will the Assembly approve the proposed Position Statement: *Call to Action: Accountability for Persons with Serious Mental Illness* and if approved, forward it to the Board of Trustees for consideration?

Item 4.B.15 Retire Position Statement: A Call to Action for the Chronic Mental Patient (JRCJAN168.G.5)

If the proposed Position Statement: *The Call to Action: Accountability for Persons with Serious Mental Illness* is approved by the Assembly (see item 4.B.14), will the Assembly retire the Position Statement: *A Call to Action for the Chronic Mental Patient* and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.16 Proposed Position Statement: College and University Mental Health (JRCJAN168.J.1)

Will the Assembly approve the proposed Position Statement: *College University Mental Health* and if approved, forward it to the Board of Trustees for consideration?

N.B. this position statement replaces the 2005 position statement of the same name.

Item 4.B.17 Retire Position Statement: College and University Mental Health (JRCJAN168.J.1)

If the proposed Position Statement: *College and University Mental Health* is approved by the Assembly (see item 4.B.16) will the Assembly retire Position Statement: *College and University Mental Health* 2005 and forward to the Board of Trustees for a similar vote on retirement?

Item 4.B.18 Retain Position Statement: Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research (JRCJAN168.L.1)

Will the Assembly retain the Position Statement: *Conflict of Interests for Clinical Practice and Research* and if approved, forward it to the Board of Trustees for consideration?

Rationale: The Council on Quality Care recommends retaining the position statement as the current evidence continues to support the stated position.

Item 4.B.19 Proposed Position Statement: Emergency Department Boarding of Patients with Acute Mental Illness (ASMMAY1512.S; JRCOCT156.13; JRCJAN168.K.1)

Will the Assembly approve the proposed Position Statement: *Emergency Department Boarding of Patients with Acute Mental Illness* and if approved, forward it to the Board of Trustees for consideration?

American Psychiatric Association
Position Statement

Title: **Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone With That Of Co-occurring Mental Illnesses**

Issue: The prevalence of Opioid Use Disorders (OUD) and the mortality from opioid overdoses continue to increase significantly in the United States. Buprenorphine is an approved and effective treatment for OUD, with special licensing requirements for the provider that prescribes it. Regional disparities in the supply of credentialed providers may impede access to care for many patients with OUD.
Patients with substance use disorders are twice as likely to suffer from a co-occurring mental illness as those without it and opioid use disorders are nine times more prevalent among patients with psychiatric comorbidities. While mental health comorbidities are associated with poorer outcomes, integrated treatment models have demonstrated improved quality of life, reduced illicit opioid use, and notable improvements in comorbidities, crime, and health costs. Recent and continuing changes in healthcare policy and cost prioritize the integration of evidence-based substance use disorders treatments into general medical settings.

For patients, access to treatment with buprenorphine is complicated due to the scarcity of buprenorphine waivered providers, low supply of opioid treatment programs, and the fact that general psychiatrists frequently opt out of providing buprenorphine treatment. In such cases, patients are often referred out to costly addiction treatment providers who typically offer medication with little or no wrap around services or no treatment at all for co-occurring mental disorders.

Position of the American Psychiatric Association:

1. The diagnosis and treatment of OUD are essential parts of psychiatric care. Patients with identified OUD should be educated about the condition and offered appropriate treatment.
2. The integration of care for OUD and co-occurring mental illnesses leads to improved patient care outcomes and should be practiced by general psychiatrists whenever possible.
3. Psychiatrists should be familiar with treatment options for OUD, manage uncomplicated patients with OUD, and seek consultation or referral with an addiction specialist for complicated cases.
4. Psychiatrists should complete training on the treatment of Opioid Use Disorder with buprenorphine and complete the additional licensing requirements to prescribe it.
5. In rural areas, consultation services with psychiatrists and addiction specialists should be made available via telemedicine to assist the local providers in treating complicated cases.

Background:
Over the past two decades, the prevalence of Opioid Use Disorders (OUD) has increased significantly in the United States [(1)]. While it is true that rates of heroin use have increased in many parts of the country, the most noteworthy factor driving these numbers is the dependence on narcotic pain medications [(2-5)]. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2013 national survey on drug use and health, 4.5 million Americans (1.7% of those older than 12 years old) were non-medical users of opioid pain medication, 289,000 or 0.1% of the overall population used heroin in the past month and 681,000 or 0.2% used heroin in the past year. Overall, close to 2.5 million Americans meet diagnostic criteria for OUD [(6)]. Such trends correlate with mortality from opioid overdoses, whereby, in 2009, lethal overdoses from pain medications were reported four times more frequently than from heroin, a threefold increase since 1999 [(5)].

Effective treatments for OUD have been developed and are supported by the understanding that it is a chronic relapsing illness and aim at halting illicit opioid use. Medication assisted treatment using naltrexone, methadone, or buprenorphine is a very effective form of treatment for OUD. Buprenorphine is of particular interest in view of its less complicated prescribing and similar effectiveness compared to methadone [7]. Buprenorphine, a partial agonist at the *mu* opioid receptor, is a controlled Schedule III substance that was approved by the Food and Drug Administration (FDA) in October of 2002 for the treatment of OUD. Physicians can prescribe it after taking an eight-hour course and obtaining a special waiver [1].

Not unlike other substance use disorders, patients with OUD often suffer from co-occurring mental illnesses. In fact, SAMHSA estimates that 17.5% of those with a non-substance related mental illness have a substance use disorder, more than twice the rates among those who do not (6.5%). Similarly, 37.8% of those with a substance use disorder (7.7 million adults) suffered from a co-occurring mental illness, more than twice the rates among those without a substance use disorder (16.7%) [4]. In fact, heroin use is 9 times more prevalent among those with co-occurring mental illness (0.9 Vs 0.1%) [4]. Such findings bear clinical significance as dual diagnoses are associated with worse outcomes in terms of relapse rates, hospital admissions, aggression, imprisonment, homelessness, and infectious diseases such as HIV and HCV [8].

Individuals with co-occurring OUD and other mental illnesses have been shown to require more costly crisis oriented services including admissions to emergency departments, inpatient psychiatric units, and the criminal justice system [9]. Conventionally, such individuals receive treatment from at least two parallel systems: one for their OUD, often using buprenorphine, and another for their other mental illnesses. This parallel but non-integrated treatment approach undermines the benefits of an integrated treatment program.

Dual diagnosis treatment models have been developed to address the fragmentation of care for those with a SUD with a co-occurring mental illness. Such models appear to address the difficulties that patients could face by navigating separate health systems. These patients often get non-concordant opinions on recovery and are being excluded from one system because of their co-morbid disorder [8]. Multiple controlled studies have demonstrated improved outcomes in treatment models that rely on multidisciplinary treatment teams for a comprehensive approach to providing clinical and psychosocial services, as compared to non-integrated programs [8]. A longitudinal study comparing integrated treatment models to parallel models found that the former leads to improved quality of life, reduced symptoms of co-occurring mental illness, increased engagement in treatment and employment rates, and a reduction in substance use. This study also showed a reduction in positive drug tests, hospitalization rates and number of hospital days, felony or misdemeanor arrests, probation violation, and days of incarceration. In addition, the integrated model was found to be advantageous from a financial point of view as it led to overall reduction in expensive crisis-oriented services [10]. One study specifically investigated the effects of integrating buprenorphine treatment in patients with HIV and demonstrated improved outcomes in terms of continued substance use and compliance with treatment both for OUD and HIV [11].

For patients, access to treatment with buprenorphine often proves to be difficult as there is a lack of buprenorphine providers. Currently, fewer than 3% of physicians in the US are licensed to prescribe buprenorphine [12]. Contributing factors include the required eight hours of training, the limits on the numbers of patients a provider can treat with buprenorphine at any given time, and the fact that it is not uncommon for physicians to opt out of buprenorphine treatment due to stigma, insufficient

training, and lack of institutional support. A survey of buprenorphine providers in Washington State reported that psychiatrists constitute only 29.5% of the overall pool, and 0% in rural areas, where primary care physicians were virtually the only providers licensed to prescribe, leading to added hurdles for the treatment of complicated patients with dual diagnoses [13]. A recent national analysis of buprenorphine prescribing in the decade after it was approved by the FDA (from 2003 to 2013) found that while the number of prescriptions increased 13 fold (from 0.16 million to 2.1 million prescriptions), and that prescribing by primary care physicians increased from 6.0% to 63.5%, buprenorphine prescribing by psychiatrists decreased from 92.2% to 32.8% [1]. Many buprenorphine providers opt out of health insurance plans and patients end up in programs that charge fees that many cannot afford. As a result, many individuals relapse to the abuse of opiates. In urban areas, buprenorphine providers are four times more likely to work in a private practice setting rather than in a safety net setting where patients with OUD are more commonly receiving treatment, opposite the trend in rural areas [13]. A study examining empirically whether to separate treatment of SUD and psychiatric disorders found no evidence in support of having different providers, adding to the evidence for continued integrated care [14]. A survey of non-psychiatric physicians who received training to use buprenorphine revealed that almost three quarters were not prescribing it, and that a lack of mental health and psychosocial training and support was the most commonly reported barrier among those who prescribe and among those who do not prescribe buprenorphine [15].

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9. Drake RE, Bartels SJ, Teague GB, et al. Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease. 1993;181:606–611.
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POSITION STATEMENT: THE ROLE OF PSYCHIATRISTS IN ASSESSING DRIVING ABILITY

BACKGROUND INFORMATION

The symptoms of psychiatric disorders, including major neurocognitive disorders (i.e., dementia), may in some cases interfere with the ability of patients to anticipate danger and avoid safety hazards, including those encountered while driving. Furthermore, the medications prescribed to ameliorate psychiatric symptoms may cause drowsiness and/or otherwise compromise the ability of patients to drive safely. Psychiatrists should therefore be aware of the possibility that their patients may be unable to drive safely and should be prepared to advise their patients and their caregivers that they should find alternatives to driving. Laws vary from state to state as to whether physicians, including psychiatrists, are obligated to inform the appropriate state agency if they believe that it is unsafe for their patients to operate a motor vehicle.

POSITION STATEMENT

The presence of a mental or neurocognitive disorder does not in itself signify impaired driving capacity. Nonetheless, persons suffering from mental disorders may experience symptoms that interfere with their ability to operate motor vehicles safely. Accurate assessment of the impact of symptoms on functional abilities usually is not possible in an office or hospital setting because such an assessment typically requires specialized equipment or observation of actual driving, which goes well beyond the scope of ordinary psychiatric care. However, psychiatrists may discover impairments affecting driving ability in the course of a comprehensive psychiatric evaluation, including an assessment of cognition.

Therefore, psychiatrists do have a role in advising patients about the potential impact of their illnesses and treatments on driving ability. When appropriate, psychiatrists should discuss with patients, caregivers, and family members symptoms of their patients' mental disorders that may substantially impair driving ability. Like all physicians, psychiatrists should warn their patients about the possible effects of medications, including psychotropic medications, on alertness and coordination. When clinically appropriate, medication with low potential for impairing driving ability should be chosen preferentially, taking into account the patient's driving requirements and habits.

Maintaining confidentiality in physician-patient relationships is important. At the same time psychiatrists should follow the laws in their state regarding reporting information on their patients' driving ability to the appropriate authority. Ultimately the responsibility for assessing driving ability resides with the Department of Motor Vehicles or other appropriate state agency. In states where reporting is not mandatory, reports made in good faith should be accompanied by immunity for psychiatrists from subsequent liability.

Developed by the Council on Geriatric Psychiatry

Proposed Position Statement on Patient Access to Electronic Mental Health Records
Draft September 15, 2015

Systems that provide patients with online access to their mental health records should implement appropriate procedures and safeguards. These include:

(a) methods for ensuring that treating psychiatrists in the system are notified when patients access their records,
(b) methods for ensuring that information likely to result in harm to the patient or others will not be disclosed,
(c) methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed,
(d) methods for facilitating patients' comprehension of disclosed information, and
(e) methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist.

Background

"Health records" refers to evaluations, progress notes, discharge summaries, and other clinical documentation that is created by health professionals for the purpose of evaluation and treatment for a specific patient. As established by law, patients have a right to access their health records.[1]

Health care systems, including the Veterans Administration health care system, have begun to allow patients to access their treatment records online. This development has raised concerns.

In the past, patients' access to their medical information required physical access to a paper record. Typically, patient access would occur following a request to an individual psychiatrist or, in institutional settings, the medical records department. Medical records departments generally have followed the practice of obtaining the treating psychiatrist's approval prior allowing patients access. In many settings, the treating psychiatrist or a colleague would be present or available while the patient reviewed their information. These procedures provided an opportunity for the psychiatrist to review the available records, to restrict access to

[1] The HIPAA Privacy Rule provides an exception to patients' right to access for "psychotherapy notes." As defined by the Rule, psychotherapy notes are those notes made by mental health professionals documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. To qualify as psychotherapy notes, the documentation must exclude information regarding medication prescription and monitoring, counseling session start and stop times, the modalities of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. HIPAA-defined psychotherapy notes are not equivalent to psychotherapy progress notes - they are akin to process notes. State laws may grant patients the right to greater access; psychiatrists should familiarize themselves with the laws of their jurisdiction.

information as appropriate, and to be available to address questions, concerns, or emotional reactions that may arise.

The establishment of electronic medical records in some medical care systems has led to the availability of online access to personal medical records.

Patient access to information may benefit the therapeutic process in a number of ways:

- Online access provides a written source of information to patients about their care that can serve as valuable aid to memory. Patients can review the directions and other information from prior visits. This may lead to improvements in patient education and compliance.
- Access to the records provides an opportunity for patients to review documentation for accuracy and completeness.
- Ready patient access to records may promote active patient engagement in treatment. In reviewing the records, patients may gain a greater understanding of the information their psychiatrists have conveyed to them. The documentation may provide additional perspectives regarding their diagnoses, treatments, and treatment options. As a result, patients may have questions to discuss with their psychiatrists. Such discussions are important therapeutic opportunities that provide the psychiatrist with insight into their patients' hopes, fears, and concerns about their illness, treatment, and prognosis.
- Patients may use online access to facilitate the transfer of information from a past treatment episode to a new treating clinician. This may be an important as a means of providing continuity of care. Also, in emergencies, online access may be a means of conveying critical information.
- Online access to past records may be valuable to patients who have become estranged from care. Patients who review past treatment records may gain insight that will prompt them to seek ongoing care.

However, there are potential problems with online access to psychiatric records that require safeguards. These safeguards are discussed below:

(a) There should be methods for ensuring that treating psychiatrists in the system are notified when patients access their records

Electronic medical record systems with online portals enable patients to access their medical records, in any location, and at any time. As a result, psychiatrists may not be aware that their patients have accessed records. In some cases, patients may be affected by what they have read; their attitude toward treating psychiatrists and treatment may be changed. In the absence of notification of patient access, psychiatrists may miss the opportunity to clarify misunderstandings. As a result, the therapeutic relationship may be adversely affected. Psychiatrists should be notified when their patients access records.

(b) There must be methods for ensuring that information likely to result in harm to the patient or others will not be disclosed

Some patients may have extremely negative reactions to the recorded information to such an extent that their life or safety, or the life or safety of someone else, may be endangered.

Medical records systems that permit online patient access should allow for this sort of sensitive information to be protected from viewing.

(c) There should be methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed

Patients may get inappropriate access to information. For example, a family member or other party may have given the psychiatrist information regarding the patient under the promise of confidentiality. Record systems that are accessible to patients should have the capability of blocking this information from viewing.

(d) There should be methods for facilitating patients' comprehension of disclosed information

Patients who access records may be confused by what they read or misinterpret documentation. Confusion may be lessened if the patient has ready access to online sources of information regarding psychiatric terminology and abbreviations commonly used in medical records. However, they may be no adequate substitute for a psychiatrist's explanation of the clinical notes and related documentation. The treating psychiatrists, of course, will be the best guides for their patients. Treating psychiatrists can explain their intents in writing the documentation and how they employed medical terminology and abbreviations in context. Systems should include information about abbreviations and terms. As previously discussed above, treating psychiatrists should be notified so that they can follow up with their patients to address any questions.

(e) There should be methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist

In some settings, it may be possible for inpatients to access their records during the course of hospitalization. Given the probability that psychiatric inpatients are acutely ill, and that the information accessed will include recent notes by psychiatrists, nurses, and other staff that may be disturbing to patients during acutely symptomatic periods, immediate access should not be routinely granted. As psychiatrists and other treatment staff are readily available, access should be granted by clinical discretion and, when deemed necessary, under the supervision of treatment providers. In cases in which there are disputes about access, resolution via mechanisms such as patients' ombudsmen, offices of patients' rights, or similar bodies should be available.

Documentation

If safeguards are not in place to prevent inappropriate access to information, clinicians may intentionally restrict the scope and detail of documentation to that which is minimally necessary. As a result, allied caregivers and subsequent treating psychiatrists may not have access to a rich record of treatment. This unintended outcome may be prevented by ensuring that electronic health records provide a mechanism to maintain highly sensitive information in a domain that is not generally accessible to patients through online access. Documenters need to

be sensitive about language and clinical descriptions within their documentation. Additional education about patient-sensitive documentation may be necessary.

Developed by the Workgroup on Access to Mental Health Records, Council on Psychiatry and Law. Grace Lee, MD (Chair), Elizabeth Ford, MD, Mark Komrad, MD, Steven Daviss, MD, Andrea Stolar, MD, Jenny Boyer, MD, Richard Milone, MD, and Brenda Jensen, MD.

Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System

Juvenile justice systems in the United States are undergoing substantial reform based on impressive advances in neurobehavioral understanding of adolescent development and on strong evidence regarding the effectiveness of developmentally grounded interventions. This body of knowledge has been summarized in a landmark report of the National Research Council (2013) and referenced by the Supreme Court in important decisions banning the juvenile death penalty (*Roper v. Simmons*, 2005) and severely restricting sentences of life without parole (*Graham v. Florida,* 2010; *Miller v. Alabama*, 2012). Despite these developments, statutes in many states permit or even require adolescents charged with crimes to be tried in criminal courts as adults, thereby becoming exposed to substantial terms of imprisonment

It is the position of the American Psychiatric Association that juvenile courts should have exclusive original jurisdiction in all cases in which individuals less than age 18 have been charged with a criminal offense. The law should presume that the youth will remain within the jurisdiction of the juvenile court unless the prosecution presents a clear and convincing case for transferring the case to the criminal court. Transfer should be permitted only if a youth is older than 14 at the time of the offense, has been charged with a violent crime, and the juvenile court finds, based on individualized consideration of all of the circumstances, that the youth poses a significant risk of further offending and has demonstrated that he or she is not amenable to treatment with the range of clinically appropriate services that should be available to the juvenile justice system.

Background:

Juvenile transfer laws, also known as waiver or certification laws, transfer an individual less than age 18 and charged with an offense from the juvenile court system to the adult criminal justice system for trial and sentencing. There are three main transfer mechanisms: (1) judicial waiver laws that permit or mandate judges to decide, in accordance with statutory criteria, whether a youth should be removed from juvenile court jurisdiction and tried in adult court; (2) concurrent jurisdiction laws that authorize prosecutors to file a case in criminal court; and (3) statutory exclusion laws that grant criminal courts original jurisdiction over juveniles who meet defined criteria (e.g. specific crime type committed by a youth of a particular age). Transfer laws of all types expanded significantly during the 1980s and 1990s and played a significant role in placing increasing numbers of youth in the adult criminal justice system (Hockenberry and Puzzanchera 2014).

The vast majority of adolescents with antisocial behavior desist from criminal behavior as they enter adulthood. Even serious juvenile offenders demonstrate an increasing ability to control impulses, suppress aggression, consider the impact of their behavior on others, take personal responsibility for their actions, and resist the influence of peers between the ages of 14 and 25. (Steinberg, Cauffman, and Monahan 2015). Multi-faceted community interventions, both residential and non-residential, available to juvenile courts have been shown to reduce reoffending and to prodeuce remarkably large economic returns relative to their costs (National Research Council, 2013).

Potentially detrimental effects of transfer include a longer or harsher sentence than may have been experienced by the juvenile if maintained in the juvenile justice system, physical, sexual, or psychological victimization from adult inmates or correctional officers, and harmful disruptions in the youth's developmental progress and to the process of forming identity and a responsible, law-abiding person (Mulvey and Schubert 2012). In addition, many juveniles who are tried in adult court will have a higher recidivism rate when compared to similarly matched juveniles adjudicated in the juvenile justice system (National Research Council, 2013; Schubert et al 2010). Finally, transfer for less serious crimes may result in stigma combined with the substantial economic cost of housing juveniles with adult offenders.

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Position Statement on Adjudication of Youths as Adults in the Criminal Justice System

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The ostensible goals of transfer, or waiver, to the criminal justice system include: (1) deterrence of youth from committing crimes, (2) reduction in recidivism among youth who are transferred, and (3) improvement of public safety. However, instead of accomplishing their intended goals, waivers have seriously disrupted the lives of youth, and their families, especially those from minority communities. The federal government, in concert with states, should review and develop a strategy to reform current transfer/waiver practices. The general goals of such reform must be: to reduce the number of youth inappropriately transferred to the criminal justice system who could be better served by the juvenile justice system, to provide rehabilitation services that support the development of youth as valued members of society, and to ensure community safety. Reform should specifically include:

1. a moratorium on the expansion of eligibility criteria for transfer.
2. limiting transfer only to judicial discretion (or sole authority by judge).
3. an elimination of transfers for nonviolent offenders.
4. an elimination of transfer of first-time offenders.
5. the development of specialized facilities for transferred youth. Such facilities would include small living units that are secure and safe; programming that addresses the developmental, educational, health, mental health, religious, and other special needs of these youth; and
6. adequately staffed with qualified workers to ensure safety and specialized programming (Council of Juvenile Correctional Administrators, 2005).

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Position Statement on Infectious Disease Epidemics Including H1N1

Approved by the Board of Trustees, May 2010
Approved by the Assembly, November 2009

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Developed by the Council on Research and Quality Care.

ISSUE: As the nation faces the onset of seasonal flu season and H1N1 continues to spread the APA acknowledges the increasing impact this will continue to make on the community. Many populations are vulnerable due to their situation, disease or socioeconomic position. Additionally individuals in schools and institutions are at additional risk due to their close proximity with each other.

POSITION STATEMENT:

With the infectious diseases such as H1N1 APA strongly supports:

1. Increased collaboration between psychiatry and primary care and public health to foster adherence, behavioral and medical interventions including psychiatric care for those exposed and infected.
2. Active and rapid planning for the special needs of vulnerable populations. In particular care and outreach is critically important for children; child and adult psychiatric patients, particularly those with chronic mental illnesses; those infected with HIV; schools; pregnant women; and the elderly.

The APA encourages psychiatrists and others to stay informed of the CDC guidelines and the vaccine recommendations in the statement.

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Attachment #15
Item 2015A2 4.B.9
Assembly
October 30-November 1, 2015

Position Statement on Sexual Harassment

Approved by the Board of Trustees, June 1992
Approved by the Assembly, May 1992
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA opposes and condemns all forms of sexual harassment ~~in the workplace;~~ and ~~further votes to~~ will advocate and lobby for legislative and judicial action to recognize and facilitate any necessary treatment for victims of sexual ~~workplace~~ harassment.

Revised by the Joint Reference Committee – January 2016

Proposed Position Statement
American Psychiatric Association

Title: Equitable Access to Quality Medical Care for Substance Related Disorders

Issue: Persons with substance related disorders have often been excluded from both medical treatment and medical coverage by insurance companies due to false beliefs that (1) there is no efficacious treatment, and (2) providing medical coverage for substance related disorders on par with medical disorders would result in skyrocketing health care costs. Given the prevalence of substance related disorders and the morbidity, mortality and costs associated with them, they can no longer be ignored or excluded.

Position Statement:

- All substance related disorders are diagnosable mental illnesses for which effective treatments are readily available.
- APA opposes the exclusion of substance related disorders from legislation or programs that pertain to parity of insurance coverage, access to health care services, and quality of care.
- Access must be expanded to effective prevention and treatment for substance related disorders, including medication assisted treatment others, are not subject to the same restricted limits on access to and coverage of care as are substance related disorders.
- It is discriminatory and contrary to the scientific findings of the clinical, research, health economics and policy communities to exclude substance related disorder diagnoses and patients with these diagnoses and to limit access to effective behavioral and medication assisted treatments.

Background:

Roughly 21.6 million people ages 12 and over in the United States were classified with substance abuse or dependence in 2013.[(1)] There is a large body of evidence that confirms both the biological underpinnings of these illnesses as well as the high rates of Substance Use Disorder treatment success.[(2,3-9)] A 1996 report of the National Treatment Improvement Evaluation Study (NTIES) demonstrated that 12 months after treatment completion, there were substantial reductions in the use of substances as well as other gains in employment, declines in criminal activity, and decreases in alcohol and drug related medical visits.[(7)] Yet, only 4.1 million people (19%) received treatment for alcohol or illicit drug use problems and only 2.5 million people (12%) received treatment in a specialty setting in 2013, which represents a consistently large gap in the number of people needing treatment and those who receive it.[(1)]

In 2008, the US Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which required health insurers to provide equal coverage for mental health and substance use disorder (SUD) services and general medical services. It also prohibited health plans from using nonquantitative treatment limitations (NQTL) such as medical necessity, prior authorization, and utilization review that are more restrictive than those used for medical/surgical health benefits. The Affordable Care Act (ACA) of 2010 added to that by expanding the parity requirement to Medicaid and Medicaid-managed plans, as well as state health insurance exchange plans. It also mandated that coverage for SUD treatment be included in health plans as an essential health benefit, equivalent to that provided for medical and surgical treatment. Historically, employers

and health insurers have stated concerns about the implementation of parity regulations; that it would result in significant increases in healthcare costs.[10] While many studies exploring the effect of state-level parity mandates prior to MHPAEA have shown this not to be the case [2,11-14], a more recent study exploring the effect of the addition of NQTL have confirmed these findings. The study explored Oregon's 2007 state parity law, which is similar to MHPAEA in that it also limits use of NQTL for behavioral health that is not on par with medical and surgical services, and found that spending on drug abuse treatment was not associated with statistically significant spending increases.[15] Furthermore, a study that explored the effect of the MHPAEA on costs associated with treatment of SUD in a large health plan provider across 10 different states found only a modest increase of $9.99 per enrollee.[16]

While the effects of parity have not resulted in a significant increase in healthcare costs, neither has it resulted in an substantial increase in utilization of substance use disorder treatment services which is needed to close the aforementioned treatment gap [16-18], nor has it extended access to effective behavioral and medication assisted treatment for substance use disorders.[19] Another significant barrier to care is societal stigma and the internalization of that stigma by those who suffer from these disorders.[2] Such internalization may deter individuals from seeking care. On the other hand, legislation of full parity, as well as implementation of enhanced access to effective treatment including behavioral and medication assisted treatments, for those with both mental health and substance related disorders can send a strong message to the public that these are medical disorders for which effective and evidence-based treatments exist, and that these treatments are offered within a health care system that provides equivalent care for all disorders whether they be medical, surgical, or psychiatric, including all substance related disorders.

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Developed by the Council on Addiction Psychiatry

Position Statement on Any Willing Physician

Approved by the Board of Trustees, July 1995
Approved by the Assembly, May 1995
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA believes that treatment by a non-medical licensed professional cannot substitute for medical treatment by a physician.

Accordingly, the APA supports "any willing physician" legislation which requires any public or private third party payer, health plan, or organized system of health care (hereinafter referred to as "payer") to contract with any duly licensed physician who is willing to accept the payer's published criteria, terms and conditions for participation and payment for the medical treatment for which the payer is responsible.

However, the APA recognizes that the concept of patient freedom-of-choice and the concept of an affordable point-of-service option may be superior to "any willing physician" in their value to physicians and patients.

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PROPOSED Final Draft Revision to
Position Statement on Psychiatric Hospitalization of Children and Adolescents
December 16, 2015

ISSUE:

In America today, many children and adolescents who suffer from mental health and behavioral disorders are not able to access appropriate mental health care due to the nationwide shortage of inpatient mental health services for their age group. Inpatient psychiatric hospitalization is often necessary to evaluate, acutely stabilize, treat and transition children and adolescent patients who present to emergency facilities in crisis. The CDC approximates that, each year, approximately one in five children in the United States experiences a seriously debilitating mental illness described as "serious deviations from expected cognitive, social, and emotional development". It is estimated that up to 12 million children in the U.S. under the age of 18 suffer from mental illnesses that include depression, anxiety, PTSD, mood disturbances, eating disorders, substance use, psychosis and suicidal ideation.

The nationwide shortage of inpatient mental health services for children and adolescents can be attributed to several factors including the overall decrease in psychiatric hospitals and long-term facilities from the 1960s to the present. Ninety five percent of public psychiatry beds available in 1955 were no longer available as of 2005. Currently, the majority of states in America have less than half the number of public psychiatry beds needed to serve community mental health needs due to the continued closing of inpatient units triggered by cost cutting measures by hospital systems. As a result, children and adolescents are often kept for long periods of time in Emergency Departments awaiting placement for long term or inpatient care. If an inpatient bed is found, these individuals may be sent to distant hospitals making it difficult for parents and families to visit, provide support and participate in the treatment process. More often, due to lack of facilities, children and adolescents are sent home with their families to wait for outpatient follow up. It is estimated that only 21% of children and adolescents receive care for their symptoms due to the lack of appropriate mental health facilities, and wait times often range from three months up to one year for assessment and treatment. Without appropriate inpatient psychiatric hospitals and adequate treatment facilities, many children and families do not receive appropriate intervention and treatment and are left to suffer from untreated and under-treated mental illness.

The consequence of untreated mental health illness in children and adolescents can be devastating for patients and their families. More adolescents die by suicide than all other natural causes combined. According to The Academy of Child and Adolescent Psychiatry, approximately 50% of students aged 14 and older with mental illness drop out of high school—the highest dropout rate of any disability group. 70% of youth in state and local juvenile justice systems have mental illness, with at least 20% experiencing severe symptoms. These youth are often diverted into the juvenile justice system for treatment and management of their mental illnesses due to a lack of alternative mental health care options which, consequently, can have numerous negative repercussions including worsening of mental illness and recurrent or long-term incarceration. These statistics attest to the importance of early intervention and treatment for all children and adolescents with mental illness symptoms. With additional inpatient and hospital-based resources, providers will be able to reduce the long-term sequelae of untreated mental health in the juvenile population.

APA POSITION:

It is the position of The American Psychiatric Association to:

1) **Advocate for the development of a full spectrum of appropriate, financially affordable, inpatient facilities and services for the diagnosis and treatment of children and adolescent in need of psychiatric care in the United States. These facilities are to include both psychiatric and general medical hospitals. Efforts should be focused on both increasing current inpatient services and also minimizing the current trend of closing existing units due to financial reasons.**
2) **Emphasize that the health of children and adolescents will be best served if primary treatment decisions such as admissions, medications, psychotherapy and appropriate disposition planning are the responsibility of a psychiatrist specialized in child and adolescent psychiatry whenever available.**
3) **Emphasize that, when possible, inpatient psychiatric hospitalization of children and adolescents should be provided close to their homes, so that their families may be included and participate during the treatment process**
4) **Work to provide parity in mental health treatment for all age groups by increasing mental health resources for children and adolescents and subsequently providing opportunities for early treatment and intervention to benefit young patients suffering from mental illness.**
5) **Work to educate the public and health care community that inpatient psychiatric care is necessary and justified when psychiatric illness severely affects a young person's safety or ability to function.**
6) **Address the shortage in Child and Adolescent Psychiatrists by recruiting psychiatrists-in-training and early career psychiatrists into specialized training**

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American Psychiatric Association

[Proposed] Position Statement on Integrated Care

January 2016

Issue: The American Psychiatric Association (APA) recognizes the well documented impact of untreated behavioral health conditions on outcomes, total healthcare expenditures and the patient care experience. Enhancing health care quality, access and value, including psychiatric services, requires employing new models of care with organized, proactive approaches to individuals' and populations' health. Patients with behavioral health conditions present in all sectors of the health care system and the APA can provide vital input in designing evidence-based approaches that provide comprehensive, high quality health care to the populations they serve while judiciously allocating precious healthcare resources.

It is the position of the APA that:

- Five Core Principles of Effective Integrated Care[1] are founded in the Wagner Chronic Care Model[2] and should serve as a guide for implementing and designing programs:

    1. Team-Based: Care is patient-centered and provided by teams using shared care plans. Effective teams in the primary care setting include at a minimum primary care providers, behavioral care managers and psychiatric consultants. Careful attention to cultural differences and change management are crucial to success.
    2. Population-Based: Patient populations are defined in advance, screened and triaged for targeted illnesses and/or health complexity, tracked in databases (referred to as registries), and followed for adherence and response to treatment. Caseloads are regularly reviewed for patients who have not followed-up and those who continue to have significant symptoms.
    3. Measurement-Based treatment to target: Outcomes are regularly measured using patient and illness-specific assessment tools (standardized when possible) and treatment adjustments made when improvement is not occurring. This is an iterative process until health stabilizes at a desired level (treatment to target).
    4. Evidence-Based: Treatments with evidence of effectiveness are used first, including evidence-based brief psychosocial interventions and/or pharmacotherapy proven to work in the primary care setting, followed by secondary and tertiary interventions if the initial treatment is ineffective.
    5. Accountability and Quality Improvement: Systems adopting the above elements track quality of care and outcome measures that allow for quality improvement and accountability during implementation and ongoing practice.

- In the Primary Care setting, the APA recognizes a model of integrated care known as the *Collaborative Care Model* (CoCM) as the most effective approach with demonstrated positive outcomes and cost containment across different mental health diagnoses and treatment locations[3]. This model enables enhanced access to the available psychiatric workforce to provide more optimal care outside of traditional psychiatric settings. There are other practice tested approaches that have merit but currently have a more limited research base. Utilization of blended models with adaptation to local practice conditions is common and may eventually merge with the CoCM model.
- In Critical Care/Medical/Surgical settings, the APA supports the use of evidence-based models of care to improve total health outcomes, reduce admissions, readmissions, and lengths of medical/surgical hospitalization, and to promote health stabilization in inpatients with medical complexity.

[1] http://aims.uw.edu

[2] Wager EH, Austin BT, Von Korff M: Organizing care for patients with chronic illness. Milbank Q 1996; 74:511–544

[3] Archer J, Bower P, Gilbody S, et al: Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev 2012;10:CD006525

- In the Public Mental Health sector, the APA will advocate aggressively for efforts to develop effective models to address the physical health disease burden and subsequent 20-30 year mortality gap experienced by psychiatric patients with serious mental illnesses ("reverse integration"). Successful models are emerging that include nurse care managers and an emphasis on health behavior change in a behavioral health home setting. There is a responsibility to monitor and address chronic medical conditions associated with mental illness and psychotropic medications. The APA will support the efforts of psychiatrists to utilize their full range of medical training to oversee the total health needs of patients.
- The APA must be at the forefront of supporting the development of best practices in integrated care. Psychiatrists utilize unique skills among behavioral health professionals, including knowledge about the interaction of medical and behavioral conditions. This approach supports effective patient-centered care and the ability to successfully treat psychiatric symptoms in the face of comorbid medical/surgical conditions. As a result, the APA will marshal its resources in education, research and advocacy to prepare psychiatrists for new roles in providing patient-centered outcome changing integrated health care.
- The APA will work with relevant payer, stakeholder and health systems to find sustainable reimbursement strategies, consistent with the requirements of Mental Health Parity and Addiction Equity Act (MHPAEA), for the essential processes and functions of evidence-based models of integrated care services including quality outcomes, timely access, and related performance measures.

Author(s): Lori Raney, MD and Eliot Sorel, MD (primary); APA Workgroup on Integrated Care and Council on Healthcare Systems and Financing

Adoption Date:

American Psychiatric Association

[Proposed] Position Statement on Off-Label Treatments

January 2016

Issue

Management of a patient's clinical care by third party payers (both public and private) has infringed on physician autonomy and clinical decision-making authority. This is especially problematic when prescribing drugs for off-label use. Management techniques, including additional administrative hurdles and financial penalties for patients, open the door for sub-optimal care.

Position Statement

The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an off-label[i] indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA encourages the use of the current drug compendia recognized by the Centers for Medicare and Medicaid Services (American Hospital Formulary Service-Drug Information, Gold Standard Inc. Clinical Pharmacology Compendium, National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Thomson Micromedex DrugDex® Compendium, Thomson Healthcare DrugPoints® Compendium) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses; APA further affirms that when the prescription of a drug or use of a device represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate off-label uses of drugs on their formularies.

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[Footnote] [i] The FDA describes off-label use of approved drugs as "when a drug is used in a way that is different from that described in the FDA-approved drug label…New uses for these drugs may have been found, and often medical evidence supports the new use. But the makers of the drugs have not put them through the formal, lengthy, and often costly studies required by FDA to officially approve the drug for new uses."

For example, the drug is:

- Used for a different disease or medical condition.
- Given in a different way (such as by a different route).
- Given in a different dose.
- Given for a different patient population (e.g., age, gender)
- Given to patients with conditions for which the drug is contraindicated (e.g. specific medical conditions, pregnancy)
- Given in combination with another drug or drugs that are contraindicated in the label

Authors: Joseph Mawhinney, MD and Susan McLeer MD (primary); Council on Healthcare Systems and Financing

Adoption Date:

Position Statement on Patient Access to Treatments Prescribed by Their Physicians

Approved by the Board of Trustees, July 2007
Approved by the Assembly, May 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA affirms strong support for the autonomous clinical decision-making authority of a physician and for a physician's lawful use of an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence in conjunction with sound medical judgment; APA further affirms that when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, should fulfill their obligation to their beneficiaries by covering such therapy, and should be required to cover appropriate "off-label" uses of drugs on their formularies. The APA recommends the following:

Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses

1. APA reaffirms the following policies:

a. A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion;

b. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy; and

c. APA encourages the use of three compendia (AMA's *Drug Evaluations**; *United States Pharmacopeia-Drug Information*, Volume I*; and *American Hospital Formulary Service-Drug Information*) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (*These two compendia currently are being merged as the result of an alliance between the American Medical Association and the United States Pharmacopeia.)

Dissemination of Information about Unlabeled Uses of Drugs and Devices by Manufacturers

2. APA strongly supports the need for physicians to have access to accurate and unbiased information about unlabeled uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.

3. APA supports the dissemination of independently derived scientific information about unlabeled uses by manufacturers to physicians, if the independent information is provided in its entirety [including comprehensive results of relevant clinical trials], is not edited or altered by the manufacturer, and is clearly distinguished from manufacturer-sponsored materials. Dissemination of information by manufacturers to physicians about unlabeled uses can be supported under the following conditions:

a. **For Reprints** of independently derived articles from reputable, peer-reviewed journals, the following criteria must be met:

   i. The article should be peer reviewed and published in accordance with the regular peer review procedure of the journal in which it is published;

   ii. The reprint should be from a peer-reviewed journal that both has an editorial board and utilizes experts to review and objectively select, reject, or provide comments about proposed articles; such experts should have demonstrated expertise in the subject of the article under review, and be independent from the journal;

   iii. The journal should be recognized to be of national scope and reputation, as defined by an advisory panel to the FDA; among its members, this advisory panel should have representatives from national psychiatric societies;

   iv. The journal must be indexed in the *Index Medicus* of the National Library of Medicine;

   v. The journal must have and adhere to a publicly stated policy of full disclosure of any conflicts of interest or biases for all authors or contributors;

   vi. When the subject of the article is an unlabeled use, or the article contains information that differs from approved labeling, the industry sponsor disseminating the reprint must disclose that the reprint includes information that has not been approved by the FDA and attach a copy of the FDA-approved professional labeling with the reprint;

   vii. If financial support for the study and/or the author(s) was provided by the industry sponsor disseminating the reprint, and this is not already stated in the article, then this information should be clearly disclosed with the reprint.

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b. **For Reprints of monographs or chapters from the three compendia** (AMA's *Drug Evaluations*; *United States Pharmacopeia-Drug Information*, Volume I; and *American Hospital Formulary Service-Drug Information*) named in federal statutes for determining the medical acceptability of unlabeled uses, the following criteria must be met:

i. The monograph or chapter should be reprinted in entirety by the publisher of the compendia, and the reprints then sent to the requesting industry sponsor;

ii. The reprints of the monographs or chapters should not be altered in any way by the industry sponsor;

iii. The industry sponsor disseminating the reprint of the monograph or chapters should disclose that the reprint includes information that has not been approved by the FDA and should attach a copy of the FDA-approved professional labeling with the reprint.

c. **For Complete Textbooks** the following criteria must be met:

i. The reference text should not have been written, edited, excerpted, or published specifically for, or at the request of, a drug, device, or biologic firm; when financial support is provided by a drug, device, or biologic firm, it should be disclosed clearly in the textbook;

ii. The content of the reference text should not have been edited or significantly influenced by a drug, device, or biologic firm, or agent thereof;

iii. The reference text should be generally available for sale in bookstores or other distribution channels where similar texts are normally available and should not be distributed only or primarily through drug, device, or biologic firms;

iv. The reference text should not focus primarily on any particular drug(s), device(s), or biologic(s) of the disseminating company, nor should it have a significant focus on unapproved uses of drug(s), device(s), or biologic(s) marketed or under investigation by the firm supporting the dissemination of the text;

v. Specific product information (other than the approved package insert) should not be physically appended to the reference text.

d. **For Proprietary Information** indicating that a drug is ineffective or unsafe when used for a specific unlabeled indication, manufacturers should report to the FDA and share with all physicians all of the proprietary information.

e. **For Continuing Medical Education (CME) activities and information**:

i. The FDA should continue to support principles in the FDA Draft Policy Statement on Industry-Supported Scientific and Educational Activities (Fed. Reg. 1992; 57:56412-56414); the FDA Draft Policy Statement acknowledges the importance of relying on professional health-care communities, rather than the FDA, to monitor independent provider activities;

ii. The FDA should continue a policy of regulatory deference for industry-supported CME activities conducted by organizations accredited by the Accred-itation Council for Continuing Medical Education (ACCME), state medical societies, and specialty societies such as the American Psychiatric Association (APA), that follow the Essentials and Standards of the ACCME and that may be certified for AMA PRA credit under the auspices of the American Medical Association Physician's Recognition Award program.

4. APA strongly supports the responsibility of physicians to interpret and put into context evidence received from all sources [including pharmaceutical manufacturers], before making clinical decisions (i.e.., prescribing a drug for an unlabeled use).

Improving the Supplemental New Drug Application (SNDA) Process

5. APA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. APA strongly encourages the US Congress, the FDA, pharmaceutical manufacturers, the United States Pharmacopeia, patient organizations, APA and other medical specialty societies to work together to ensure that Supplemental New Drug Applications (SNDAs) for new indications (efficacy supplements), including those for uses in populations with mental disorders , are submitted and acted upon in a timely manner. Specific recommendations include:

a. **User fee legislation should be re-authorized** to ensure that the FDA has the necessary resources to act on all efficacy supplements within six months of submission;

b. **The SNDA process should be streamlined** as much as possible without compromising the requirements for substantial evidence of efficacy and safety;

c. **Legislation should be enacted** that provides extensions of marketing exclusivity for a product to manufacturers who conduct supplemental research [i.e., Phase IV studies] and submit efficacy supplements gaining FDA approval for additional indications; the legislation should place a limit on total length of extended marketing exclusivity;

d. **For drugs no longer under patent and for which generic versions are available**, the FDA, other governmental agencies (e.g., the National Insti-tutes of Health), the pharmaceutical industry, the United States Pharmacopeia, patient organiza-tions, the APA and other medical specialty societies should discuss and mutually agree on alternative mechanisms to ensure that efficacy supplements based on relevant research findings will be submitted to and acted upon by the FDA in a timely manner.

Encouraging Clinical Research in Child and Adolescent Psychiatry

7. APA urges pharmaceutical manufacturers and the FDA to work with the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American College of Neuropsychopharmacology and other experts in pediatric medicine to identify those investigational drugs that should have pediatric indications and set up a mechanism to ensure that necessary pediatric clinical studies are completed prior to submission of NDAs for approval of these drug products.

American Psychiatric Association

[Proposed] Position Statement
The Call to Action: Accountability for Persons with Serious Mental Illness

(Adapted from the Position Statement: A Call to Action for the Chronic Mental Patient)

January 2016

REVISED BY JRC – January 2016

Issue: Failure to meet the needs of persons with serious mental illness, including persistent mental illness, early presentation of mental illness, and comorbid substance use disorders, remains a national crisis.

Serious mental illness spans all ages, genders, and sociocultural groups. It includes a wide variety of diagnoses, including psychotic disorders, mood disorders, anxiety disorders, neurodevelopmental disorders, neurodegenerative disorders, traumatic brain injury, and substance-related syndromes. Obstacles to recovery are everywhere. State hospital closures, community hospital downsizing, and the absence of essential community systems are driving forces behind poor outcomes, homelessness, and increasing social costs. Poor quality of care, social disadvantage, and adverse health behaviors lead to premature mortality in this population. Life expectancy of persons with serious mental illness is decreased by as much as 20 years compared with otherwise similar groups without mental illness.

Ensuring appropriate treatment, rehabilitation, and opportunities for recovery of persons with serious mental illness is ***a public health responsibility***. Federal, state, and local governments must be accountable for ensuring access to comprehensive assessment, treatment, and evidence-based care. Psychiatrists have a unique role and responsibility for developing strategies to address these challenges.

Position: The American Psychiatric Association shall work with psychiatrists, other physicians, and professionals, communities, and partners to achieve the best possible clinical outcomes, functioning, and quality of life for persons with serious mental illness. Priorities and strategies include:

1. **Ensuring access to all levels of effective and efficient care and treatment.**

   Services shall be:
   - Person-centered and recovery oriented, fostering self-sufficiency, independence, and positive self-worth.
   - Culturally and linguistically sensitive.
   - Available to persons across the lifespan.
   - Available to persons of all social, cultural, ethnic, racial, gender, sexual orientation, economic backgrounds, and population densities.
   - Provided in the least restrictive setting appropriate to the person's needs.
   - Overseen in a meaningful way by a physician, preferably a psychiatrist.

- Reimbursed by all health insurances (including Medicare and Medicaid) and provided by all health systems (including the Veteran's Administration).
- Adequately funded.

Services shall include but not be limited to:

- Comprehensive diagnostic assessments of psychiatric, substance use, and physical health, taking into consideration the impacts of psychosocial factors (such as homelessness, poverty, trauma, gender, and sexual orientation).
- Comprehensive plans of care and treatment based upon comprehensive and timely assessments.
- Follow-up assessments of sufficient frequency and duration.
- 24-hour emergency assessment and care, inpatient care, transitional care, respite care, clinic-based outpatient care, and therapeutic day care.
- Proactive crisis prevention with prompt and appropriate crisis intervention and stabilization, available and accessible at all times.
- Integrated psychiatric and substance use disorder care and treatment.
- Evidence based treatments (such as Assertive Community Treatment, supported employment, peer support, ECT, and DBT).
- Access to a comprehensive formulary of psychotropic medications.
- Comprehensive case management and functional support services.
- Support for education, socialization, and rehabilitation.
- Home-based, school-based, and community-based programs.
- Prevention and early recognition and intervention programs.
- Engagement of family and other primary supports, including the financial, social, and behavioral health resources to do so.
- Full spectrum housing from structured residential care to independent living.
- Full spectrum employment from supported employment to long-term, independent, and sustainable employment.
- Benefits counseling and coordination including assistance to the uninsured and underinsured.
- Review of social security eligibility to better reflect disability and to foster transition to sustainable employment.

2. Coordinating and integrating medical and psychiatric care.

Care and treatment shall be coordinated with primary care providers to alleviate the burden of medical illness, so the life spans of persons with serious mental illness will not be compromised or shortened because of inadequate or inadequately integrated services. Coordination shall include comprehensive care management services.

3. Ensuring interagency coordination of federal, state, and local: human service, health, and criminal justice agencies.

An individual's transition between levels, locations, and jurisdictions of care and treatment shall be seamless. Funding shall follow individuals through transitions.

4. **Enhancing education and training at every level of potential intervention.**

   Elements shall include but not be limited to:
   - Family engagement and participation in education.
   - Peer support knowledge and skill development.
   - Educational opportunities for students and trainees in all relevant fields.
   - Interdisciplinary and cross-discipline training.
   - Medical student and resident training in primary care, specialty care, and emergency care.
   - Reaching out to community partners and other interested stakeholders.
   - Opportunities for academic career development.
   - Partnerships of state health authorities, medical schools, and academic medical centers.
   - Training of psychiatric residents and early career psychiatrists regarding administrative and leadership roles in the public/community sector.
   - Availability and accessibility of adequately trained and supervised psychiatrists and other practitioners, at all levels of education and training, to meet clinical and social service needs.

5. **Increasing research about serious mental illness and the individuals it affects.**

   Research shall include epidemiology, etiologies, treatments, comorbidities, prevention, outcomes, interdisciplinary management, and service delivery.

6. **Eliminating discrimination against persons with serious mental illness by informing the public, elected leaders, and community leaders that any individual with serious mental illness may be meaningfully integrated into their community**.

   Individuals with serious mental illness, family members, professionals, paraprofessionals, and interested others shall inform the public, elected leaders, and community leaders about what must be done to overcome the discrimination, stigma, and obstacles of meaningful community acceptance and integration of persons with serious mental illness.

Authors: Laurence Miller, MD, Isabel Norian, MD (Primary), APA Assembly Committee on Public and Community Psychiatry, in consultation with the APA BOT Workgroup on Healthcare Reform, American Association of Community Psychiatrists, and the Council on Healthcare Systems and Financing and its Workgroup on Integrated Care.

Adoption Date:

Am J Psychiatry 136:5, May 1979

OFFICIAL ACTIONS

Position Statement: A Call to Action for the Chronic Mental Patient

This statement was approved by the Assembly at its October 1978 meeting and by the Board of Trustees at its December 1978 meeting upon recommendation of the Ad Hoc Committee on the Chronic Mental Patient. It was prepared by the Ad Hoc Committee on the Chronic Mental Patient.[1]

THERE IS no more urgent concern than the needs of the chronic mentally ill who suffer from severe, persistent, or recurrent mental illnesses with residual social and vocational disabilities. As a result of the deinstitutionalization programs of the past decade and the continuing growth of high-risk populations that generate chronic illness, the problems associated with the care of these patients constitute a national crisis. The Conference on the Chronic Mental Patient, sponsored by the American Psychiatric Association in collaboration with the President's Commission on Mental Health, was held in Washington, D.C., January 11-14, 1978, and addressed the striking inadequacy of care, treatment, and rehabilitation of this group, estimated to number over one million Americans.

The chronic mentally ill are of all ages, including children, and have a variety of diagnoses.[2] They may reside in community or institutional settings. Such patients must be distinguished from those individuals who may be receiving various forms of psychotherapy for mental disorders without attendant long-term disabilities. The chronically ill have a host of special and unique problems including extreme dependency needs, high vulnerability to stress, and difficulty coping with the demands of everyday living, resulting in difficulty securing adequate income and housing and holding down a job.

The term "chronic mentally ill patient" stigmatizes persons so designated and obscures their diversity and potential for improvement. It is not a desirable appellation because of its implication of hopelessness and progressive deterioration but has been used in this report because of its historical and current use in the literature and by the profession and because of its descriptive clarity. While these people have a chronic illness that requires medical and psychiatric attention over a long period of time and are, therefore, appropriately called patients, it is equally important to recognize them as persons with continuing disability. This disability concept carries the positive implication that a psychosocial rehabilitation approach should complement any treatment provided.

Successful programs for helping the chronically ill patient offer a continuum of residential and nonresidential services to ensure that care is tailored to meet individual needs and to provide easy access and reentry to services and responsiveness to crises. Such programs use the skills of persons with an interest in and knowledge about chronic mentally ill patients. They provide thorough monitoring and balance active outreach with the encouragement of self-sufficiency and independence. They also encourage interagency cooperation and referral and serve as patient advocates. They have effective vertical (e.g., up higher governmental levels) and horizontal (e.g., across to other community agencies) structures. Sensitivity to incremental degrees of progress, economic stability, accountability, and responsibility are also essential features of effective programs.

Obstacles to effective delivery of services to the chronically mentally ill are monumental. They include the attitudes of patients, families, communities, community leaders, and professionals; the lack of an integrated community support system; fragmentation of federal programs; the absence of unified funding; the failure to designate responsibility for treatment, care, and rehabilitation of the chronically ill patient; widespread discrimination in employment, ambulatory care funding, zoning, etc.; and conflicting and/or limiting federal and state regulations.

POLICY STATEMENT

To address the needs of the chronic mentally ill, a national public policy must be adopted. This policy must include the following:

1. *Public sensitivity and financial commitment to a system of opportunities and services.* A systematic approach to caring for the chronic mentally ill must include at a minimum active case-finding and outreach; 24-hour emergency and crisis stabilization services; functional evaluation; medical and psychiatric care; training in skills of everyday living; so-

[1]The Ad Hoc Committee on the Chronic Mental Patient included John A. Talbott, M.D., chairperson, James T. Barter, M.D., Maurice Laufer, M.D. (deceased), W. Walter Menninger, M.D., Arthur T. Meyerson, M.D., Mildred Mitchell-Bateman, M.D., Lucy Ozarin, M.D., John P. Spiegel, M.D., and Harold Visotsky; Dr. Richard Duke, Dr. Z. Erik Farag, Dr. Henry Foley, Dr. Eli Ginzberg, Dr. Sam Keith, Dr. David Mechanic, Ms. Judith Turner, and Ms. Jane Yohalem were consultants, and Donald Hammersley, M.D., and Sam Muszynski, M.S.W., represented APA staff.

[2]In this report, the population we are concerned with are primarily those suffering from major psychoses, e.g., chronic schizophrenia, chronic recurrent affective disorders, etc. For reasons of simplicity and expeditiousness, the term, as used in this report, does not include persons suffering from alcoholism or drug abuse or the mentally retarded.

cialization; an array of specialized living arrangements; subsistence, prevocational evaluation, clinical work adjustment programs, and subsidized transitional and permanent full- and part-time work opportunities that are meaningful and feasible; and assistance to families—all of which are monitored and managed in accordance with individual needs. In addition, provision should be made for indirect services such as community consultation, community education, community organization, and interagency collaboration. The system should recognize that some patients, while chronically disabled, are only partially disabled and can function in supportive situations. The system should be designed to promote growth and sustain functioning to the maximum degree feasible for each individual and should be directed toward patients who voluntarily request assistance.

2. *Designation of clear responsibility for providing services at appropriate levels of government.* The assurance of care, treatment, and rehabilitation of the chronically mentally ill is a national public health responsibility. Thus, every level of government bears some responsibility to assure adequate services to this population.

The federal government should have the responsibility for defining eligibility; identifying and assuring levels of benefits; funding services under national health insurance or categorical programs; establishing regulations ensuring access to services, quality care, and cost effectiveness; and monitoring program implementation. The state government should assume responsibility for statewide planning, approval of local plans consistent with that statewide plan, supplementary funding and benefits, standards, and program monitoring within the state. At the local level, appropriate organizational entities should be responsible for local planning and integration of services for the chronic mental patient, administering and/or managing those services either directly or by contract, and evaluating programs.

3. *Full civil rights for the chronically mentally ill.* There should be no discrimination against the mentally ill. The right to adequate treatment in the community and to confidentiality must be guaranteed. Chronic mentally ill patients should have full access to medical, legal, educational, vocational, occupational, and housing services and opportunities. These services and opportunities to the mentally ill should be provided in settings that allow the maximum independence consistent with the patient's needs.

4. *Reform of funding mechanisms.* These should be designed to remove incentives toward more restrictive forms of care, to remove discrimination against the chronically mentally ill, and to assure their access to health, human service, rehabilitation, and housing programs. Funding should also increase the availability of vitally needed services such as active outreach, crisis stabilization in the normal environment, diminution of symptomatic behavior, remediation of functional skills, meaningful daytime activities, long-term supportive work opportunities, and case management.

5. *The same policy and implementation requirements* for classes of service, levels of care, and accountability that are required of public and private, state and local health systems and facilities should be applied to programs run directly by the federal government (i.e., the Veterans Administration and Public Health Service systems).

6. *Social and cultural factors.* There should be an equitable allocation of mental health resources in the community to citizens from all social, economic, and racial (ethnic) backgrounds and population densities. All services delivered must be adapted to meet the cultural values and perceptions or needs of various ethnic, minority, and subcultural groups.

7. *Utilization of families.* Wherever possible, patients' families should be involved in their treatment and care rather than depending on more expensive and less caring substitutes. While women in the home have traditionally assumed the caretaking responsibility, changing roles suggest that their presence can no longer be taken for granted; there must be adequate financial, social, and mental health supports available when families assume such responsibility.

RECOMMENDATIONS

Psychiatry's Role in the Care of Chronic Mentally Ill Patients

Since care of the chronic mentally ill patient is a major health concern to the public, it is incumbent on psychiatrists and other physicians to take an active role in attending to the needs of this population. Even though psychosocial problems may predominate, the medical and psychiatric needs of the chronic mentally ill require vigilant monitoring. In addition, psychiatrists have a responsibility in the development of comprehensive services for the chronic mentally ill and should be involved at all levels of program planning, public education, training, and research related to preventive care and rehabilitative services.

The American Psychiatric Association should take the lead in undertaking programs to elevate the prestige and value of work with chronic mentally ill patients. Portions of the scientific programs of annual meetings, regional meetings, and district branch scientific meetings should be devoted to this population. Research should be sponsored and groups working with this population should be encouraged. APA should also take steps to encourage psychiatrists and others to monitor the quality of care administered to the chronic mentally ill patient population by their peers.

The prestige and status of psychiatrists who work in programs with chronic mentally ill patients will be enhanced by affiliation with medical school departments of psychiatry; teaching and/or clinical assignments at medical schools by psychiatrists who work with the chronic mentally ill; clinical and supervisory assignments by faculty of academic departments to programs for chronic mentally ill patients; continuing medical education programs held at the site of programs for chronic patients by medical schools and APA district branches; academic appointments for psychiatrists working in programs for the chronic mentally ill patient; and a referral system involving private psychiatrists, which will ensure continuity of care.

Community Education

1. All involved consumer, professional, paraprofessional, and governmental bodies should mount a coordinated education and lobbying program, using professional communication expertise (lobbying, marketing, community education) to inform the public about the chronic mentally ill and how to meet their needs.

2. Community education must be oriented toward increasing the visibility and status of programs directed to chronic mental patients.

3. A major effort should be undertaken to develop a constituency for the chronic mentally ill patient population.

4. District branches should make an effort to include the subject of care and treatment of the chronic mentally ill in both their community and scientific programs.

APA Document 197801

Research

There must be a continuing emphasis on research in the area of chronic mental illness, including epidemiology, etiology, therapy, outcome, and effective service delivery. In addition, new efforts should be undertaken to clarify the conditions under which family care is helpful or harmful; to ascertain the rate and nature of problems faced by the (current) deinstitutionalized population as compared with the (formerly) institutionalized chronically ill population; to study the criteria for deinstitutionalization and for various types of group maintenance, including continued hospitalization; to define and refine the tasks, skills, and process of case management; and to reexamine the issues relating to confidentiality. Uniform data collection regarding the size, composition, and service needs of the chronic population at the local level is needed to help identify special problems and needs and to improve program planning and monitoring. Another fruitful area for research is the prevention of chronicity, especially in children and adolescents as well as in the aging.

Training

1. Training programs should be expanded or established for persons, including family members, in the skills appropriate to the needs of the chronic mentally ill.
2. Current professional training programs, including psychiatric residency programs, should be modified and reoriented toward an interdisciplinary focus to enhance the capacity of professionals to treat and care for the chronic mentally ill patient. Persons who have been working in chronic care settings should be retrained to be able to function within a community/rehabilitation model, nursing homes, and geriatric facilities, as well as in programs that help patients in strength assessment and the acquisition of the skills of everyday living.
3. Funding is required to implement the above retraining provisions and provide incentives for state governments to carry out this statutory responsibility where necessary. Consideration should be given to mechanisms whereby psychiatric residents could "pay back" the money spent on their training by serving in shortage areas (e.g., state hospitals).
4. Psychiatric residency training programs should be encouraged to include training for more chronic mentally ill patients than the 10 specified in the residency training guidelines, as well as to include training in administration and planning. Consideration should also be given to a new subspecialty—rehabilitation psychiatry.
5. A program for volunteer case aides should be established to promote local volunteer mobilization around the chronic mentally ill patient.
6. Training programs should be established for medical students and primary care physicians, especially those working in emergency settings, to focus on the special treatment needs of patients with chronic mental illness, since these patients have a higher incidence of medical illness and are often resistant to medical care due to their mental disability. Such programs should include experience with ambulatory chronically mentally ill patients, with particular emphasis on appropriate and inappropriate psychopharmacological medications, the concomitant social and vocational disabilities, and the full array of ambulatory treatment programs necessary for chronically ill patients.
7. The establishment of guidelines for training and career development of psychiatrists involved with program planning for and treatment of chronic mentally ill patients should be encouraged. A study of psychiatrists currently working in this area may offer data relevant to the development of successful educational experiences and career pathways.

Continuity and Provision of Services

1. Barriers should be removed to assure chronic mentally ill patients access to a full range of medical, psychiatric, rehabilitative, income maintenance, social, employment, and related opportunities and services appropriate to their needs in the least restrictive setting.
2. The system of care should be continuous between institutions and local programs, and there should be well developed systems for interservice program referral. It is necessary to establish and support case management to enable the chronically ill patient to use and benefit from community resources and programs. Such management should be based on a comprehensive treatment and management plan; the patient, and if possible the family, should be involved in the planning and delineation of responsibilities. Before extensive programs of case management are undertaken, however, there is a need to define the role, responsibility, and function of care, fixing of responsibility, and linking of hospitals with community services. Interagency linkage should be encouraged through inducements and sanctions written into legislation, regulations, and procedures. Adequate resources should be provided for case management functions, and funding should allow for an adequate period of time for training staff and establishing information systems, etc., to phase in such a system.

Financial Needs

The financial recommendations that follow include consideration of cost savings resulting from the shift of chronically ill patients from higher cost institutional programs to lower cost community alternatives. Attention to the ways in which financing mechanisms perpetuate higher cost care can prevent escalating and outrageous costs for programs serving chronic mentally ill patients. Some evidence exists that high quality integrated programs based on a least restrictive but full service model are no more costly than state hospital incarceration.

1. Programmatic funds should, as a long-term goal, flow from the federal to the state level and be earmarked for the chronic mentally ill patient where possible. This includes monies currently administered in the Departments of Health, Education, and Welfare, Housing and Urban Development, Labor, etc. Thus, a specified share of welfare, housing, rehabilitation, health, and mental health dollars would be directed to this population either on a capitation or index of need basis. These monies would be allocated to local communities or agencies only if programs were accountable in relation to the chronic mentally ill patients' needs for service.
2. On the federal level, structures should be created to provide oversight, both by Congress and the executive branch, of legislation and regulations affecting the needs of chronic mentally ill patients. A comparable structure should be established on the state and local levels.
3. The Department of Health, Education, and Welfare should perform a national survey of Medicare and Medicaid eligibility requirements, benefit services, and reimbursement schedules. This survey would elucidate current inequities and help establish national parity.
4. Chronic mentally ill patients are entitled to full participation in the health care system. Medicare, Medicaid, and

future national health insurance should not single out the chronic mentally ill as a class or discriminate against them in any way. This is especially important regarding private psychiatric care, which is often less costly than that provided by institutions.

5. Medicare, Medicaid, and future national health insurance benefits should include a full range of inpatient, day treatment, and outpatient services encompassing periodic medical and psychological evaluation and treatment, resocialization, and rehabilitation. In all future funding, there should be differentiation between health services (e.g., evaluation, diagnosis, medical, and psychiatric treatment) and social and supportive services (e.g., escort services, housing, etc.).

6. Any future national health insurance should also include cost effective but positive financial incentives to encourage professionals to care for the chronic mentally ill patient, so that the existing disincentives to providing long-term care are reversed.

7. Financing of psychiatric and human services should be modified to remove fiscal disincentives (e.g., Medicare restrictions on ambulatory care) and unnecessarily restrictive or debilitating settings or forms of care, such as inpatient hospitals or nursing homes.

8. All federally funded comprehensive community mental health centers should be required to provide comprehensive services to the chronically ill mental patient as one of the mandated essential services.

9. A federal technical assistance program, along the model of the agricultural extension program, should be developed to help localities develop appropriate programs for chronic mentally ill patients.

10. Funding mechanisms should encourage states and localities to move individuals out of the human services system into mainstream community life through rehabilitative programs.

11. Priority should be given to proposed systems ensuring that money follows chronic mentally ill patients, either through a voucher system that would enable patients to buy any or all necessary services or by some other mechanism.

12. There is agreement on the following points regarding recommendation 13 in the Preliminary Report of the President's Commission on Mental Health (advocating establishment of a class of intermediate care facilities for mental patients under Medicaid): there is a current *shortage of federal and state funding* for community living arrangements for the mentally disabled; there is a need for a *continuum* of types of living arrangements, offering varying degrees of supervision and support; funding policies should promote a planned, accountable *system* of living arrangements within each state and local planning area; there is a critical need for improved methods to *link* special living arrangements with nonresidential treatment, rehabilitation, and support services; and it is vital to recognize that appropriate living arrangements are *necessary* but not sufficient in meeting the needs of the mentally disabled.

Based on these areas of agreement, it is recommended that additional resources for community living arrangements for the mentally disabled be made available through earmarking federal and state housing and social service funds.

With respect to the advisability of specific federal funds for intermediate care facilities for the mentally ill, while we support the intent of the proposal, we believe that no such facilities should be established, because specific federal funding for a particular class of facilities will result in overdevelopment of one type of residential arrangement at the expense of other types, it will detract from the availability of adequate resources for essential nonresidential rehabilitation and support services, it will interfere with developing flexible local systems based on community needs, and it will be more expensive than a policy that would limit use of medical funds to more narrowly defined medical needs and would support housing arrangements from nonmedical resources.

13. Provisions of Supplemental Security Income legislation and procedures should be modified to replace the current disincentives against patients' returning to productive employment with positive incentives; e.g., allowances should be made for patients' rehabilitation potential.

Administrative Issues

As a long-term goal, the federal government should take responsibility for leadership and advocacy of care for the chronic mentally ill patient; establish policy and ensure consistency in all relevant agency policies; set basic programmatic guidelines and regulations; establish minimal care and accountability standards; issue guidelines setting forth broad parameters for the ulitization of funds; provide strong incentives and bonuses for care of the chronic mentally ill patient in the community; stimulate collaboration among agencies involved in policy planning and program implementation; develop technical assistance and disseminate information concerning the chronic mentally ill patient; develop criteria for determination of local government's ability to assume planning, management, and service operation responsibility and to establish programs for those localities without sufficient capacity to provide training, assistance, and funding to attain an acceptable level; and provide assurances that any jurisdictional level that has oversight/coordination responsibilities (and has reduced or eliminated its service operations) maintains the necessary staff expertise to carry out its responsibilities in the areas of planning, licensure, etc.

State governments should carry out the leadership, patient advocacy, and planning functions on a statewide basis for distribution of federal monies; supplement federal funds with state monies; and designate local authorities to have programmatic responsibility. They should also establish and provide assurances that coordination mechanisms are in place and operating to ensure chronically ill patients' access to appropriate support programs, develop appropriate standards for programs on a state level, establish regulatory/guideline appeals mechanisms, provide services for specific populations when it is not feasible for any other entity to assume this function, and monitor local service operations.

Local authorities should designate specific local entities to perform program activities; coordinate the planning and provision of services; hold local entities accountable for these services; establish entitlement for chronic mentally ill patients to relevant support systems; ensure nondiscrimination; ensure maximum consumer (public and nonprofit) participation; and provide local entities with formal authority over support-system resources such as welfare, rehabilitation, etc., applicable to this population.

Local entities should be the final common pathway for program funding directed toward providing the chronic mentally ill with a holistic integrated program based on the least restrictive, rehabilitative model with appropriate medical-psychiatric input. Local entities eligible for designation as the authority responsible for chronic mentally ill patients should include both public and nonprofit facilities.

The immediate goals should include the following:

1. Oversight mechanisms should be established at the fed-

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eral level; examples are a select committee in Congress comparable to the Select Committee on Aging, and an executive branch equivalent, which would oversee federal legislation and regulations applying to chronic mentally ill patients.

2. Each state mental health authority should designate a single person/office to assume primary responsibility for acting in behalf of, planning, and supporting services for chronic mentally ill patients. Such person/office should develop knowledge about all potential federal and state programs that may provide funding and/or services for chronic mentally ill patients and transmit that knowledge to appropriate mental health service providers. Further, that person/office should review legislation, appropriations, and rules and regulations and should serve as an advocate for policies that will enhance services for chronic mentally ill patients.

3. Each state should produce a plan which guarantees that the needs of the chronically ill population will be provided for. Such plans should fix responsibility within each local planning area with a single community agency that assumes the role of convener, catalyst, coordinator, community organizer, and advocate for meeting the full range of needs of chronic mentally ill patients. The type of agency that can best assume this role may vary from community to community, depending on what is available. In all cases, it is essential that such responsibility be clearly assigned and recognized.

4. Clinical integration should be done by the local area health or mental health planning body independent of any care delivery system of its own that might represent a competitive interest. This also applies on the state level.

5. Accountability is a critical element to assure that the services promised are actually delivered. Evaluation of these services must be consistent and equally applicable to all service providers. Efforts should be made to limit the costs and bureaucracy of the evaluation process—possibly by utilizing the Health Systems Agency structure or an equivalent—and to encourage a positive attitude in enforcing accountability; i.e., evaluators should be oriented toward helping recipients satisfy not only regulatory requirements but also toward improving services, in addition to identifying service deficiencies and threatening penalties. Affirmative approaches to quality of life and social and vocational disabilities should be a primary objective.

6. Rather than building a whole new network of programs and services, the emphasis should be on the development of staff and facilities for the chronic mentally ill patient, making use of existing functions and resources, including the family whenever possible, and restructuring and reordering such programs in ways that better meet the needs of the chronic mentally ill patient. The development of new approaches and capacity should be encouraged at the local level, and technical assistance should be provided to enable this.

7. States should be discouraged from developing new state-operated facilities for chronic mentally ill patients and should phase down present facilities over time. While states must assure an adequate supply of facilities to meet the needs of chronic mentally ill patients, in order to encourage the local development of programs these facilities should not be state operated.

8. The federal government should eliminate any state or regional options in the utilization of essential federal funds, e.g., Section 8 of the Housing Law of 1975, and establish mechanisms whereby states and localities may appeal restrictive regulations.

Civil Rights

There should be federal legislation or regulations to accomplish the following:

1. *Prohibit discrimination against chronic mentally ill patients in vocational rehabilitation, employment, and education.* Specifically, Title VII of the Civil Rights Act of 1964 should be amended to prohibit "unjustified" discrimination in employment on the basis of handicap. In addition, there should be vigorous enforcement of Sections 503 and 504 of the Rehabilitation Act of 1973, federal legislation to encourage the hiring of the mentally handicapped (either through bonuses or tax incentives), and assurance that the severely and chronically mentally disabled are served by vocational rehabilitation agencies. Also, the concept of equal job opportunity should be applied to women in both institutional and community rehabilitative and vocational programs.

2. *Prohibit discrimination against chronic mentally ill patients in housing.* Specifically, Title VIII, Fair Housing, of the Civil Rights Act of 1968, should be amended to prohibit discrimination in housing on the basis of handicap. The Department of Housing and Urban Development should promulgate regulations to encourage states and localities to allocate additional Section 196 funds to develop more group care facilities, and to make additional Section 8 rental assistance funds available to mentally disabled persons living in group homes.

Federal legislation should be enacted encouraging the private market to provide housing to the mentally handicapped and conditioning receipt of federal revenue sharing or other funds to states having a plan for the development of community care and community residencies for the mentally disabled.

3. *Endorse the right to adequate treatment for both voluntary and involuntary patients in the hospital and the community, in the least restrictive setting consistent with individual treatment needs.* This includes the establishment of a mechanism whereby the patient may object to any aspect of his/her treatment plan, including transfer to another facility or to the community.

4. *Protect confidentiality, while allowing access to relevant information for legitimate treatment, planning, and research needs.* Centralized records should contain the minimum amount of information needed to meet the patient's future treatment needs, with access to records limited to a "need to know" basis, and patients should have the right to consent to the release of particular items of information from their records for time-limited periods, revocable by the patient. Stringent protection should govern access to treatment records, and stringent criminal penalties should be mandated for misuse of information included in records. Insurance claims (private and governmental) should be reviewed by a claims review system in which physicians would review patients' records without their names attached.

5. *Develop and fund an advocacy system independent of service providers to help ensure the implementation of patients' rights.* This system should either be part of the protection and advocacy system created by the Developmental Disabilities Act or should be modeled on that system.

6. *Prohibit zoning discrimination against the mentally ill by requiring that receipt of revenue sharing, housing, and other federal funds be predicated on the absence of exclusionary zoning laws or regulations in an area.*

7. *Enact a "Bill of Rights" for mentally disabled persons residing in the community.*

American Psychiatric Association
Position Statement on College and University Mental Health

Approved by the Council on Psychiatry and Law, September 12, 2015*

The need for mental health services on college and university campuses is increasingly recognized. Many students enter college already taking psychiatric medications and most colleges report that the number of prescriptions written at their student health and counseling centers has grown in recent years (National Survey of College Counseling Centers, 2015). Mental health visits are among the most frequent types of healthcare visits among college students (Turner and Keller, 2015). Further, most colleges report increasing numbers of students with histories of binge drinking, substance abuse, and severe psychopathology (Center for Collegiate Mental Health, 2015). Suicide is the second leading cause of death in college students (Blanco et al, 2008). Attending college is often very stressful for young adults, especially when faced with intense academic pressure to perform. Stressors also include separation from parents and other family members and the ongoing process of forming one's personal identity. In addition, several psychiatric disorders begin during late adolescence and early adulthood, highlighting the importance of early identification and treatment during this time.

Strong evidence shows that mental health problems adversely affect rates of graduation among college students (Hunt et al., 2010). Unfortunately, however, utilization of mental health services varies greatly among colleges (Lipson, et al, 2015). Many college students do not have ready access to psychiatric services or do not take advantage of the services that are available to them. Most community colleges do not have student health or counseling services at all. Many college students continue to lack health insurance. Moreover, students who leave home for college typically also leave their adolescent health care providers and do not successfully negotiate a transition to new providers who understand the special needs and vulnerabilities of young adults. (IOM, 2014)

It is the position of the APA that:

1. All colleges and universities, including community colleges, should have an established arrangement for timely access to psychiatric evaluation and treatment and other necessary and appropriate mental health services for all students in need of them. All colleges without student health programs should have the capacity to provide screening and referral for mental health services. Every student health program should make arrangements for access to an employed or consulting psychiatrist or for referral to a local private psychiatric practitioner or community clinic. Arrangements should be in place for psychiatric care to be coordinated in an appropriate manner with care delivered by the student health service or counseling center. Psychiatrists should have the opportunity to participate in assessment and treatment planning to a degree commensurate with their clinical responsibility.

2. A treating psychiatrist should not serve as a decision-maker regarding academic matters, including withdrawal from classes or from school, due to the potential conflict of interest between the academic mission of the university and fidelity to the welfare of the student. A treating psychiatrist should serve in a consultative capacity in academic decisions, but the final decisions should rest with those not involved in the direct health care of students.

* This Position Statement replaces the 2005 statement by the same name

3. All colleges and universities should either require or strongly encourage students to have comprehensive health insurance coverage, especially for mental health and substance abuse treatment, and should assist students to obtain coverage if they are not insured. Psychiatric problems arising while students are enrolled should be treated on or off campus adequately and at parity with any other health problems.

4. Colleges and universities should provide students, parents and staff with easily accessible and culturally sensitive orientation, and ongoing education, regarding health and wellness. Particular attention should be paid to mental health literacy, including recognizing mental health problems and understanding appropriate interventions, including how to respond to disturbing behavior or apparent distress, whom to contact and how to access services both for routine care and for urgent and emergency interventions. Colleges should implement comprehensive programs to reduce suicide risk, prevent alcohol and substance use problems, and reduce sexual assault and respond compassionately to its victims.

5. Colleges and universities should work with community partners and state, federal agencies (such as NIMH, NIDA, SAMHSA) and college MH focused non-profits (such as JED Foundation and Active Minds) to educate the public regarding challenges and risks related to young adulthood, the prevalence of mental disorders among young adults, the importance of recognizing and responding to signs of distress and strategies for stress management and resiliency.

6. Protection of confidentiality and trust in the treatment relationship are especially important for college students. Colleges are relatively self-contained communities and college students transitioning from adolescence to adulthood are growing into their sense of themselves as independent individuals. At the same time, parents also have a strong interest in being involved in their children's health care -- even when their child has become an adult, legally speaking. In rare cases involving students who present a risk of harm to themselves or others, the university administration also has a strong interest in being aware of the student's status. The primary regulations governing privacy in college mental health settings are FERPA, HIPAA, state confidentiality statutes, and codes of professional practice. Clinicians and college officials should encourage young students who may be still dependent on their parents emotionally and financially to share appropriate information with them and seek their support when clinically indicated. Even in case of student's refusal to contact the parent, the perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations. The federal laws and regulations, including updated guidance on FERPA, generally provide an adequate framework for thoughtful clinical decision-making and allow disclosure to university officials and parents when there is genuine concern about the students' safety or the safety of others.

7. Indiscriminately requiring students with mental health problems to take a medical leave can exacerbate students' mental health conditions and adversely affect their self-esteem, and it also violates the American with Disabilities Act. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the risk of violence to self or others cannot be managed safely in the school environment, but students should have appropriate due process protections in these determinations. Students' safety prior to returning to college should be determined by a mental health care provider on a case-by-case basis.

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Developed by the Council on Psychiatry and Law

Position Statement on College and University Mental Health

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

A Presidential Task Force on Mental Health on College Campuses was appointed by the American Psychiatric Association (APA) in 2005. An earlier group, the 1972 APA Task Force on College Mental Health, issued a statement focusing on the need for psychiatrists working in college settings to understand the special nature of work in colleges. While we agree with the general thrust of these comments, changes in both psychiatric practice and the college student population necessitate a new policy statement:

The need for mental health services on college and university campuses is increasing. More students enter college already taking psychiatric medications and most colleges report increases in medications being prescribed at their mental health services. Further, most colleges report seeing increases in students with binge drinking, substance abuse, and severe psychopathology. Suicide is the second leading cause of death in college students. Going to college is often very stressful for late adolescents when faced with more intensive grade pressure, separation from parents and friends, and the continuing formation of one's identity. In addition, several disorders begin during late adolescence and early treatment is necessary.

There are institutional benefits to providing excellent mental health care on college and university campuses. Data show that treatment for mental health problems results in higher rates of student retention and graduation.

It is the position of the APA that all colleges and universities should:

1. have an established arrangement for timely access to necessary and appropriate psychiatric services for all students in need of mental health services. Such arrangements may include employed and/or consulting psychiatrists, as well as referral arrangements with local private practitioners. Arrangements should be in place for care to be coordinated in an appropriate manner.
2. ensure that psychiatrists have authority commensurate with their responsibility. This should include significant participation in assessment and treatment planning for students served in college and university mental health settings.
3. assure that the treating psychiatrist role is clearly separated from the role of psychiatrist as practitioners, hospitals, university health services and/or community mental health centers. When students are referred out of their student health systems, care should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts.
4. offer health insurance coverage programs to students that provide comprehensive coverage for mental health, including substance abuse treatment.
5. provide students, parents and staff with easily accessible and culturally sensitive orientation information and ongoing education regarding wellness, general health, and mental health issues (including information about accessing emergency services). This should include problems associated with re-entry of students who have had to interrupt their education.
6. educate student health personnel about recognition of mental health problems.
7. have comprehensive suicide risk reduction and substance abuse prevention programs.
8. establish clinically informed policies that are responsive to and consistent with the ADA (Americans with Disabilities Act).
9. work with psychiatric residency training programs to increase educational opportunities in college and university mental health services. Consideration should be given to the establishment of post-graduate fellowship programs in college psychiatry.
10. work to educate the public as to the challenges and risks related to the college years, in partnership with the appropriate agencies (such as NIMH, NIDA, SAMSA).
11. work toward de-stigmatization of psychiatric illness and helping young people and their families make thoughtful choices about college.
12. support the expansion of research endeavors around college mental health issues and exploration of factors relating to prevention and resiliency.

Prepared by the Task Force on College Mental Health, May, 2005; revised by the Council on Children, Adolescents & Their Families, September 2005; and revised by the Joint Reference Committee, October 2005

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Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research

Approved by the Board of Trustees, December 2010
Approved by the Assembly, November 2010

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

The APA, as a professional medical association, joins with other medical specialties in promoting, supporting, and advocating, as its primary interest, the highest level of evidence based practice, ethically based and scientifically valid research, and quality continuing education for the benefit of patients, the profession and society. As a medical specialty, we affirm our support of the Institute of Medicine report [*Conflict of Interest in Medical Research, Education and Practice*].

Members involved in clinical practice, education, research, and administration must be diligent and aware in identifying, minimizing, and appropriately managing secondary (personal) interests (financial, contractual, career-centered) that may inhibit, distract, or unduly influence their judgment or behavior in a manner that detracts from or subordinates the primary interest of patients and may be perceived by some as undermining public trust.

Principles and Guidelines

The following situations, contexts, and associations have been noted to be of special concern, both by accumulated evidence and heightened public focus. Accordingly, members should exercise vigilance, caution, and strive for the prevention of conflict whenever possible.

A. Gifts and meals often accompanied by product endorsement and promotional literature may influence physicians' decisions about prescriptions, laboratory tests, or procedures.

B. Contact with pharmaceutical representatives represents marketing and should be distinguished from balanced education and critical scientific information as a basis for prescribing. Samples and starter packets may influence decisions to prescribe products that have equivalent and less costly alternatives.

C. Conflict of interest ethical principles and ongoing studies should be integrated parts of continuing medical education, including distinguishing marketing and promotion from balanced, scientific clinical evidence.

D. Consulting arrangements with industry should be based on a substantive contribution and commensurate compensation.

E. Constructive collaboration with industry for research of new products and public education for the benefit of the community should not be discouraged. However, funding should be commensurate to the research and reflect active participation and documented remuneration. The role of the member in a scientific publication or sponsored information document should be specifically and accurately acknowledged.

F. Physicians have a continuing responsibility to review the scientific and clinical evidence base on newly developed treatment options and incorporate new options for the patient populations they treat.

This policy was developed by the Assembly Conflicts of Interest Work Group. The principles and guidelines in this document are derived from the Institute of Medicine report:

Lo B, Field MJ, Institute of Medicine, Committee on Conflict of Interest in Medical Research, Education, and Practice: Conflict of Interest in Medical Research, Education, and Practice. Washington, DC: National Academies Press, 2009. (www.nap.edu/catalog/12598.html)

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American Psychiatric Association

Proposed Position Statement
Title: Emergency Department Boarding of Patients with Acute Mental Illness

Issue:
Individuals with acute mental illness are increasingly seeking psychiatric care in emergency department (ED) settings. This situation is, in part, a culmination of a failure of states and localities to invest adequately in preventive mental health and substance use services, coupled with reductions in inpatient and crisis services. The inability or failure to access lower levels of care, such as outpatient services, respite care and subacute services, has led patients and families to seek more expensive emergency care during decompensated states. There are few psychiatric emergency services nationwide dedicated to the evaluation and treatment of patients during an exacerbation. Care is more often being provided by emergency medicine physicians who generally have received little training in the evaluation and management of psychiatric disorders. As a consequence, the default treatment disposition typically becomes psychiatric admission for these patients. Unfortunately, over the years, the number of psychiatric beds has been reduced, leading to a backup of patients in emergency departments awaiting an inpatient psychiatric bed. This is particularly true for the most vulnerable psychiatric populations, including children and adolescents, developmentally disabled individuals, and persons with serious and persistent mentally illness.

Once a patient has been evaluated and is awaiting disposition, the patient is considered to be "boarded" in the ED. The wait for boarded patients can be hours, and even days to weeks. During this time, there is often little active psychiatric treatment available. Furthermore, environmental factors in the ED may result in further exacerbation of underlying psychiatric symptoms.

APA Position:

Prolonged boarding of patients with acute mental illness in emergency departments leads to inadequate care, may be harmful, and is unacceptable. All efforts should be made to help place each patient at the appropriate level of psychiatric care. When boarding is unavoidable, the emergency department should ensure that the patient is receiving active, appropriate, and humane mental health treatment in a safe setting with periodic re-evaluation for any emerging physical health problems. Depending on the needs of each patient, this treatment may include appropriate interventions for agitation and other acute symptoms, supportive therapy, and initiation of medications for their primary mental illness. Attention should also be paid to patient comfort and the ED staff should provide regular updates for the patient and family. All emergency settings should have access to psychiatrists, on-site or via telepsychiatry, to assist in conducting an adequate evaluation and in providing optimal care.

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Council on Psychosomatic Medicine

Adoption Date:

American Psychiatric Association

Background
Title: Emergency Department Boarding of Patients with Acute Mental Illness

With "deinstitutionalization" of psychiatric patients in the 1960s, and the advent of managed care starting in the 1980's, the emphasis of caring for persons with mental disorders shifted toward community-based treatment facilities, both inpatient and outpatient, and largely away from state-run facilities. This has led to market forces determining the total number of inpatient psychiatric beds in a given state, rather than population indices. The end result has been a trend towards decreasing beds, which worsens when there is an economic downturn such as with the recent recession.

More patients are seeking mental health care in emergency departments (EDs). The annual number of ED visits from 1996 to 2006 has increased from 90.3 million to 119.2 million,[1,2] with 6 to 10% of patients presenting for mental health concerns.[3,4] Mental health visits have been found to be 42% longer than non-mental health visits. In the same study, the mental health visits demonstrated a higher rate of inpatient admission (24% versus 12%), higher rates of transfer (16% versus 1%), and higher percentage of self-pay or charity care (22% versus 16%). Furthermore, the duration of time spent in the ED was especially long for patients who required transfer to a different facility or with a diagnosis of significant mental illness or substance use disorder.[5]

The term "ED boarding" is subject to interpretation, as there is not one agreed upon definition. Some have described it as remaining in the ED for four additional hours after the decision is made to admit.[6] Others define it as a stay in the ED exceeding 24 hours.[7] Nolan and colleagues went further in their definition to an actual description. "Boarding describes ED patients whose evaluation is complete and for whom the decision has been made to either admit or transfer, but for whom there is no available bed."[8] These patients may be kept in the emergency department, in ED hallways, or sent to inpatient medical floors or other "improper placements" while awaiting an appropriate psychiatric bed. This can apply to both voluntary and involuntary patients.[8] And finally, the Joint Commission has defined boarding as "patients being held in the emergency department or another location after the decision to admit or transfer has been made."[9] One thing that is clear with each definition is that ED boarding is a term used for all patients that are awaiting hospitalization, not only those with a mental health condition. Though, one survey revealed that 11% of all ED patients boarded but 21.5% of all psychiatric ED patients boarded and odds of boarding for psychiatric patients were 4.78 (2.63-8.66) times higher than non-psychiatric patients.[8]

The extent of boarding is not clear because of the lack of an agreed upon meaning to the term. In 2008, The American College of Emergency Physicians surveyed ED directors regarding psychiatric boarding ("Psychiatric and Substance Abuse Survey"). They surveyed 1400 emergency department directors, of which 328 responded. In this survey, 79% of respondents reported having psychiatric patients boarding in their emergency department;55% of emergency department directors reported boarders on a daily or at least multiple day per week basis;62% reported that there are no psychiatric services involved with the patient's care while they are being boarded prior to their admission or transfer.[6] Average boarding times vary but published average ranges are from 6.8 hours[10] to 34 hours.[11]

ED Boarding of psychiatric patients is caused by multiple factors, only one of which is the frequently cited inpatient bed shortages. Inpatient unit closures, bed reductions, delays in discharge for already admitted patients as they wait for outpatient services to become available all contribute to decreasing numbers of available psychiatric beds.[12] The hesitation of private hospitals in accepting manageable public health patients is a factor. Though lack of available beds is an issue, it is far downstream in patient care. Other causes are related to lack of sufficient funding and care at lower levels (such as intensive outpatient services, crisis stabilization units, and respite). Of the respondents to the ACEP survey, 23 percent replied they have no community psychiatric resources available and 59 percent had no substance abuse or dual diagnosis patient services available.[6]

Once in the ED, there is also a lack of available mental health resources and psychiatric clinicians to evaluate and treat patients.[13] Timely, active treatment in the ED setting can avoid the need for some admissions. Additionally, other factors may include lack of ambulances willing to provide transport,[14] time spent handling pre-authorization from insurance carriers and other managed care hurdles, lack of insurance or having public insurance,[13] absence of alternative placement options aside from admission,[15] patient characteristics such as homelessness,[13] and concerns about liability issues by evaluating emergency clinicians.[16] Iatrogenic worsening due to less than optimal conditions in the ED can be a factor. Finally, characteristics of boarded patients include higher rates of psychotic disorders, personality disorders, and those that require physical restraints/seclusions (i.e. those with substantial illness burden).[17] These characteristics may make placement difficult.

ED boarding costs the system, other ED patients, as well as the individual patient. The average monetary cost to an ED to board a psychiatric patient has been estimated at $2,264.[4] Other than the direct monetary costs, the system becomes less efficient. ED Boarding in general contributes to reduced availability of emergency staff, longer wait times for patients in waiting rooms, increased patient frustration, reduced ED capacity, increased pressure on staff, increased rates of patients who leave

without being seen, longer inpatient stays, lost hospital revenue and consumption of ED resources.[4,8,12,15] For providers, boarding is also associated with a higher degree of stress, greater risk of adverse events, and lower levels of reported patient satisfaction. [10]

Costs to the individual patient are numerous. The ED environment can be loud and chaotic, which may exacerbate underlying conditions or agitation.[12] Resulting anxiety or agitation may require medications or additional interventions such as restraint or seclusion.[18] These patients require increased use of ancillary support (such as security officers, safety attendants) and have increased risk of elopement.[4] The ED also lacks the therapeutic milieu, programming, and consistent provider teams available on inpatient psychiatric units.[17] Additionally, emergency physicians and nurses may carry negative attitudes towards psychiatric patients that affect the treatment they provide and may lead to adverse outcomes.[18] In fact, a major concern about psychiatric boarding is that there is often minimal to no active treatment for the psychiatric condition. As noted previously, 62% of ED medical directors responding to the ACEP survey reported that there are no psychiatric services involved with the patient's care while they are being boarded prior to their admission or transfer.[6]

There have been many different proposed solutions to include opening of more inpatient beds, increased mental health resources in EDs, emergency telepsychiatry, establishing crisis stabilization units, as well as increasing funding to outpatient mental health services. Allen et al have described the many beneficial effects of specialized psychiatric emergency departments.[19] Most recently, Zeller and colleagues published a study on the use of regional psychiatric emergency services to divert patient from EDs and inpatient units and to allow for directed psychiatric care.[20]

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EXECUTIVE SUMMARY

Committee on Bylaws

The Committee on Bylaws met on August 6, 2015 via conference call, and referred the following proposed language to the Board of Trustees (BOT) at its October meeting in Arlington, VA. The proposal was approved. The full report is provided as **Attachment 1.**

Section 2.1. of the APA Bylaws:
(j) International Resident-Fellow Members. International Resident-Fellow Members shall be physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada who obtain written verification from the training program director. International Resident-Fellow Member status shall not exceed ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

ACTION 1: Will the Assembly vote to ratify the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws?

ATTACHMENT 1 - REPORT OF THE COMMITTEE ON BYLAWS

Chairperson: Rebecca W. Brendel, MD, JD
Members: Edyth P. Harvey, MD, Roger Peele, MD, Christopher Pelic, MD, Rudra Prakash, MD, JD and Sidney H. Weissman, MD
Administration: Margaret C. Dewar and Chiharu Tobita

At the July 2015 meeting, the Board of Trustees (BOT) voted to approve the recommendation of the Membership Committee, chaired by Dr. Rahn Bailey, to establish a new category of membership for international psychiatry residents, as follows:

"International Resident-Fellow Member: Physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, verified with a letter from the training program."

With the assistance of APA Assistant General Counsel, Ms. Shari Graham, the Committee on Bylaws drafted and completed the following proposed *APA Bylaws* language in August 2015:

Section 2.1. of the *APA Bylaws*:

(j) International Resident-Fellow Members. International Resident-Fellow Members shall be physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada who obtain written verification from the training program director. International Resident-Fellow Member status shall not exceed ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

This Bylaws language includes the membership application requirement of a written verification from the training program director, as indicated in the July 2015 report of the Membership Committee.

The Committee on Bylaws discussed and addressed the concerns noted by the Board of Trustees (BOT) and the Membership Committee that some countries do not have an accrediting organization for residency training programs similar to the ACGME. As a result, the length of residency and fellowship training in psychiatry varies by country. At least two medical societies allow international residents to be in the category for up to ten years. In accordance with the BOT and the Membership Committee, the *Bylaws* language states that an international resident is permitted to remain in the category for up to ten years or the duration of residency and fellowship training in psychiatry, whichever is shorter.

The Board of Trustees voted to approve the proposed language at its meeting in October 2015.

ACTION 1: Will the Assembly vote to ratify the Board-approved language of the International Resident-Fellow Member Category to be incorporated into the APA bylaws?