American Psychiatric Association
Joint Reference Committee
January, 2016

MATERIALS INCLUDED IN THE PACKET

NB: The action items in the JRC Agenda, not the council reports, are the final actions for the JRC

Click on the Item Number to view

Draft Agenda

2. Draft Summary of Actions from the October 2015 Joint Reference Committee Meeting

3. Report of the CEO and Medical Director

4. Referral from the Board of Trustees

5. Report of the Membership Committee

6. Report of the Assembly

7. Council Assessments
   - 7.A Council on Psychiatry and Law – Assessment
   - 7.B Council on Quality Care – Assessment

8. Council Reports
   - 8.A Council on Addiction Psychiatry
   - 8.B Council on Advocacy and Government Relations
   - 8.C Council on Children, Adolescents, and Their Families
   - 8.D Council on Communications
   - 8.E Council on Geriatric Psychiatry
   - 8.F Council on Healthcare Systems and Financing
   - 8.G Council on International Psychiatry
   - 8.H Council on Medical Educations and Lifelong Learning
   - 8.I Council on Minority Mental Health and Health Disparities
   - 8.J Council on Psychiatry and Law
   - 8.K Council on Psychosomatic Medicine
   - 8.L Council on Quality Care
   - 8.M Council on Research

9. Awards
   - 9.A 2016 Nancy Roeske Award
   - 9.B 2016 Irma Bland Award

10. Proposed Revisions to the JRC Composition

Joint Reference Committee
October 17, 2015
Arlington, VA
DRAFT SUMMARY OF ACTIONS
11-18-2015

N.B: *When a **LEAD** Component is designated in a referral, all other entities to which that item is referred report to the **LEAD** component. The LEAD component then submits its report as requested by the JRC.*

JRC Members Present:
Maria Oquendo, MD: JRC Chairperson; APA President-Elect (stipend); Salaried at Columbia and NYSPI; royalties from suicide severity rating scale; NIMH Council; Council for the American College of Neuropsychopharmacology; Vice President of the Board of the American Foundation for Suicide Prevention;
Daniel Anzia, MD: JRC Vice Chairperson; APA Speaker-Elect (stipend); 80% employed at Advocate Lutheran Health and Hospitals Corporation; Spouse and father of Advanced Practice Nurses.
Jenny Boyer, MD: Department of Veterans Affairs – salaried; small private practice; Board of Trustee member of the Oklahoma State Medical Association
Saul M. Levin, MD, MPA: CEO/Medical Director – APA salary; Chair of the APAF Board of Directors
Theresa Miskimen, MD: Robert Wood Johnson School of Medicine – salaried; Consultant for involuntary medical panels;
Gail Robinson, MD: Professor of Psychiatry – University of Toronto; Expert witness; Member – Ministry of Health Task Force on Sexual Abuse of Patients; GAP Board; Vice President of ACP.
Paul Summergrad, MD: excused

JRC Administration:
Margaret Cawley Dewar – Director, Association Governance
Laurie McQueen, MSSW – Associate Director, Association Governance

APA Administration:
Rodger Currie, JD – Chief of Government Affairs
Yoshie Davison, MSW – Chief of Staff
Tristan Gorrindo, MD – Director, Division of Education
Kristin Kroeger – Chief, Policy, Programs, & Partnerships
Ranna Parekh, MD, MPH – Director, Division of Diversity and Health Equity
Shaun Snyder, JD – Chief Operating Officer
Philip Wang, MD, PhD – Director, Division of Research
Jason Young – Chief Communications Officer

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
2	Review and Approval of the Summary of Actions from the July 2015 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the July 2015 meeting?**	The Joint Reference Committee approved the draft summary of actions from the July 2015 meeting.	Shaun Snyder, JD Margaret Dewar Laurie McQueen, MSSW	Association Governance
3	CEO/Medical Director's Office Report **Updates on Referrals**			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
3.A	Fostering the Next Generation of Leaders within the APA (ASMMAY1512.J) The development of the next generation of leaders within APA is a critical function that will require input and collaboration from across the organization. The Administration, Divisions of Membership, Education, and Diversity and Health Equity are working on addressing this issue. The Administration has also solicited feedback from the Council on Medical Education and Lifelong Learning. We agree with the author's cost estimate as the scope of the paper was narrowed. The Council on Medical Education and Lifelong Learning had a robust discussion of this topic which they deemed important. Focusing on this issue primarily through the lens of GME training, the Council noted that there is already a day-long leadership conference for residents at the Annual Meeting. In future years, this conference will be available to all senior residents and fellows, not just chief residents. Additionally, the scientific program committee is evaluating a number of proposals which would also include leadership forums at the next Annual Meeting in conjunction with potential sponsorship from the Association for Academic Psychiatry. The new online transition to practice curriculum will also focus on basic leadership and managements skills that residents require. The Council will continue to support leadership opportunities of this nature for trainees. The Council is supportive of one-to-one mentorship with APA leadership. The Education Department is exploring ways in which to incorporate a community service activity during the annual meeting that includes leadership opportunities for residents and medical students.	The Joint Reference Committee thanked the CEO and Medical Director for the update on this referral.		N/A

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4.A	Caucus: Korean American Psychiatrists Will the Joint Reference Committee recommend that the Board of Trustees approve the establishment of a Caucus of Korean American Psychiatrists under the auspices of the Council on Minority Mental Health and Health Disparities?	The Joint Reference Committee recommended that the Board of Trustees establish a Caucus of Korean American Psychiatrists under the Council on Minority Mental Health and Health Disparities. The JRC noted that it may be prudent to clarify the procedures and requirements for establishing a caucus under the auspices of a council and under the auspices of the Assembly.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
4.B	Proposed Position Statement on Telepsychiatry Will the Joint Reference Committee recommend that the Assembly approve the proposed position statement on *Telepsychiatry*, and if approved, forward to the Board of Trustees for consideration?	The JRC reviewed the proposed position statement and made revisions to the 1995 statement. The Joint Reference Committee recommended that the Assembly approve the position statement on *Telemedicine in Psychiatry* as revised by the JRC, and add it to the October/November 2015 Assembly agenda as new business.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly October/November 2015
4.c	Senior Psychiatrists (ASMMAY1512.CC) The Board of Trustees referred the action paper *Senior Psychiatrists* to the Joint Reference Committee for further action. The action paper asked that the Board of Trustees appoint a work group comprised of members from the Board and Assembly to include senior psychiatrists. The work group will be charged to explore mechanisms to best meet the needs of this group of members and bring its recommendations to the Assembly and to the Board within 1 year for implementation.	The Joint Reference Committee referred the action paper to the Membership Committee and requested that they provide feedback on how best to address this action paper. The JRC requested a report for the January 2016 meeting.	Jon Fanning Susan Kuper	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
5	Award Nominees			
5.A	2015 Jacob Javits Award Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 Jacob Javits Award nominee, US Representative Tim Murphy (R-PA)?	The Joint Reference Committee deferred recommendation on the Jacob Javits Award until the January 2016 JRC Meeting.	Shaun Snyder, JD Margaret Dewar Laurie McQueen	Joint Reference Committee January 2016 (Deadline: 1/6/2016)

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5.B	2016 George Tarjan Award Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 George Tarjan Award nominee, Emmanuel Cassimatis, MD	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 George Tarjan Award nominee, Emmanuel Cassimatis, MD.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
5.C	2016 Jack Weinberg Award Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 Jack Weinberg Award nominee, Constantine G Lyketsos, MD, MHS, DFAPA, FAPM, FACNP?	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 Jack Weinberg Award nominee, Constantine G Lyketsos, MD, MHS, DFAPA, FAPM, FACNP.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
5.D	2015 Psychiatric Services Achievement Award Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 Psychiatric Services Achievement Awards as detailed in attachment 5.D?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 Psychiatric Services Achievement Awards as detailed in attachment 5.D	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
5.E	2016 Bruno Lima Award Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 Bruno Lima Award nominee, Kathleen Clegg, MD?	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 Bruno Lima Award nominee, Kathleen Clegg, MD.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
6	Assembly Report	Dr. Anzia noted that the Assembly will be meeting October 30th – November 1st, 2015 at the Omni Shoreham in Washington, DC. A primary issue to be addressed will be the direct referral of action papers to the Board of Trustees.		N/A

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7	Council Assessments	In the course of their review and discussion of the council assessments, the JRC considered the gaps in knowledge-base that may occur on councils. It was thought that enriching the appointment process may support and expand the council role by increasing their member depth of knowledge and breadth of diversity and experience. One change is to provide a description of each council and the work and areas covered and detail the requisite experience each council requires. From year to year, the knowledge base and expertise on any given council may be altered based on the work plan and current membership. Applications, which would include a bio-sketch and an individual's credentials to serve, for the open council positions would be requested from the APA membership. Operationalizing the appointments process with a clear structure and procedures would create a more transparent and fair activity and serve the needs of the Association. APA Administration will create a template for an appointment application and council descriptions. Such procedures, if supported by the Board of Trustees, could be implemented for the next Presidential cycle.	Shaun Snyder, JD Margaret Dewar Laurie McQueen	Association Governance

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7.A	Council on Advocacy and Government Relations	The Joint Reference Committee thanked the Council for submitting the assessment information as requested. Overall, the JRC found that the information was not presented in an easily digestible way. The Administration will revise the format of the assessment documents. Specifically, the JRC found the tasks of the Council to be general, lacking any specific projects or initiatives. It was suggested that the Council could take on specific projects for themselves and when needed, established task oriented work groups under its auspices. The JRC thanked the Council for dedicating their time to the Council and the APA and looks forward to a reinvigorated and proactive Council work plan.	Rodger Currie, JD Deana McRae	Council on Advocacy and Government Relations
7.B	Council on Healthcare Systems and Financing	The Joint Reference Committee thanked the Council for submitting the assessment information as requested. The JRC noted that the Council has many ongoing projects requiring a lot of time and effort from its members and the Administration. The Council's work plan was seen as comprehensive, broad and ambitious. The JRC supported the Council's utilization of work groups to parse the workload and involve experts from outside the Council.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing
8.A	Council on Addiction Psychiatry			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.A.1	Proposed Position Statement: Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses (Please see attachment #1) **Will the Joint Reference Committee recommend that 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?**	The Joint Reference Committee recommended that the Assembly approve the proposed position statement on *Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses*. A few minor edits to the language were requested by the JRC that did not affect the content of the statement. These edits will be made and circulated to the JRC prior to the Assembly action deadline.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly May 2016 (Deadline: 3/24/2016)
8.A.2	Revised Position Statement: Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder (Please see attachment #2) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder, and if approved, forward it to the Board of Trustees for consideration?** N.B. If the revised position statement is approved, the 2007 PS on Care of Pregnant and Newly Delivered Women Addicts will be retired.	The Joint Reference Committee referred the revised position statement back to the Council on Addiction Psychiatry. It was requested that the revised statement be formatted into a resource document and a shorter and more concise statement be drafted as a position statement. The position statement template will be sent to the chairperson and administration liaison. The redrafted documents are requested for the JRC's January meeting.	Kristin Kroeger Bea Eld	Council on Addiction Psychiatry Joint Reference Committee January 2016 (Deadline: 1/6/2016)

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8.A.3	Revised Position Statement: Equitable Access to Quality Medical Care for Persons with Substance Related Disorders (Please see attachment #3) **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement: Equitable Access to Quality Medical Care for Persons with Substance Related Disorders, and if approved, forward it to the Board of Trustees for consideration?** N.B. If the revised position statement is approved, the 2007 PS on Inclusion of Substance-Related Disorders as Psychiatric Disorders in Any Program Designed to Assure Access and Quality Care for Persons with Mental Illness will be retired.	The Joint Reference Committee referred the revised position statement back to the Council on Addiction Psychiatry for revision. Non-emotive language is to be used in position statements. The JRC requested the statement be revised and returned to for review at its January 2016 meeting.	Kristin Kroeger Bea Eld	Council on Addiction Psychiatry Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.B	Council on Advocacy and Government Relations			
8.B.1	Revision to Council's Composition **Will the Joint Reference Committee recommend that the Board of Trustees approve adding one additional member position to the Council on Advocacy and Government Relations, for a total of 15 members, meeting the conditions state below?** a) The chairperson of the APA*PAC* shall serve as an ex officio member of the Council b) The position held would remain a voting member of the Council, and c) The position held will be term-limited to align with the term length as chairperson of the APA*PAC* Board of Directors.	The Joint Reference Committee recommended that the Board of Trustees approve that the chairperson of the APA*PAC* be appointed, ex officio, as a corresponding member to the Council on Advocacy and Government Relations. Additionally, it is understood that the APA*PAC*, will include the Chairperson of the Council on Advocacy and Government Relations as an ex officio corresponding member to the APA*PAC* Board of Directors.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/2015)

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8.B.2	Referral Update (see also 8.L.4) Promoting Military Cultural Knowledge among Psychiatrists (ASMMAY1512.M; JRCJULY156.10) The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Promoting Military Cultural Knowledge among Psychiatrists." Of the five Resolves within the Action Paper, the Council unanimously supported the three Resolves concerning the promotion of educational awareness and the development of military cultural competency educational materials and resources. While the Council supported Resolve #5, members agreed the development of a position statement would not be in the purview of the Council. Furthermore, from the Council's discussion members remained divided in supporting the first Resolve requiring the question as a core professional component of the clinical evaluation. In summary, there was general support by the Council for Resolves #2, #3, #4 and #5; and an inconclusive outcome on Resolve #1. The Action Paper addresses an important issue impacting the field of psychiatry, in which educational modules should be made available to physicians. The APA should urge our membership to become familiar with military cultural competency in order to be a well-educated psychiatrist. The Council has shared their recommendations with the Council on Medical Education and Lifelong Learning (LEAD) and will await feedback for further participation in the development of a position statement.	The Joint Reference Committee thanked the Council for the update.		Please see item 8.L.7

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8.B.3	Referral Update (see also 8.G.7) Emergency Department Boarding of Individuals with Psychiatric Disorders (ASMMAY1512.S; JRCJULY156.13) The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Emergency Department Boarding of Individuals with Psychiatric Disorders." From the discussion, members of the Council were of a mind that boarding is unacceptable and needs to be remedied. In response to the JRC directive, the Council established the following recommendations: a) The Council should continue advising APA on relevant federal advocacy both in terms of current policy and recommendations. APA will continue to support federal legislation driving forward comprehensive mental health reform, because of its significant impact on psychiatric bed availability. b) APA should—through the Department of Government Relations and Communications—collaborate with state associations/district branches so states encountering this problem can develop a campaign which will inform citizens and state legislators about the consequences of diminishing mental health funding and the repercussions on bed availability. The Council and APA's State Government Affairs infrastructure could assist APA's DBs/SAs in their advocacy activities related to expanding community and inpatient access. c) In working with state associations/district branches, APA should use the crisis of the boarding issue and the handling of violent patients to inform state legislators of the ramifications associated with substantial cuts to mental health budgets; emphasizing the justification for expanding mental health resources and program allocations. d) APA should continue to highlight the consequences of trans-institutionalization. Understanding this is a complicated issue; the Council will collaborate with the Council on Psychosomatic Medicine (LEAD) in exploring these mechanisms. A position statement examining these causes is currently being developed by the Council on Psychosomatic Medicine in consultation with other Councils including CAGR. The Council has shared their recommendations with the Council on Psychosomatic Medicine (LEAD).	The Joint Reference Committee thanked the Council for the update. With regard to item B in the recommendations, the JRC referred this to the Council on Communication in order that they may be aware and involved in any communications campaign regarding this issue.	Jason Young James Carty	Council on Communications

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B.4	Referral Update (See also 8.J.7) Location of Civil Commitment Hearings (ASMMAY1512.V; JRCJULY156.16) The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Location of Civil Commitment Hearing." The Council's directive is to provide input on the issue to the Council on Psychiatry and Law (LEAD). In advance of the October 2016 deadline, CAGR member (Newkirk) and visiting RFM (Reid) volunteered to participate as Council representatives to the newly created Council of Psychiatry and Law work group to address the issue. The Council has shared their recommendations with the Council on Psychiatry and Law (LEAD); DGR staff will remain attentive to the progress of the work group.	The Joint Reference Committee thanked the Council for the update.		Please see 8.J.7
8.B.5	Referral Update (see also 8.G.10) Multiple Co-payments Charged for Single Prescriptions (ASMMAY1412.A) The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Multiple Co-payments Charged for Single Prescription." DGR staff has worked closely with the Office of Healthcare Systems and Financing. They have learned that the Council on Healthcare Systems and Financing (LEAD) is in the process of reviewing the developed survey. It is our understanding that once this survey is approved by the lead Council, it will be sent to APA membership requesting feedback on this issue. Following the compilation of the survey results, the lead Council will forward their recommendations to be reviewed by our Council.	The Joint Reference Committee thanked the Council for the update.		Please see 8.G.10

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.B.6	Referral Update Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights (JRCOCT148.G.17) The Council on Advocacy and Government Relations discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." Following the May 2015 meeting, the Council moved to form a work group led by Drs. Bailey and Badaracco (Council on Health Care Systems and Financing). DGR staff worked with other council staff liaisons to gather facts on the use of the current Bill of Rights and made inquiries with APA Administration policy staff to best inform deliberation by the work group. The Council members, being advised of the CHSF initial recommendation to retire the paper and the ongoing deliberation by the joint Council work group, voted the following recommendations, while the work group continues their work: a) Retire the position statement (originated 1996, reaffirmed 2007); b) Notify signatories and other components; c) The joint Council work group will review existing APA policies to see if said policies satisfy the need of members with regards to having an organizational statement of a patient's bill of rights. d) Based on their evaluation, the joint Council work group will determine the potential need, recommending whether or not the drafting of a new bill of rights is essential. Contingent on the results of reviewing APA policies and if determined as necessary, the Council instructed the work group to craft a new APA document which would address the rights of patients, revised to reflect developments in law and policy over the past 15 years. Additional members of the Council volunteered to serve on the work group: Drs. Jenny Boyer, Napoleon Higgins, and Morgan Melock (RFM).	The Joint Reference Committee thanked the Council for the update. While the joint council work group deliberates, the JRC thought it best not to retire the position statement. To kick start the functioning of joint work group, the JRC transferred 'ownership' of the work group from the Council on Advocacy and Government Relations to the Council on Healthcare Systems and Financing. A conference call of the work group was requested within the next month. The JRC would like the position statement revised as it would be useful from both a member and advocacy standpoint.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Joint Reference Committee January 2016 (deadline: 1/6/2016)
8.C	Council on Children, Adolescents and Their Families			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.C.1	Request for Caucus: Infancy and Early Childhood **Will the Joint Reference Committee recommend that the Board of Trustees approve the establishment of a Caucus on Infancy and Early Childhood under the auspices of the Council on Children, Adolescents and Their Families?**	The Joint Reference Committee recommended that the Board of Trustees establish a Caucus on Infancy and Early Childhood under the Council on Children, Adolescents and Their Families.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
8.C.2	Referral Update Mental Health Leave in Colleges (ASMMAY1512.Y; JRCJULY156.18) A work group of council members was formed at the September council meeting to determine if the existing APA Position Statement on College Mental Health should be revised to address college mental health leave or if a separate policy should be developed. Upon consideration, the work group believes the action paper has merit (in that forced leave of absence due to mental health issues may be detrimental) and is best served as part of a revised Position Statement on College Mental Health. The work group intends to have this revised position statement prepared and vetted by the entire council in time for submission to JRC in January.	The Joint Reference Committee thanked the Council for the update and was pleased to know that after review of the Council, the position statement as drafted by the Council on Psychiatry and Law will be coming to the JRC in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.C.3	Referral Update Revision to Position Statement: Psychiatric Hospitalization of Children and Adolescents A reworked draft of the position statement incorporates within the body of the statement salient points articulated in the Recommendations section of the previously revised document, as was suggested by JRC last July. This latest draft is currently being evaluated by the council. The council-approved iteration will be forwarded to JRC in January.	The Joint Reference Committee thanked the Council for the update and was pleased to know that a revised position statement would be forwarded to the JRC in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.D	Council on Communications **No actions**			
8.E	Council on Geriatric Psychiatry			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.E.1	Proposed Position Statement: Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8) **Will the Joint Reference Committee recommend that the Assembly approve the proposed position statement: Role of Psychiatrists in Assessing Driving Ability, and if approved, forward it to the Board of Trustees for consideration? (Please see attachment #1)**	The Joint Reference Committee recommended that the Assembly approve the proposed position statement on the *Role of Psychiatrists in Assessing Driving Ability*. 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. The JRC requested some minor formatting changes prior to the action deadline for the May 2016 Assembly meeting.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly May 2016 (Deadline: 3/24/2016)
8.E.2	Referral Update Revision of the position statement Principles of End of Life Care for Psychiatry (2001) (JRCJAN158.E.1) The Council is working with the Council on Psychosomatic Medicine to revise the position statement. Both councils have appointed volunteers to serve on a workgroup to develop the document. The council plans to discuss this further in the October conference call.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving a draft of the position statement in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Sejal Patel	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.F	Council on International Psychiatry **No actions**			
8.F.1	2016 Human Rights Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2016 Human Rights Award nominee, Dr. David Satcher?**	The Joint Reference Committee recommended that the Board of Trustees approve the 2016 Human Rights Award nominee, Dr. David Satcher.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/15)
8.G	Council on Healthcare Systems and Financing			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.1	Referral of Position Statement for Review **Will the Joint Reference Committee refer the position statement Any Willing Physician to the Council on Advocacy and Government Relations for their review and recommendation whether to retire or revise the statement?** The Council on Healthcare Systems and Financing reviewed the statement and consensus was that the statement was no longer necessary and could be retired.	The Joint Reference Committee referred the position statement *Any Willing Physician* to the Council on Advocacy and Government Relations. The CAGR is requested to review the position statement and provide an opinion with regard to retiring the position statement and report back to the JRC for the January 2016 meeting.	Rodger Currie, JD Deana McRae	Council on Advocacy and Government Relations Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.G.2	Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U; JRCJULY156.15) **Will the Joint Reference Committee request the Division of Government Affairs to draft a letter to the Veterans Administration (VA) to address the specific concerns raised in the Assembly action paper Parity in Payment, Parity in Policy Implementation within the VA System?** The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns rose within the VA system.	The Joint Reference Committee requested that the APA Administration send a letter to the Veterans Administration to address the concerns raised in the Assembly action paper. The letter would be drafted by DGR and reviewed by CHSF and the CEO/Medical Director.	Rodger Currie, JD Kristen Kroeger	Letter drafted and sent by November 25, 2015

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8.G.3	Referral Update Access to Care Related Action Papers Developing an Access to Care Toolkit (ASMMAY1512.C) Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D Access to Care Survey (ASMMAY1512.E) The Council on Healthcare Systems and Financing reviewed the three access to care related items at their September meeting. The Council supported the actions and will incorporate this work into its work plan. It was felt that the survey would provide data that will be necessary to advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will lead the project.	The Joint Reference Committee thanked the Council for the update and noted that the Council on Communications and the Division of Communications should be utilized in the development of a communications plan. The JRC requested that a timeline of the work and communications plans be forwarded to the JRC not later than its January Meeting.	Kristin Kroeger Becky Yowell Jason Young	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.G.4	Referral Update Level of Service Intensity Instrument (ASMMAY1512.F) APA staff have begun to compile information on the various level of care criteria (i.e., LOCUS, CANS, ANSA, Interqual/Milliman) to see what is currently available. This is an important issue as it is tied to medical necessity decision making and there are many parity issues inherent in this. CHSF thinks that this task is a very large undertaking and likely involves expertise from several APA councils and perhaps from experts who are not currently on an APA component. CHFS recommends that if this project is to be accomplished due consideration needs to be given to creating a special APA workgroup to do this.	The Joint Reference Committee thanked the Council for the update.		N/A

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.5	Referral Update (see also 8.L.4) Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G) The Council discussed the paper and suggests that it be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that the paper be referred to the Council on Advocacy and Government Relations for input as well.	The Joint Reference Committee thanked the Council for the information and referred the item to the Council on Advocacy and Government Relations for their input regarding the action paper.	Rodger Currie, JD Deana McRae	Council on Advocacy and Government Relations Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.G.6	Referral Update (see also 8.L.5; 8.I.1) Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H) The Council discussed item 4 of the action paper. There was consensus that an individual's health insurance provides coverage for mental health services. There is no evidence to show that benefits/coverage for these services do not already exist. Absent specific data to the contrary the CHSF has no basis for further recommendations. CHSF does not feel it is the appropriate council to deal with this request. FYI: Council on Minority Mental Health and Health Disparities is the LEAD.	The Joint Reference Committee thanked the Council for the update and forwards the CHSF comments to the Council on Minority Mental Health and Health Disparities (LEAD).		Please see 8.I.1
8.G.7	Referral Update (see also 8.B.3) Emergency Department Boarding of Individuals with Psychiatric Disorders (ASMMAY1512.S) The CHSF is in the process of reviewing the draft position statement and will provide comment back to the Council on Psychosomatic Medicine.	The Joint Reference Committee thanked the Council for the update and requested that the Council on Healthcare Systems and Financing provide its comments on the draft position statement by November 25, 2015.	Kristin Kroeger Becky Yowell	Please see 8.B.3 Comments to the Council on Psychosomatic Medicine by November 25, 2015

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.8	Referral Update Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W) CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar id spent on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.	The Joint Reference Committee thanked the Council for the update and referred the action paper back to the Council for review and feedback. The JRC noted that once approved by the Assembly, the action paper is a product of the Assembly.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.G.9	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by their Physicians (JRCOCT148.G.9) The CHSF was advised of the CAGR recommendation to maintain the existing position statement. A subsequent discussion with CAGR resulted in CAGR endorsing our support for the revised statement. It was reiterated that members of the CHSF thought that the original statement combined too many issues, and lacked clarity for that reason. The Councils on Government Relations and Research support the revised position statement as proposed by the CHSF. The Council on Children has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was needed.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving the proposed position statement on *Patient Access to Treatments Prescribed by their Physicians* once it has been vetted by the Council on Children, Adolescents and Their Families.	Kristin Kroeger Becky Yowell Ranna Parekh, MD, MPH Allison Bondurant	Council on Healthcare Systems and Financing (LEAD) Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.G.10	Referral Update (see also 8.B.5) Multiple Co-payments Charged for Single Prescriptions (ASMMAY1412.A) The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's work plan for the next 12 months.	The Joint Reference Committee thanked the Council for the update and requested a timeline for the dissemination of the survey.	Kristin Kroeger Becky Yowell	Report to JRC on timeline by November 25, 2015

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.G.11	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers (ASMNOV1412.D) The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers, but also the Indian Health Service, Veterans Administration, and other federal programs. General consensus is that this is an issue in other areas also. CHSF does not think there are any current APA position statements that speak to the issue of compensation. The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back on what kinds of salary income data we are able to discover.	The Joint Reference Committee thanked the Council for the update and requests a progress report and timeline from the Council as part of its report to the JRC in January 2016.	Kristin Kroeger Becky Yowell	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.H	Council on Medical Education and Lifelong Learning			
8.H.1	Referral Update Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior (ASMMAY1512.T; JRCJULY156.14) (Please see attachment #1) **Will the Joint Reference Committee reassign the referral of this action paper from the Council on Medical Education to the Council on Children, Adolescents and Their Families and request that they form a work group on this topic?** Rationale: CMELL is supportive of this action paper but does not see a role for the Council. Primary responsibility for implementation should remain with the Division of Education. The Council on Children should constitute a workgroup of advisors on this topic to advise the Division of Education.	The Joint Reference Committee referred the action paper to the Council on Children, Adolescents and Their Families. The Council on Children will be the LEAD council on this referral.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.H.2	Revision of Charge: APA/Minority Fellowship Selection and Advisory Committee (please see attachment #2) **Will the Joint Reference Committee recommend that the Board of Trustees approve revising the charge to the APA/Minority Fellowship Selection and Advisory Committee to include the assignment of mentors to the fellowship recipients?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the APA/Minority Fellowship Selection and Advisory Committee.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/2015)
8.H.3	Revision of Charge: APA Public Psychiatry Fellowship Selection and Advisory Committee (Please see attachment #3) **Will the Joint Reference Committee recommend that the Board of Trustees approve revising the charge to the APA Public Psychiatry Fellowship Selection and Advisory Committee to include the assignment of mentors to the fellowship recipients?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the APA Public Psychiatry Fellowship Selection and Advisory Committee.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/2015)
8.H.4	Revision of Charge: American Psychiatric Leadership Fellowship Selection Committee (Please see attachment #4) **Will the Joint Reference Committee recommend that the Board of Trustees approve revising the charge to the American Psychiatric Leadership Fellowship Selection Committee to include the assignment of mentors to the fellowship recipients?**	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the American Psychiatric Leadership Fellowship Selection Committee.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/2015)
8.I	Council on Minority Mental Health and Health Disparities			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.I.1	Referral Update (see also 8.G.6; 8.L.5) Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H; JRCJULY156.7) The Council established a work group to study the feasibility of this action paper and to whom the APA would advocate around this issue. Members of the work group are Drs. Ludmila De Faria (chair), Daena Petersen, Pamela Montano, Matthew Dominguez, and Racquel Reid. The work group met for one hour during the September Components Meetings and will have its first conference call on October 20. A report of this effort will be submitted to JRC in January.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving a report on the workgroup's progress and plans in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.I.2	Referral Update Impact of Global Climate Change on Mental Health (ASMMAY1512.L; JRCJULY156.9) Dr. Nyapati Rao is leading a work group, including Drs. Puneet Sahota, Debbie Carter, and Pamela Montano, that will study and produce a position statement on the mental health impact of severe weather events and disasters resulting from global climate change. As part of the process, the work group is seeking additional input from the Councils on International Psychiatry and Communications and Committee on Psychiatric Dimensions of Disasters. Dr. Rao will submit a report in January.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving a progress report and plans from the workgroup as part of the Council's report to the JRC in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.I.3	Improving APA Support of Mental Health of African American Males (ASMMAY1512.O; JRCJULY156.12) Attachment 1 presents input from the Council concerning this action paper. The document was delivered to the action paper's lead, the Division of Education.	The Joint Reference Committee thanked the Council for the update and forwards the council's input to the Division of Education.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant Tristan Gorrindo, MD	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.J	Council on Psychiatry and Law			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.1	Resource Document: Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment (Please see attachment #4) **Will the Joint Reference Committee approve the Resource Document: Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment?** Developed by the Council on Psychiatry and Law, reviewed by the Ethics Committee	The Joint Reference Committee approved the Resource Document: *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	FYI: Board of Trustees December 2015
8.J.2	Proposed Position Statement: Patient Access to Electronic Mental Health Records (Please see attachment #5) **Will the Joint Reference Committee recommend that the Assembly consider the proposed Position Statement Patient Access to Electronic Mental Health Records and if approved, forward it to the Board of Trustees for consideration?** Developed by the Council on Psychiatry and Law and the Committee on Mental Health Technology. The current version addressed the concerns of the Assembly – May 2015	The Joint Reference Committee recommended that the Assembly approve the proposed position statement on *Patient Access to Electronic Mental Health Records*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly May 2016 (Deadline: 3/24/2016)
8.J.3	Proposed Position Statement: Trial and Sentencing of Juveniles in the Criminal Justice System (Please see attachment #6) **Will the Joint Reference Committee recommend that the Assembly consider 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?** The Council on Psychiatry and Law rewrote the 2005 Position Statement Adjudication of Youths as Adults in the Criminal Justice System and is now submitting the above proposed position statement.	The Joint Reference Committee recommended that the Assembly approve the proposed position statement on *Trial and Sentencing of Juveniles in the Criminal Justice System*, and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly May 2016 (Deadline: 3/24/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.J.4	Retire Position Statement: 2005 Adjudication of Youth as Adults in the Criminal Justice System (Please see attachment #7) **Will the Joint Reference Committee recommend that the Assembly retire the 2005 Position Statement Adjudication of Youths as Adults in the Criminal Justice System, and if retired, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retire the 2005 position statement *Adjudication of Youth as Adults in the Criminal Justice System*, as a revised statement *Trial and Sentencing of Juveniles in the Criminal Justice System*, has been drafted to replace it.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly May 2016 (Deadline: 3/24/2016)
8.J.5	Referral Update Proposed Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Disorders and Mental Health Services The Council on Psychiatry and Law discussed the JRC referral. The Council felt that the suggested changes would not strengthen the paper and believe that no edits are necessary at this time to the existing position statement.	The Joint Reference Committee thanked the Council for the update. The Joint Reference Committee supported maintaining the position statement as written.		N/A
8.J.6	Referral Update Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H; JRCJULY156.7) The Council discussed the referral and there was some confusion on the Council as to why this was referred to the Council on Psychiatry and Law since there are no legal issues. The Council has no comment at this time. (This has been reported back to the **lead**, Council on Minority Mental Health and Health Disparities)	The Joint Reference Committee thanked the Council for the update.		See item 8.I.1
8.J.7	Referral Update (see also 8.B.4) Location of Civil Commitment (ASMMAY1512.V; JRCJULY156.16) The Council on Psychiatry and Law discussed this issue at their meeting in September. A workgroup was formed and is being chaired by Dr. Elizabeth Ford. A proposed position paper will be available for JRC review at their meeting in January.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving the position statement.	Rodger Currie, JD Lori Klinedinst	Joint Reference Committee January 2016 (Deadline: 1/6/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.K	Council on Psychosomatic Medicine			
8.K.1	Resource Document: Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model **Will the Joint Reference Committee approve the resource document Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model which identifies the roles and responsibilities of psychiatrists?**	The Joint Reference Committee approved the resource document *Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model* and recommended that the Board of Trustees consider releasing the authors to publish/submit for peer review the resource document.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	FYI: Board of Trustees December 2015 (Deadline: 11/18/2015)
8.K.2	Referral Update Position Statement: Emergency Department Board of Individuals with Psychiatric Disorders (ASMMAY1512.S; JRCJULY156.13) Kim Nordstrom, MD, lead author, completed the draft position statement. The Council reviewed the document, suggested revisions and it was revised. The position statement is being reviewed by Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law and awaiting revisions.	The Joint Reference Committee thanked the Council for the update. Given that this issue is a high priority for the Assembly, the JRC requested that the draft position statement be ready for the JRC to review at their meeting in January 2016.	Kristin Kroeger Karen Sanders	Council on Psychosomatic Medicine Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.K.3	Referral Update Revision of Position Statement: Principles of End-of-Life Care for Psychiatry (JRCJULY158.E.3) The CPM and the Council on Geriatric Psychiatry (**LEAD**) have created a small work group to collaborate on re-drafting the position statement.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving a draft of the position statement in January 2016.	Kristin Kroeger Ranna Parekh, MD, MPH Sejal Patel Karen Sanders	Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.L	Council on Quality Care			

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.1	Unnecessary Interventions in Psychiatry **Will the Joint Reference Committee recommend to the Board of Trustees that additional unnecessary interventions in psychiatry be determined under the premise that a new ABIM Foundation Choosing Wisely list will be developed?** (Please see attachment #1 ABIM Foundation Choosing Wisely materials and attachment #2 original APA Choosing Wisely List)	The Joint Reference Committee recommended to the Board of Trustees that additional unnecessary interventions in psychiatry be determined under the premise that a new ABIM Foundation Choosing Wisely list will be developed.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Board of Trustees December 2015 (Deadline: 11/18/2015)
8.L.2	Retire Position Statement: Infectious Disease Epidemics Including H1N1 **Will the Joint Reference Committee recommend that the Assembly retire the position statement: Infectious Disease Epidemics Including H1N1, and if retired, forward it to the Board of Trustees for consideration?** (Please see attachment #5)	The Joint Reference Committee recommended that 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.	Shaun Snyder, JD Margaret Dewar Ardell Lockerman	Assembly May 2016 (Deadline: 3/24/2016)
8.L.3	Development of Position Statement on Vaccines **Will the Joint Reference Committee support and approve the development of a position statement on vaccines in general?**	The Joint Reference Committee supported the development of a position statement on vaccines and believed that this issue could be addressed within the scope of a statement on *Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior*, currently under development by the Council on Children, Adolescents and Their Families.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 (Deadline: 1/6/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.5	Referral Update (see also 8.G.5) Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G; JRCJULY156.6) The Council on Quality Care yields to the opinion of the Council on Health Systems and Financing (CHSF) that this paper be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that this be referred to the Council on Advocacy and Government Relations for input as well. Per the CHSF recommendations, and the opinion of the Council on Quality Care, the Council on Quality Care requests to be removed from this assignment at present time, as this is not currently a quality issue.	The Joint Reference Committee thanked the Council for the update and noted that action papers could not be sent back to the authors.		N/A
8.L.6	Referral Update (see also 8.G.6; 8.I.1) Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H; JRCJULY156.7) In response to the request that the Council on Quality Care provide their opinion to the Council on Minority Mental Health and Health Disparities the Council recommends working with outside groups that assist with victim advocacy.	The Joint Reference Committee thanked the Council for the update and referred the comments to the Council on Minority Mental Health and Health Disparities.		Please see item 8.I.1

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.L.7	Referral Update (see also 8.B.2) Promoting Military Cultural Knowledge among Psychiatrists (ASMMAY1512.M; JRCJULY1512.10) In response to the request that the Council on Quality Care provide their opinion to the Council on Medical Education and Lifelong Learning (LEAD), the Council on Quality Care agreed that the question, "Have you or someone close to you served in the military?" as part of the clinical evaluation, is a good question to ask as related to quality care, but that it will be important to develop educational materials to assist psychiatrists in what to do with the information they elicit from this question.	The Joint Reference Committee thanked the Council for the update and referred the comments to the Council on Medical Education and Lifelong Learning (LEAD). The Joint Reference Committee requested that the question be referred to the Caucus on VA Psychiatrists and back to the Council on Quality Care to determine how a 'standard of care' question on this topic would be worded.	Kristin Kroeger Samantha Shugarman Rodger Currie, JD Deana McRae Tristan Gorrindo, MD	Council on Quality Care Caucus on VA Psychiatrists Council on Medical Education and Lifelong Learning Joint Reference Committee January 2016 (Deadline: 1/6/2016)
8.M	Council on Research			
8.M.1	Revised Position Statement: Atypical Antipsychotic Medication (Please see attachment #1) **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement Atypical Antipsychotic Medication, and if approved, forward it to the Board of Trustees for consideration?** The statement is still relevant, but the Council is recommending that this statement be slightly revised for language and clarity. It has also been reformatted so that it conforms to the latest APA position statement formatting guidelines. N.B. If the revised position statement is approved, the 2009 PS Atypical Antipsychotic Medication will be retired.	The Joint Reference Committee referred the revised position statement back to the Council on Research for additional revision. The JRC noted that antipsychotics should not be used as sleep aides or be prescribed for anxiety. The statement should include language regarding the use of antipsychotics for the FDA approved indications. The JRC requested that the revisions be made and a revised position statement be submitted to the JRC in January 2016.	Kristin Kroeger Philip Wang, MD, PhD Emily Kuhl, PhD	Council on Research Joint Reference Committee January 2016 (Deadline: 1/6/2016)

Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up & Due Date
8.M.2	Referral Update Current Health Services Literature on Integrated Care Models (JRCOCT148.G.22)(Please see attachment #2) The Division of Research has completed its compilation of the literature, which is included here as attachment 2. A more detailed report based on the literature review is under development.	The Joint Reference Committee thanked the Council for the update and requested a progress report in the Council's report to the JRC in January 2016.	Kristin Kroeger Philip Wang, MD, PhD Emily Kuhl, PhD	Joint Reference Committee January 2016 (Deadline: 1/6/2016)

CEO Report to the JRC, January 2016

Action	CEO/MDO Response	Staff/Component Responsible	Status
Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U; JRCJUN156.15) **Will the Joint Reference Committee request the Division of Government Affairs to draft a letter to the Veterans Administration (VA) to address the specific concerns raised in the Assembly action paper Parity in Payment, Parity in Policy Implementation within the VA System?** The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns rose within the VA system.	The Joint Reference Committee requested that the APA Administration send a letter to the Veterans Administration to address the concerns raised in the Assembly action paper. Per the email sent to the JRC on December 4, 2015, The APA Administration, through research and staff discussions across divisions (Government Relations, Healthcare Systems and Financing and the Office of the General Counsel), determined that barring the discovery of certain evidence, it was premature to address this topic with the VA at this time.	Saul Levin, MD, MPA; Kristin Kroeger Rodger Currie, JD Deanna McRae	The APA Administration's recommendation to the JRC is twofold: (1) that we educate psychiatrists employed by the VA on potential parity violations from third party payers that require vigilance and potential reporting and (2) encourage action through the appropriate internal channel (e.g., the regional business units and the VA Office of the Inspector General) since there are empowered actors in place within the VA who are highly interested in any taxpayer money that is not being utilized.

4 Referrals to the JRC from the Board of Trustees

At the December Board of Trustees meeting, the following items were referred back to the Joint Reference Committee in order that the charges of these three entities be made consistent.

Will the Joint Reference Committee refer the following three items to the Council on Medical Education and Lifelong Learning for further revision?

4.A Revised Charge to APA/SAMHSA Minority Fellowship Selection and Advisory Committee

CHARGE:

The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee serves in an advisory capacity to the staff in monitoring and evaluating the program in terms of meeting objectives and the impact on training programs. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor.

4.B Revised Charge to APA Public Psychiatry Fellowship Selection Committee

CHARGE:

The APA Public Psychiatry Fellowship Selection Committee is composed of five members appointed by the APA President for three-year terms. It has representation from the IPS Program Committee, APA Public Psychiatry alumni, and three members at large. The committee is not authorized to meet in person except at the APA Annual Meeting. The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor.

4.C American Psychiatric Leadership Fellowship Selection and Advisory Committee

CHARGE:

The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor. The purposes of the APA Public Psychiatry Fellowship are (1) to heighten the awareness of psychiatric residents of the many activities of psychiatry in the public sector and of the career opportunities in this area and (2) to provide experiences that will contribute to the professional development of those residents who will play leadership roles within the public sector in future years. The APA Public Psychiatry Fellowship program provides support for outstanding residents in psychiatry to participate in APA components and attend the APA Institute on Psychiatric Services (IPS). Funds for travel, hotel, and out-of-pocket expenses are provided. During the IPS, special functions are held to recognize and honor current fellowship recipients, and activities are scheduled to augment and enrich the educational opportunities of this meeting. During the fellowship term, the Fellows are given the opportunity to plan and present a series of workshops to be presented at the next IPS. The fellowship encourages all fellows to attend the APA Annual Meeting; however, no fellowship funding is provided for this purpose.

Item #5
Joint Reference Committee
January 2015

Membership Committee Report to the
Joint Reference Committee
Rahn Kennedy Bailey, M.D., Chairperson

Information Items/Follow-up from JRC Referrals

Agenda Item 6.11 Changing ECP Status to 8 Years Following Completion of Training (ASMMAY1512.N)
In June 2015 meeting, the Joint Reference Committee referred an Assembly Action Paper entitled "Changing ECP Status to 8 Years Following Completion of Training" to the Membership Committee and the Finance and Budget Committee. It was requested that both committees look into the feasibility of implementing the action paper including a cost/benefit analysis. The action paper asks that the APA adopt a similar position to the AMA in defining the ECP period as eight years following the completion of residency/fellowship training. The Membership Committee did not fully understand the benefits of extending ECP status by one year. The paper referenced mentorship and leadership opportunities, so giving the opportunity to serve as the ECP representative to the Assembly to more members would be a benefit. APA offers a complimentary online subscription to FOCUS, which is a benefit that would then be extended to an additional 850 members at a *potential* cost of $336 per subscription were these members to purchase a subscription. An analysis of the paid subscriber list for FOCUS, shows that there are currently 52 members in their 8th year after training who subscribe, so a more realistic cost is the loss of these paid subscriptions which is $17,472). Of the voting members present, three were in favor, three were opposed, and three abstained from voting.

Agenda Item 4.C Senior Psychiatrists (ASMMAY1512.CC)
In October 2015, the Joint Reference Committee referred an Assembly Action Paper entitled "Senior Psychiatrists" to the Membership Committee. The Committee was asked to provide feedback on how best to address this action paper.

The Membership Committee discussed the Action Paper and the general consensus of the committee is to support the recommendation to appoint a work group comprised of members from the Board of Trustees and the Assembly and to include senior psychiatrists. The understanding is that the work group would be charged with exploring mechanisms to best meet the needs of senior psychiatrists and make recommendations within one year.

It was noted that there has been considerable concern among many senior members that they would like to "give back" at this stage of their careers but that APA has not had an appropriate place for them within the organization. Several members recommended that the appointed work group include Resident-Fellow Members and Early Career Psychiatrists to bring a different dynamic and diversity to the discussions. And having a diverse representation of member segments could lead to more collaboration and mutually beneficial partnerships between older and younger members. There was also a suggestion to include Pat Troy to participate in the work group, in her role as the Executive Director of the APA Lifers.

It was suggested that the following information would be helpful in any future decision-making:

- Percent of members in Life status under the age of 65 (9.5%, 817 of 8,645 total members in Life status)
- Percent of members 65 or older not in Life status (25.8%, 2,719 of 10,541 members 65+; includes Inactive Members/Fellows and International Members/Fellows; 736 or 7% of members 65+ are General Members, Fellows, or Distinguished Fellows on track to reach Life status)
- Breakdown of current occupational status (current information not available)
- Data from formal surveys of senior psychiatrists, especially regarding their interests in and feedback on APA (not aware of any recent surveys to this member segment)
- APA's vision on the role of senior psychiatrists

In response to the last bullet requesting information about the APA's vision on the role of senior psychiatrists, the CEO and Medical Director's Office reported that the APA is approaching the needs of senior psychiatrists like it does other segments in an effort to build member value. Based on feedback from senior psychiatrist leaders and general members, APA will launch a new webpage in mid-December that is dedicated to this segment. The page will include both new and existing resources, and ways to stay involved. Moreover, similar to other segments, the APA is asking leaders to identify any gaps that exist and then trying to identify experts on those topics to create products that are meaningful to general members of that segment. These resources will be promoted via e-mail in the first quarter of 2016. APA is also looking at sessions given at the 2016 Annual Meeting to expand educational opportunities.

EXECUTIVE SUMMARY
Assembly

The Assembly met in Washington, DC, October 30-November 1, 2015, and passed several actions that are referred to the Joint Reference Committee (JRC), below. The draft summary of actions from the meeting is provided as attachment 16.

The Assembly brings the following action items:

1. **Access to Care Provided by the Department of Veterans Affairs (ASM Item #2015A2 12.A)**

   [attachment 1]

   Action paper 2015A2 12.A asks:

   That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans.

   That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans.

   That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA.

   Action: Will the JRC refer the Assembly passed action paper *2015A2 12.A: Access to Care Provided by the Department of Veterans Affairs* to the appropriate Component(s) for input or follow-up?

2. **Prior Authorization (ASM Item #2015A2 12.D) [attachment 2]**

   Action paper 2015A2 12.D asks that the APA explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization.

   Action: Will the JRC refer the Assembly passed action paper *2015A2 12.D: Prior Authorization* to the appropriate Component(s) for input or follow-up?

3. **Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Support Product**

(ASM Item #2015A2 12.E) [attachment 3]

Action paper 2015A2 12.E asks:

That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and

That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.

Action: Will the JRC refer the Assembly passed action paper *2015A2 12.E: Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Support Product* to the appropriate Component(s) for input or follow-up?

4. **Payer Coverage for Prescriptions from Nonparticipating Prescribers (ASM Item # 2015A2 12.F) [attachment 4]**

Action paper 2015A2 12.F asks:

That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and

That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and

That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and

That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.

Action: Will the JRC refer the Assembly passed action paper *2015A2 12.F: Payer Coverage for Prescriptions from Nonparticipating Prescribers* to the appropriate Component(s) for input or follow-up?

5. **APA Support for NIMH Funding of Clinical Research (ASM Item # 2015A2 12.G) [attachment 5]**

Action paper 2015A2 12.G asks that the APA shall:

1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget.

2. The APA will advocate the implementation of the recommendations of the White Paper.

Action: Will the JRC refer the Assembly passed action paper *2015A2 12.G: APA Support for NIMH Funding of Clinical Research* to the appropriate Component(s) for input or follow-up?

6. **<u>It is Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fair to Comply with Parity?</u> (ASM Item # 2015A2 12.H) [attachment 6]**

The Assembly voted to refer Action paper 2015A2 12.H to the Council on Healthcare Systems and Financing. The action paper asks:

That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting.

The Ethics Committee review will specifically address at least the following questions:

1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law?

2) If an insurance company policy or the review standards that guide a psychiatrist reviewer's decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer?

3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law?

Action: Will the JRC refer the Assembly passed action paper *2015A2 12.H: Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?* to the appropriate Component(s) for input or follow-up?

7. **<u>Strengthening the Role of Residency Training to Improve Access to Buprenorphine</u> (ASM Item #2015A2 12.I) [attachment 7]**

Action paper 2015A2 12.I asks that the DSM Steering Committee explores adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5.

Action: Will the JRC refer the Assembly passed action paper 2014A2 12.N: *Exploration: Whether to Add Some Symptoms to the Next DSM* to the appropriate Component(s) for input or follow-up?

8. **<u>Equality in Permanent Licensure Policy</u> (ASM Item #2015A2 12.K) [attachment 8]**

Action paper 2015A2 12.K asks:
That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards.

That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.K: *Equality in Permanent Licensure Policy* to the appropriate Component(s) for input or follow-up?

9. **<u>Partial Hospital Training in Psychiatry Residency</u> (ASM Item #2015A2 12.L) [attachment 9]**

Action paper 2015A2 12.L asks that the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.L: *Partial Hospital Training in Psychiatry Residency* to the appropriate Component(s) for input or follow-up?

10. **<u>Advocating for Medicaid Expansion</u> (ASM Item #2015A2 12.N) [attachment 10]**

Action paper 2015A2 12.N asks:
That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion (2);

That a status report and recommendations be made to the Assembly at the May 2016 meeting.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.N: *Advocating for Medicaid Expansion* to the appropriate Component(s) for input or follow-up?

11. **<u>Systems to Coordinate Psychiatric Inpatient Bed Availability</u> (ASM Item #2015A2 12.O) [attachment 11]**

Action paper 2015A2 12.O asks that the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.O: *Systems to Coordinate Psychiatric Inpatient Bed Availability* to the appropriate Component(s) for input or follow-up?

12. **Making Access to Treatment for Erectile Disorder Available Under Medicare (ASM Item #2015A2 12.P) [attachment 12]**

Action paper 2015A2 12.P asks:

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.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.N: *Advocating for Medicaid Expansion* to the appropriate Component(s) for input or follow-up?

13. **Senior Psychiatrist Seat on the Board of Trustees (BOT) (ASM Item #2015A2 12.R) [attachment 13]**

The Assembly voted to refer Action paper 2015A2 12.T to the Joint Reference Committee. The action paper asks that asks:

1. Create a Senior Psychiatrist seat on the BOT.
2. The Senior Psychiatrist Trustee would be elected by the Life Members.

Action: Will the JRC refer the Assembly passed action paper 2015A2 12.N: *Advocating for Medicaid Expansion* to the appropriate Component(s) for input or follow-up?

14. **Reaffirm APA's Adoption of the AMA's 2010 Position Statement: Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices (JRCJUL158.B.1/ASMNOV154.B.5) [attachment 14]**

The Assembly voted to refer the Position Statement to the Joint Reference Committee to assign to relevant bodies to draft a more meaningful position statement on DTC Advertising. The draft position statement should be presented to the Assembly in November, 2016.

Action: Will the JRC refer the AMA's 2010 Position Statement: *Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices* to the appropriate Component(s) for input or follow-up?

15. **Retire 2007 Position Statement: Sexual Harassment (JRCJUL158.J.2/ASMNOV154.B.9) [attachment 15]**

The Assembly voted to **retain** the 2007 Position Statement: *Sexual Harassment* as the Assembly felt the position is still relevant and includes the recommendation for necessary treatment and recognition of the need for treatment.

Action: Will the JRC refer Position Statement: *Sexual Harassment* to the appropriate Component(s) for input or follow-up?

The Assembly brings the following informational items:

1. Assembly Nominating Committee Report

The Assembly voted to approve the slate of candidates for the May 2015 Assembly election as follows:

Speaker-Elect:	John de Figueiredo, M.D., Area 1 Theresa Miskimen, M.D., Area 3
Recorder:	James R. (Bob) Batterson, M.D., Area 3 David Scasta, M.D., Area 3

2. **Retain 2012 Position Statement: Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV (JRCOCT148.A.2/ASM Item #2015A2 4.B.1)**

The Assembly voted, on its Consent Calendar, to retain the 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retaining the position statement.

3. **Retain 2008 Position Statement: Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly (JRCOCT148.E.3/ASM Item #2015A2 4.B.2)**

The Assembly voted, on its Consent Calendar, to retain the 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retaining the position statement.

4. **Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP (JRCJULY158.A.3/ASM Item #2015A2 4.B.4)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the position statement.

5. **Proposed Position Statement: Substance Use Disorders in Older Adults (JRCOCT148.A.5/JRCJULY158.E.1/ASM Item #2015A2 4.B.6)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Substance Use Disorders in Older Adults*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the position statement.

6. **Revised Position Statement: Bias-Related Incidents (JRCJAN158.I.1/JRCJUL158.I.1/ASM Item #2015A2 4.B.7)**

The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Bias-Related Incidents*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the revised position statement.

7. **Retire 2007 Position Statement: The Right to Privacy (JRCJULY158.J.1/ASM Item #2015A2 4.B.8)**

The Assembly voted, on its Consent Calendar, to retire the 2007 Position Statement: *The Right to Privacy*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retiring the position statement.

8. **Retire Position Statement: Interference with Scientific Research and Medical Care (JRCJAN158.M.6/JRCJUL158.M.1/ASM Item #2015A2 4.B.10)**

The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Interference with Scientific Research and Medical Care*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retiring the position statement.

9. **Revised Position Statement: Hypnosis (JRCJAN158.M.3/ASM Item #2015A2 4.B.11)**

The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Hypnosis*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the revised position statement.

10. **Retain 2010 Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury (JRCJULY158.M.3/ASM Item #2015A2 4.B.12)**

The Assembly voted, on its Consent Calendar, to retain the 2010 Position Statement on *Posttraumatic Stress Disorder and Traumatic Brain Injury*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retaining the position statement.

11. **Retain 2010 Position Statement on High Volume Psychiatric Practice and Quality of Patient Care (JRCJULY158.L.2/ASM Item #2015A2 4.B.13)**

The Assembly voted, on its Consent Calendar to retain the 2010 Position Statement on *High Volume Psychiatric Practice and Quality of Patient Care*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retaining the position statement.

12. **Proposed Position Statement on Tobacco Use Disorder(JRCJULY158.A.1/ASM Item #2015A2 4.B.14)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement on *Tobacco Use Disorder*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the position statement.

12. **Retain Position Statement: Psychotherapy as an Essential Skill of Psychiatrists (JRCJULY158.L.3/ASM Item #2015A2 4.B.15)**

The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved retaining the position statement.

13. **Proposed Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment (ASMMAY1512.I/JRCJUL158.J.4/ASM Item #2015A2 4.B.16)**

The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the position statement.

14. **Revised Position Statement on Telemedicine in Psychiatry (JRCOCT148.J.15/ASM Item #2015A2 14.A)**

The Assembly voted to approve the Revised Position Statement on *Telemedicine in Psychiatry*. This was forwarded to the Board of Trustees for consideration in December 2015. The Board of Trustees approved the revised position statement.

15. **Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Correctional Facilities (JRCOCT148.J.3/ASM Item #2015A2 4.B3)**

The Proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities* was withdrawn by the Council on Psychiatry and Law as the draft position statement is still being finalized.

Attachment #1
Item 2015A2 12.A
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Access to Care Provided by the Department of Veterans Affairs

WHEREAS:
Whereas, The Department of Veterans Affairs' (VA) mandate, as first articulated by President Lincoln, in his Second Inaugural Address, is to:

"Care for him who shall have borne the battle and for his widow, and his orphan."

Whereas, with these words, rendered more than a century ago, President Lincoln affirmed the government's obligation to care for those injured during war and to provide for the families of those who perish~~ed~~ on the battlefield,

Whereas, veteran access to Psychiatric Care~~,~~ continues to be inadequate, according to the August 2015[2] and September 2015[1] Inspector General of the Department of Veterans Affairs reports, and the listings of vacancies in USAJOBS.GOV for available psychiatrist positions.

Whereas, many long-time employed VA psychiatrists, under the current pay structure, are often paid less than new hires based on personal knowledge and survey data from the VA Caucus members.

Whereas, new hires with loan repayment obligations have limited access to receiving loan forgiveness based on length of employment with the VA compared to those employed by other federal agencies.

BE IT RESOLVED:
That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans.

That the APA correspond with the Secretary of the VA, Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans.

That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to fund~~s~~ mental health care and suicide prevention programs within the VA.

AUTHORS:
Harold Ginzburg, M.D., J.D., M.P.H., Representative, Oklahoma Psychiatric Physicians Association
Jenny L. Boyer, M.D., J.D., Ph.D., Immediate Past Speaker

ESTIMATED COST:
Author: $2,940
APA: $4,106.67

ESTIMATED SAVINGS: none
ESTIMATED REVENUE GENERATED: More psychiatrists working for the VA would mean more potential members of APA and VA Caucus.

ENDORSED BY: Area 5

KEY WORDS: Department of Veterans Affairs, Access to Care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations

REFERENCES:

1. Report No. 15-03063-511, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, September 1, 2015.
2. Report 13-03917-487, OIG Report, *Audit of VHA's Efforts To Improve Veteran's Access to Outpatient Psychiatrists August 25, 2015.*

Attachment #2
Item 2015A2 12.D
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Prior Authorization

WHEREAS:
1] Prior authorization can be time-consuming.

2] Clinicians should be reimbursed for time-consuming tasks that are required to treat the patient.

BE IT RESOLVED:
The APA should explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization.

ESTIMATED COST:
Author: $0
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society RogerPeele@aol.com

ENDORSED BY: Washington Psychiatric Society, September, 2015

KEY WORDS: Prior Authorization

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Sent to Committee on Reimbursement for Psychiatric Care

Attachment #3
Item 2015A2 12.E
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product

WHEREAS:
The APA has excellent, evidence-based practice guidelines that are authoritative, detailed, and lengthy; and

The format of the practice guidelines do not lend themselves to being used routinely in everyday practice at the average pace of care; and

Primary care practitioners and other non-psychiatrists, as well as psychiatrists, would greatly benefit from leveraging the clinical information about a specific patient that lives within various electronic tools to query a computable version of the entire set of practice guidelines to guide their clinical decision making; and

Developing such a clinical decision support product would require a combination of subject matter experts, technology experts, and knowledge representation experts, which would be a significant investment; and

Numerous universities, electronic health record vendors, registries, health information exchanges, payer, and other entities would be potential customers who would be interested in licensing an APA-developed CDS Product, with significant revenue potential; and

Users of such a product, including primary care providers, would be able to review a tailored list of treatment options for a given patient, based on the data known about the patient, ranked based on the strength of the evidence and indicating what missing data could have an impact on treatment options; and

Such a product could be very useful in developing new research, in providing CME opportunities, and simplify maintenance of certification and licensure requirements.

BE IT RESOLVED:
That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and

That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.

AUTHOR:
Steven Daviss M.D., Representative, Maryland Psychiatric Society steve@fusehealth.org

ESTIMATED COST:
Author: $5,577.95
APA: $1,700

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: Unknown at this time, but potentially on the order of millions annually when fully built out.

ENDORSED BY:

KEY WORDS: practice guidelines, clinical decision support, learning systems, electronic health records, personalized medicine, information technology

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT:
The Committee on Mental Health IT supports this concept.

The Council on Quality Care discussed the concept during the Fall Component meeting and voiced vigorous support. Dr. Phillip Wang, the new Director of Research, also agreed that this was a worthwhile endeavor to explore and pursue. The author will pursue additional review by all other relevant components in time for consideration by the Assembly.

Attachment #4
Item 2015A2 12.F
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Payer Coverage for Prescriptions from Nonparticipating Prescribers

WHEREAS:
The AMA has adopted a policy that opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it; and

Managed care has led to a reduction in the level of participation of psychiatrists in insurance, including commercial, Medicare and Medicaid; and

A significant number of solo or small practice psychiatrists who do not participate in an insurance plan continue to provide ongoing treatment to patients with insurance, at the request of the patient; and

Some payers are implementing policies that prohibit payment for prescriptions ordered by non-participating psychiatrists. This is occurring with Medicaid within a number of states now; and

For example, Maryland Medicaid has announced that as of December 1, 2015, they will not pay for prescriptions written by nonparticipating prescribers, There is concern that these policies may later spread to Medicare and commercial payers; and

If this prohibition proceeds, patients receiving care from non-participating physicians must disrupt their relationship with their long-standing psychiatrist and find one of the few participating psychiatrists to prescribe medications; and

If this prohibition proceeds, psychiatrists who work in jails or prisons (who are not participating physicians) and who provide prescriptions upon release to their patients will not have their prescriptions filled, resulting in risk of unnecessary relapse and re-arrest.

BE IT RESOLVED:
That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and

That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and

That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and

That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.

AUTHORS:
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Annette Hanson M.D., Representative, Maryland Psychiatric Society
annette.hanson@maryland.gov

ESTIMATED COST:
Author: $0
APA: $12,339.18

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Medicaid, prescriptions, insurance, nonparticipating, network

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #5
Item 2015A2 12.G
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: APA Support for NIMH Funding of Clinical Research

WHEREAS:
Whereas the NIMH has dramatically shifted its research focus to translational neuroscience to the exclusion of clinical research;

Whereas optimal clinical trials of drugs and therapies are conducted by investigators free of potential bias from funding source (e.g., NIMH funded drug trials are preferable to industry funded trials);

Whereas full implementation of mental health parity means there will be an increasing need for evidence supporting the efficacy of clinical treatments for the disorders real patients present with;

Whereas additional clinical trials research is needed because under-resourced and minority communities have been underrepresented in clinical trials, leaving these communities disproportionately affected by the NIMH policy change;

Whereas the APA has already supported the recommendation of the 2015 Institute of Medicine report on Psychosocial Interventions for Mental and Substance Use Disorders that explicitly calls for more research into psychosocial treatments and their effective core elements;
Whereas improving patient care requires commitment to the development and testing of clinical treatment methods;

Whereas future grant support for randomized controlled trials from the NIMH is crucial to demonstrating the efficacy of clinical treatments for particular treatment populations;

Whereas an optimal and comprehensive national research strategy for mental health must include clinical approaches, in addition to a basic science search for brain mechanisms;

BE IT RESOLVED:
That the APA shall:

1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget.
2. The APA will advocate the implementation of the recommendations of the White Paper.

AUTHORS:
Eric M. Plakun, M.D., Representative, Academy of Psychoanalysis and Dynamic Psychiatry, eric.plakun@austenriggs,net
Prudence L. Gourguechon, M.D., Representative, American Psychoanalytic Association
John C. Markowitz, M.D., APA Member
Barbara Milrod, M.D., APA Member
J. Christopher Perry, M.D., MPH, APA Member

ESTIMATED COST:
Author: $3,717.95
APA: $2,701.74

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Research, NIMH, RDoC criteria, clinical trials

APA STRATEGIC PRIORITES: Advancing Psychiatry, Supporting Research

REVIEWED BY RELEVANT APA COMPONENT: Comments from members of the Council on Research for comments led to revision of the action paper before submission.

Attachment #6
Item 2015A2 12.H
Assembly
October 30-November 1, 2015

ACTION PAPER
Referred to Council on Healthcare Systems and Financing

TITLE: Is It Ethical For A Psychiatrist to Serve as a Utilization Management Reviewer When Review Standards Fail to Comply With Parity?

WHEREAS:
Whereas the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or parity law) is the law of the land;

Whereas the MHPAEA 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 multiple class action lawsuits have been filed and are in process that allege that some major insurance companies use review standards that are patently out of compliance with parity (e.g., standards that exclude reimbursement for treatment of patients with personality disorders when these are treatable DSM disorders with a practice guideline and established morbidity and mortality, or that end coverage of treatment for patients with substance use disorders who continue to use substances during treatment when this would not be done for a diabetic patient who failed to follow a diet, or when arbitrary annual caps on numbers of sessions are imposed);

Whereas ethical practice by psychiatrists is of paramount importance to good clinical care;

Whereas ethical practice has a profound effect on how the field of psychiatry is viewed by the public;

Whereas public consciousness and concern are growing about flagrant abuses of the parity law, as evidenced by two recent segments on the above referenced class action lawsuits on the CBS show *60 Minutes* and two on NPR *(All Things Considered* and *On Point)*;

BE IT RESOLVED:
That the APA Ethics Committee will review the ethics of psychiatrist participation in managed care reviews that are based on standards that are clearly out of compliance with the intent of the parity law, and report back to the Assembly on this ethical review before the May 2016 Assembly meeting.

The Ethics Committee review will specifically address at least the following questions:

1) Do psychiatrists, as professionals, have a duty to the public, in addition to that to the patients with whom they have a treatment relationship? If so, can a psychiatrist managed care or insurance reviewer (who does not have a direct relationship with the patient) ethically limit care in ways known to be in violation of the parity law?

2) If an insurance company policy or the review standards that guide a psychiatrist reviewer's decision have been conclusively determined to violate the federal or a state mental health parity law (for example, by court decision), and the psychiatrist reviewer continues to apply that policy to deny mental health claims, would this be an ethical violation by the psychiatrist reviewer?

3) If, during a review, a psychiatrist reviewer learns that a review policy or standard that would result in denial of treatment might actually violate federal or state mental health parity law, but does nothing to determine whether the policy or standard is or is not in violation of the law and denies the claim based on the standard, would this be an ethical violation by the psychiatrist reviewer? What obligation, if any does the psychiatrist reviewer has to investigate whether the policy does in fact violate the parity law?

AUTHORS:
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Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
John De Figueiredo, M.D., Representative, Connecticut Psychiatric Society

ESTIMATED COST:
Author: $340
APA: $840-$2,100

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: Copy sent to Council on Healthcare Systems and Financing on August 17, 2015. No feedback received at point of submission of action paper on September 13, 2015.

Attachment #7
Item 2015A2 12.I
Assembly
October 30-November 1, 2015

FINAL
ACTION PAPER

TITLE: Strengthening the Role of Residency Training to Improve Access to Buprenorphine

WHEREAS:

1. One of the APA's Strategic Priorities is educating members, patients, families, the public and other practitioners about mental disorders and evidence-based treatment options, and
2. Opioid use disorders (OUD) are reaching epidemic proportions in the United States **(past year heroin use has increased by 34% from 681,000 to 914,000 in the past year)**, resulting in significant mortality and morbidity, and a significant overall societal cost.
3. Buprenorphine is an effective maintenance treatment for opioid use disorders and included as on the World Health Organization's list of essential medications.
4. 3% of physicians in the United States are licensed to prescribe Buprenorphine, and less than a third of Buprenorphine providers are psychiatrists.
5. The number of Buprenorphine providers in many areas falls below the patient demand for such services, and patients often find themselves unable to locate a Buprenorphine provider. Methadone maintenance is often unavailable or logistically difficult (e.g., some states only have one or two licensed methadone treatment programs and federal law requires daily visits to the methadone clinic for the first 90 days of treatment). This can contribute to continued illicit drug use and increased risk of overdose and its sequelae, including death.
6. Most residency training programs do not require their trainees to complete the Buprenorphine waiver training and waiver certification paperwork; this represents a critical missed opportunity to train tomorrow's psychiatrists to meet the demands of the growing OUD epidemic and provide services for a growing underserved patient population.
7. Many psychiatrists do not feel comfortable treating psychiatric patients with co-occurring substance use disorders. This exacerbates the vulnerability of this underserved population.
8. The APA Position Statement on "Residency Training Needs in Addiction Psychiatry for the General Psychiatrist" approved in 2014 was supported by background information that "Appropriately dosed Buprenorphine is superior to placebo in diminishing illicit opiate use and treatment retention. All psychiatry residents should receive appropriate didactic training to obtain the DATA 2000 waiver to prescribe Buprenorphine and sufficient clinical supervision to assure competency in managing patients on Buprenorphine maintenance."

BE IT RESOLVED:
That the APA liaise with ACGME/Residency Review Committee (RRC) to promote Buprenorphine training during general adult psychiatric residency training.

AUTHORS:
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Raúl J. Poulsen, M.D., RFM Deputy Representative, Area 3
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Kimberly Yang, M.D., Deputy Representative, Asian-American Psychiatrists
Erin Zerbo, M.D., APA Member

ESTIMATED COST:
Author: $680
APA: $2,058.46

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Assembly Committee of Residents and Fellows, New Jersey Psychiatric Association, Area 3 Council, Area 1 Council

KEY WORDS: Buprenorphine, Opioid Use Disorders, Access to Care

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry,

Council on Medical Education and Lifelong Learning

References:

Drug Alcohol Depend. 2006 Feb 1; 81(2):103-7. Epub 2005 Jul 14.

Barriers to Primary Care Physicians Prescribing Buprenorphine Eliza Hutchinson, BA; Mary Catlin, BSN, MPH; C. Holly A. Andrilla, MS; LauraMae, Baldwin, MD, MPH; Roger A. Rosenblatt, MD, MPH, MFR Ann Fam Med. 2014;12(2):128133.

Substance Abuse and Mental Health Services Administration, Results from the 2014 National Survey on Drug Use and Health: Summary of National Findings, Page 120, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf

Attachment #8
Item 2015A2 12.K
Assembly
October 30-Novembe 1, 2015

ACTION PAPER
FINAL

TITLE: Equality in Permanent Licensure Policy

WHEREAS:
Prior to an International Medical Graduate entering an ACGME-accredited residency training program, a rigorous credentialing process by the Educational Commission for Foreign Medical Graduates (ECFMG) is required to assess the mastery of medical school basic science curriculum as well as the clinical knowledge and skills of each physician, which must match, if not exceed, the mastery standards required of US medical grads.

The ACGME reviews and accredits graduate medical education (residency and fellowship) and the institutions that sponsor them in the United States with the mission of assessing and advancing the quality of resident physicians' education through accreditation. Length of time and quality in residency training, as established by ACGME accreditation, rather than location of prior medical school education, should be the determining factor in granting a permanent medical license.

Each state has its own regulations for obtaining a permanent medical license and all require a specific amount of time in an ACGME-accredited residency before a medical license can be approved. Currently, 37 States require U.S. residency-trained International Medical Graduates to spend more time in the same ACGME-accredited training programs than their US medical grad counterparts prior to obtaining permanent licensure.

The Association of American Medical Colleges (AAMC) predicts a workforce shortage of between 46,000 and 90,000 physicians by 2025*, largely created by passage of the Affordable Care Act. Action is required *now* to address this anticipated workforce shortage. A more timely entrance into the workforce of trained residents from ACGME-accredited residencies, will increase the workforce. Training programs are being relied on more to provide care for underserved populations via funding from State or County, and often there are licensure requirements. This places limits on training and also stretching the already stretched resources of training programs

Position statements from national professional associations such as the APA, the AMA, the Residency Review Committees (RRC), and the Federation of State Medical Boards (FSMB) can influence state policies.

BE IT RESOLVED:
That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards.

That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.

AUTHORS:
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Andres Jovel, M.D., APA member
Fructuoso Irigoyen M.D., DLFAPA, APA Member
Antony Fernandez, M.D., Deputy Representative, International Medical Graduate Psychiatrists
Nyapati Rao, M.D., Representative, International Medical Graduate Psychiatrists
Rajesh Tampi, M.D., APA Member

ESTIMATED COST:
Author: $ 16,613.85
APA: $5,185.64

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Nebraska Psychiatric Society, Assembly Committee of Early Career Psychiatrists, Assembly Committee of Resident Fellow members (ACORF)

KEY WORDS: medical license, licensure, international medical graduates, residency requirement, state medical board

APA STRATEGIC PRIORITIES:
Advancing Psychiatry: Advancing the integration of psychiatry as delivery system evolves a central role in all care settings, full implementation, enforcement or parity, assistance to members in practice with new technologies, reimbursement, and building and safeguarding the workforce.

Diversity: Supporting and increasing diversity within the APA, serving the needs of evolving, diverse, underrepresented and underserved patient populations, and working to end disparities in mental healthcare.

REVIEWED BY RELEVANT APA COMPONENT:
Council on International Psychiatry
Council on Medical Education and Lifelong Learning
Council on Advocacy and Government Relations
APA delegation to the AMA

Attachment #9
Item 2015A2 12.L
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Partial Hospital Training in Psychiatry Residency

WHEREAS:

1. Partial Hospital Programs (PHP's) are effective and bridge the gap in the continuum of care between inpatient and outpatient psychiatric treatment;
2. PHP's have been increasingly recognized and provided in psychiatric hospital settings across the country, particularly in light of shortened inpatient stays and need to further stabilize mentally ill patients and prevent relapses;
3. PHP's offer a unique clinical and educational experience in terms of daily intensive group therapies encompassing diverse themes and approaches supplemented by individual and family/couples therapy and close medication monitoring, all occurring over 4-6 weeks that allows observation of a patient's rapid bio-psycho-social progress in a short span of time;
4. The Accreditation Council for Graduate Medical Education (ACGME) does not formally recognize PHP experience under Curriculum Organization and Resident Experiences for psychiatry residency (Section 4. A. 6) but states in the Question and Answer Section that PHP would not fulfill the minimum six month requirement for inpatient; however, rotations in day treatment programs will be counted as part of the 16-month maximum allowed for inpatient psychiatry.
5. A majority of psychiatry residencies do not provide PHP rotations and are not aware of this valuable educational experience;
6. Many graduating residents are entering psychiatric hospital settings and are asked to work in PHP's although they have had no training in PHP;

BE IT RESOLVED:
That the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.

AUTHORS:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
Fructuoso Irigoyen-Rascon, M.D., PA, DLFAPA, APA Member

ESTIMATED COST:
Author: $0
APA: $65.64

ESTIMATED SAVINGS: Immeasurable gains in clinical knowledge and skill

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Partial hospital, Psychiatric residency

APA STRATEGIC PRIORITIES: Advancing psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
APA Council on Medical Education and Lifelong Learning- Comments:
"The Council thinks PHP rotations are important but residencies operate within the rules set by the ACGME-RRC. APA can however play a role as an advocate to ACGME through the liaison to the RRC and continue to stress the importance of PHP training in residency. While the ACGME has removed PHP requirement specifically, they have also lowered the number of required inpatient months from 9 to 6. The Council believes that this presents an opportunity for residency programs to continue to offer PHP rotations."

Attachment #10
Item 2015A2 12.N
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Advocating for Medicaid Expansion

WHEREAS:
The Affordable Care Act (ACA), passed by the US Congress in 2010 provides provisions for federal financing for states which expands eligibility for Medicaid coverage to include those with incomes up to 133% of the poverty level, 20 states still have not accepted the federal offer to expand Medicaid in their states;

Millions of Americans who do not have access to other forms of health insurance due to inability to afford private plans or lack of employer-provided insurance are forced to either forego medical and psychiatric care or attempt to access urgent or emergency care settings, leading to adverse medical outcomes and increased mortality rates. At the same time, hospitals are forced to absorb the cost of uncompensated care, in some cases causing closures which further exacerbate the access to care problems;

Expansion of Medicaid would result in increased access to care including access to critical medications for seriously and persistently mentally ill individuals. This is likely to reduce incarceration rates for minor offenses in this population, a serious and pervasive problem in the U.S. and a problem which the APA leadership, including current President Renée Binder, MD has begun to formally address (1);

It has been assumed until recently that the only way for a state to expand Medicaid is through legislative action, however in late August, a judge in Alaska blocked an effort by the state legislature to prevent the governor from accepting the federal money to expand Medicaid. This suggests another avenue for advocacy in addition to that of legislative action;

Both the APA and AMA have endorsed the ACA including Medicaid expansion but no formal advocacy effort on the state level has been undertaken by the APA;

While expansion of Medicaid will undoubtedly improve access to care for many individuals, low physician participation in the program could exacerbate access to care problems for some people who currently have Medicaid insurance but find it difficult to find a provider, thus incentive measures to encourage more physician participation in the program are needed.

BE IT RESOLVED:
That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion (2);

That a status report and recommendations be made to the Assembly at the May 2016 meeting.

AUTHORS:
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ESTIMATED COST:
Author: $ 3,123.85
APA:

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Medicaid Expansion

APA STRATEGIC GOALS: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
Council on Healthcare Systems and Financing: this Council strongly supported the intent of this action paper and recommended several changes which were all incorporated into the current (final) draft.

Council on Advocacy and Government Relations: this Council did not support the action paper in its original form and cited "resistance" in some state legislatures to Medicaid expansion and "heated discussions/debates" in these settings. (This Council did not have an opportunity to review the updated (final) draft prior to the deadline for Action Papers)

REFERENCES:
1. "Stepping Up to Address Our Nation's Shame". Psychiatric News, June 17, 2015 (Vol 50, No 14).
2. "Work Force Initiative", Assembly Action Paper, passed November 2012.

Attachment #11
Item 2015A2 12.O
Assembly
October 30-November 1, 2015

ACTION PAPER
FINAL

TITLE: Systems to Coordinate Psychiatric Inpatient Bed Availability

WHEREAS:
Whereas, in many areas of our country availability of psychiatric inpatient beds to accommodate psychiatric emergencies is inadequate or severely limited.

Whereas, regrettably patients languish in general hospital emergency rooms for hours or days after being placed on a "hold"--receiving minimal specialized treatment often further complicating their mental and physical status rendering later treatment more difficult and problematic.

Whereas, there have been efforts to devise online systems of bed registration and availability involving participating programs [Virginia Acute Psychiatric and CSB Bed Registry, Patient Valet, Maryland Institute for Emergency Medical Services Systems (MIEMSS), Minnesota Department of Human Services and Minnesota Hospital Association mental health service locator web site] in local communities and regions which can be easily accessed by emergency room staff, medical surgical staff and community providers.

Whereas a strategic approach to the bed crisis must involve prevention, early diagnosis and treatment intervention, enhanced outpatient services, and provision of additional acute beds, the establishment of registry models can be a significant immediate step in improving timely access.

BE IT RESOLVED:
That the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.

AUTHORS:
Richard Granese, M.D., Representative, Orange County Psychiatric Society
Barton Blinder, M.D., APA Member

ESTIMATED COST:
AUTHOR: $0
APA: $367.59

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Orange County Psychiatric Society

KEY WORDS: Psychiatric Emergency, Access to Care, Bed Registry

APA STRATEGIC PRIORITIES: Supporting Research

REVIEWED BY RELEVANT APA COMPONENTS: Council on Quality Care, Work Group on Access to Care, Council on Advocacy and Government Relations

Attachment #12
Item 2015A2 12.P
Assembly
October 30-November 1, 2015

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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ESTIMATED COST:
Author: $689.23 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:

Attachment #13
Item 2015A2 12.R
Assembly
October 30-November 1, 2015

ACTION PAPER
Referred to the Joint Reference Committee

TITLE: Senior Life Psychiatrist Seat on the Board of Trustees (BOT)

WHEREAS:
There will be an ever increasing number of older members in the APA. (Life expectancy in the USA went from 69.77 years in 1960 to 78.74 years in 2012. The median age of an APA member in 1996 was 52 years old; the percentage of psychiatrists practicing in the USA in 2010 over the age of 55 was 57% of all psychiatrists.)

There is no seat on the BOT specifically designated for a Life member of APA. ("Senior" is defined here as having reached "life status" membership in the APA. (The APA defines life status as: age plus total years of membership equal 95.)

There is not necessarily at any given time a Senior member on the Board.

There are seats designated for younger APA members, e.g., Resident-Fellow Trustee, ECP Trustee.

The Life Psychiatrist Trustee could be elected by the Life Members of the APA.

BE IT RESOLVED:
1. Create a Senior Psychiatrist seat on the BOT.
2. The Senior Psychiatrist Trustee would be elected by the Life Members.

AUTHORS:
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ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: BOT Trustee, Life Member, Senior Psychiatrist

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

APA Official Actions

Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988

Approved by the Board, 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*.

H-105.988
Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices

It is the policy of our AMA:

1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines:

a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for nonprescription products.
d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.
i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.

3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.

4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTC.

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 harassment in the workplace; and further votes to advocate and lobby for legislative and judicial action to recognize and facilitate any necessary treatment for victims of workplace harassment.

Attachment #16

Assembly
October 30-November 1, 2015
Washington, D.C.

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A2 4.B.1	Retain 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*	The Assembly voted, on its Consent Calendar, to retain the 2012 Position Statement: *Recognition and Management of Substance Use Disorders and other Mental Illnesses Comorbid with HIV*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016 Membership & ECP-RFT Trustee
2015 A2 4.B.2	Retain 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*	The Assembly voted, on its Consent Calendar, to retain the 2008 Position Statement: *Ensuring Access to, and Appropriate Utilization of, Psychiatric Services for the Elderly*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.3	Proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities*	The Proposed Position Statement: *Segregation of Juveniles with Serious Mental Illness in Correctional Facilities* was withdrawn by the Council on Psychiatry and Law as the draft position statement is still being finalized.	FYI- Joint Reference Committee, January 2016
2015 A2 4.B.4	Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP*	The Assembly voted to approve the Proposed Position Statement: *Opioid Overdose Education and Naloxone Distribution- Joint Position Statement of the APA/AAAP*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.5	Reaffirm APA's Adoption of the AMA's 2010 Position Statement: *Direct to Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices*	The Assembly voted to refer the Position Statement to the Joint Reference Committee to assign to the relevant bodies to draft a more meaningful position statement on DTC Advertising. The draft position statement will be presented to the Assembly in November, 2016.	Joint Reference Committee, January 2016
2015 A2 4.B.6	Proposed Position Statement: *Substance Abuse Disorders in Older Adults*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Substance Abuse Disorders in Older Adults*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.7	Revised Position Statement: Bias-*Related Incidents*	The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Bias-Related Incidents*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.8	Retire 2007 Position Statement: *The Right to Privacy*	The Assembly voted, on its Consent Calendar, to retire the 2007 Position Statement: *The Right to Privacy*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 4.B.9	Retire 2007 Position Statement: *Sexual Harassment*	The Assembly voted to **retain** the 2007 Position Statement: *Sexual Harassment*	Joint Reference Committee, January 2016
2015A2 4.B.10	Retire 2009 Position Statement: *Interference with Scientific Research and Medical Care*	The Assembly voted, on its Consent Calendar, to retire the 2009 Position Statement: *Interference with Scientific Research and Medical Care*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 4.B.11	Revised Position Statement: *Hypnosis*	The Assembly voted, on its Consent Calendar, to approve the revised Position Statement: *Hypnosis.*	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.12	Retain 2010 Position Statement on *Posttraumatic Stress Disorder and Traumatic Brain Injury*	The Assembly voted, on its Consent Calendar, to retain the 2010 Position Statement: *Posttraumatic Stress Disorder and Traumatic Brain Injury*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.13	Retain 2010 Position Statement on *High Volume Psychiatric Practice and Quality of Patient Care*	The Assembly voted, on its Consent Calendar, to retain the 2010 Position Statement: *High Volume Psychiatric Practice and Quality of Patient Care*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.14	Proposed Position Statement on *Tobacco Use Disorder*	The Assembly voted, on its Consent Calendar, to approve the Proposed Position Statement: *Tobacco Use Disorder*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.15	Retain Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015A2 4.B.16	Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*	The Assembly voted to approve the Proposed Position Statement on *Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016
2015 A2 5.A	Will the Assembly vote to approve the minutes of the May 15-17, 2015, meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the May 15-17, 2015 Assembly meeting.	Chief Operating Officer • Association Governance
2015 A2 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2015A2, 4.B.3, 4.B.5, 4.B.9 and 12.S were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2015 A2 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2015 A2 7.A	The Assembly voted to accept the report of the Nominating Committee.	The Assembly voted to accept the report of the Nominating Committee. The slate of candidates for the May 2016 Assembly election is as follows: Speaker-Elect: John de Figueiredo, M.D., Area 1 Theresa Miskimen, M.D., Area 3 Recorder: James R. (Bob) Batterson, M.D., Area 4 David Scasta, M.D., Area 3	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015 A2 7.B.1	Will the Assembly vote to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component"?	The Assembly voted to approve the recommended AEC-approved amendment to the Procedural Code incorporating the Assembly Committee on DSM composition/function based on the approved Action Paper 12 .M "Assembly DSM Component".	Chief Operating Officer • Association Governance
2015A2 8.L.1	APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*	The Assembly voted unanimously to approve the APA Practice Guideline: *Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*.	Board of Trustees, December, 2015 FYI: Chief of Policy, Programs &, Partnerships • Quality Care
2015A2 12.A	Access to Care Provided by the Department of Veterans Affairs	The Assembly voted to approve action paper 2015A2 12.A which asks: That the APA support any and all clinical activities that can improve the mental health care and treatment of veterans. That the APA correspond with the Secretary of the Veterans Administration (VA), Robert MacDonald, to actively solicit his support for arranging for fairness in pay for those physician-psychiatrists with more seniority and more administrative responsibility and for those physician-psychiatrists initially entering VA service with educational loans. That the APA actively support and advocate for Congressional appropriations for the loan repayment program provision of the Clay Hunt Suicide Prevention for American Veterans Act also known as the Clay Hunt SAV Act which is intended to funds mental health care and suicide prevention programs within the VA.	Joint Reference Committee, January 2016
2015A2 12.B	Directions to the Area Nominating Committees	The Assembly voted to approve action paper 2015A2 12.B which asks that: Areas should have the latitude to nominate more than two candidates. The Procedures Committee should be asked to change the language accordingly.	Assembly Executive Committee, January 2016 APA Nominating Committee (for information)
2015A2 12.C	New Names for Psychiatric Conditions	The Assembly did not approve action paper 2015A2 12.C.	N/A
2015A2 12.D	Prior Authorization	The Assembly voted, on its Consent Calendar, to approve action paper 2015A2 12.D which asks that the APA explore with other major medical organization whether medical organizations should advocate that clinicians be reimbursed for phone-time spent obtaining prior authorization.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.E	Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Support Product	The Assembly voted to approve action paper 2015A2 12.E which asks: That the Committee on Mental Health Information Technology and the Council on Quality Care form an ad hoc Workgroup (the "CDS Product Workgroup") for the purpose of evaluating the feasibility of developing an electronic clinical decision support (CDS) product that leverages the information and knowledge within the APA's series of Practice Guidelines, in addition to that within other appropriate APA products; and That the CDS Product Workgroup provide to the Assembly a report at the November 2016 meeting and a report at the Board of Trustees at the December 2016 meeting.	Joint Reference Committee, January 2016
2015A2 12.F	Payer Coverage for Prescriptions from Nonparticipating Prescribers	The Assembly voted to approve action paper 2015A2 12.F which asks: That the APA Department of Government Affairs engage CMS to find a mechanism to continue to pay for prescriptions ordered by psychiatrists who do not participate in Medicaid; and That APA seek legislative sponsorship if statutes and/or regulations are required to cover prescriptions ordered by nonparticipating psychiatrists; and That the relevant APA component develop a Position Statement similar to that of AMA's supporting coverage by all payers of prescriptions and tests ordered by nonparticipating psychiatrists; and That the APA work with the AMA to collect national and state level data on the extent of the problem of insurance non-coverage of prescriptions and tests when ordered by non-participating psychiatrists.	Joint Reference Committee, January 2016
2015A2 12.G	APA Support for NIMH Funding of Clinical Research	The Assembly voted to approve action paper 2015A2 12.G which asks that the APA shall: 1. Produce a white paper by the Assembly in May 2016 and the December 2016 Board of Trustees Meeting determining [a] the scope and breadth of change in NIMH funding of clinical trials associated with recent changes in research focus, [b] the public health consequences of the failure to provide such research support, including for patients served by the APA's 35,000 members and for psychiatric researchers who study clinical care; and [c] the need to provide adequate NIMH funding to support research into clinical treatment methods, including psychotherapy research, as part of a national mental health research budget. 2. The APA will advocate the implementation of the recommendations of the White Paper.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.H	Is it Ethical for a Psychiatrist to Serve as a Utilization Management Reviewer when Review Standards Fail to Comply with Parity?	The Assembly voted to refer action paper 2015A2 12.H to the Council on Healthcare Systems and Financing.	Joint Reference Committee, January 2016
2015A2 12.I	Strengthening the Role of Residency Training to Improve Access to Buprenorphine	The Assembly voted to approve action paper 2015A2 I which asks that the APA liaise with ACGME/Residency Review Committee (RRC) to promote Buprenorphine training during general adult psychiatric residency training.	Joint Reference Committee, January 2016
2015A2 12. J	Need to Gather Information on Physician Health Program (PHP) Performance	The action paper was withdrawn by the author.	N/A
2015A2 12.K	Equality in Permanent Licensure Policy	The Assembly voted to approve action paper 2015A2 12.K which asks: That the APA adopts a policy supporting equality in the number of years of ACGME-accredited training required for International Medical Graduates and US medical grads for the purposes of obtaining permanent medical licensure, and consider that a letter of this support be sent to the various state medical boards. That the APA will work with the FSMB, ACGME/RRC and the AMA to lobby for equality in ACGME-accredited residencies for International Medical Graduates equivalent to their US medical grad counterpart colleagues for the purposes of obtaining permanent licensure.	Joint Reference Committee, January 2016
2015A2 12.L	Partial Hospital Training in Psychiatry Residency	The Assembly voted to approve action paper 2015A2 12.L which asks that the APA recommend to the Residency Review Committee (RRC) of the ACGME to recognize and incorporate training in partial hospitalization and other intermediate levels of care in the section on Curriculum Organization and Resident Experiences as an important elective clinical experience for psychiatry residency.	Joint Reference Committee, January 2016
2015A2 12.M	Addressing the Shortage of Psychiatrists	The action paper was withdrawn by the author.	N/A
2015A2 12.N	Advocating for Medicaid Expansion	The Assembly voted, on its Consent Calendar, to approve action paper 2015A2 12.N which asks: That the APA Council on Advocacy and Government Relations and the new State Government Affairs Infrastructure will develop a plan to advocate for the expansion of Medicaid in those states which have not yet done so and the APA will continue address work force and other access concerns in relation to expected increased demand for services stemming from Medicaid expansion. That a status report and recommendations be made to the Assembly at the May 2016 meeting.	Joint Reference Committee, January 2016
2015A2 12.O	Systems to Coordinate Psychiatric Inpatient Bed Availability	The Assembly voted to approve action paper 2015A2 12.O which asks that the APA's Councils on Quality Care and Advocacy and Government Relations review existing models and programs of online registered psychiatric bed availability and present recommendations to develop and promote this approach to facilitating access to care.	Joint Reference Committee, January 2016

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2015A2 12.P	Making Access to Treatment for Erectile Disorder Available Under Medicare	The Assembly voted to approve action paper 2015A2 12.P which asks: 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.	Joint Reference Committee, January 2016
2015A2 12.Q	Lowering the Initial Membership Requirements for Newly Applying Established Subspecialties and Sections Organizations	The paper was not moved by the author.	N/A
2015A2 12.R	Senior Psychiatrist Seat on the Board of Trustees (BOT)	The Assembly voted to refer action paper 2015A2 12.R to the Joint Reference Committee.	Joint Reference Committee, January 2016
2015A2 12.S	Need for Position-Specific Email Addresses for Leadership Roles in the APA	The action paper was withdrawn by the author.	N/A
2015A2 12.T	Election of Assembly Officers	The Assembly voted to approve action paper 2015A2 12.T which asks that the Assembly Procedural Code be rewritten to make the election of Assembly officers based on a majority vote with each voting member of the Assembly casting one vote.	Assembly Executive Committee, January 2016
2015A2 14.A	Revised Position Statement on *Telemedicine in Psychiatry*	The Assembly voted to approve the Revised Position Statement on *Telemedicine in Psychiatry*.	Board of Trustees, December, 2015 FYI- Joint Reference Committee, January 2016

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2014 Issues:

2014 ISSUE:	Firearm Access
Work Product:	Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services and Resource Document: Access to Firearms by People with Mental Disorders
Brief Background/Rationale for the work product:	In January 2013, the JRC referred the following action to the Council on Psychiatry and Law: *The JRC noted that in light of the Obama Administration's initiatives on preventing gun violence, CPL will review all of the APA's position statements related to guns.* The Council created a workgroup, chaired by Dr. Debra Pinals, to work on reviewing and possibly consolidating the documents.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (Workgroup of the Council to include: Dr. Debra Pinals, Chair, Dr. Liza Gold, Dr. Carl Fisher (ECP), Dr. Cheryl Wills, Dr. Li-Wen G. Lee and Mr. Richard Bonnie,(Legal Advisor))
Tasks:	Review existing APA position statements and resource documents and if possible consolidate into new documents. New position paper and resource document were created.
Timeline for Completion:	Documents were sent to Joint Reference Committee in May 2014. Resource Document approved by JRC May 2014 and position paper approved by Assembly in November 2014 and was later approved by the BOT at their meeting in December 2014.

2014 ISSUE:	Professional Credentialing and Licensing
Work Product:	Proposed Position Paper on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing
Brief Background/Rationale for the work product:	The Council on Psychiatry and Law had reviewed the Louisiana Bar Examiners questionnaire which was the subject of an Americans with Disabilities litigation from the Department of Justice. The original questionnaire in that state asked about mental health history in relationship to the granting of a state law license. From this the Council on Psychiatry and Law felt it was necessary for APA to have a position on the subject.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (Workgroup of the Council to include: Dr. Patricia Recupero (Chair), Dr. Carl Fisher (ECP), Dr. Alec Buchanan, Dr. Tiffani Bell (fellow), Dr. Paul Appelbaum, Dr. Mardoche Sidor (fellow) and Mr. Richard Bonnie (legal counsel).)
Tasks:	Council on Psychiatry and Law's initial discussion include the context of what mental health history should be shared as part of a candidate's application for admission to the bar as well as for the obtainment of licensure in

	other professions. From this discussion the position paper was drafted.
Timeline for Completion:	The proposed position paper was sent to the JRC for their meeting in October 2014, Assembly in May 2015, and was approved by the BOT in July 2015.

2014 ISSUE:	Updating the APA Guidelines on Psychiatric Services in Correctional Facilities, 2nd edition
Work Product:	APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd edition
Brief Background/Rationale for the work product:	The Council on Psychiatry and Law felt that the document was out of date. The Council's Workgroup on Persons with Mental Illness in the Criminal Justice System took on the project.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (Workgroup on Persons with Mental Illness in the Criminal Justice System to include: Robert L. Trestman, Ph.D., M.D. (Chair), Michael K. Champion, M.D., Elizabeth Ford, M.D., Jeffrey L. Metzner, M.D., Cassandra F. NewKirk, M.D., Joseph V. Penn, M.D., Debra Pinals, M.D., Charles Scott, M.D., Roberta Stellman, M.D., Henry C. Weinstein, M.D., Robert Weinstock, M.D., Kenneth L. Appelbaum, M.D., (Consultant) and John L. Young, M.D., M.Th. (Consultant))
Tasks:	The focus of the workgroup was to give guidance to mental health professionals working in jails and prisons and to state that the care provided in these settings should meet the standard of what should be provided in the community.
Timeline for Completion:	The APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd edition was approved by the JRC and is now available for purchase through APA Publishing.

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2015 Issues:

2015 ISSUE:	College and University Mental Health
Work Product:	Proposed Position Paper on College and University Mental Health and Proposed Resource Document on College Mental Health and Confidentiality
Brief Background/Rationale for the work product:	In January 2015, the JRC referred an updated version of the 2005 College and Mental Health Position Paper to the Council on Psychiatry and Law for review. After reviewing the proposed revisions of the position paper, the Council and Psychiatry and Law felt that there have been a lot of changes since 2005 and a workgroup to review this position paper and the resource document was formed.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (workgroup to include: Dr. Carl Fisher (Chair - ECP), Dr. Wun Kim, Dr. Howard Zonana, Dr. Debra Pinals, Dr. Vivek Datta (Fellow) and Mr. Richard Bonnie (Legal Counsel)).
Tasks:	To review and update the 2005 College and Mental Health Position Paper and the 2009 College Mental Health and Confidentiality Resource Document.
Timeline for Completion:	The proposed position paper and resource document are scheduled to be reviewed at the January 2016 JRC meeting.

2015 ISSUE:	Involuntary Outpatient Commitment/Assisted Outpatient Treatment
Work Product:	Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment and the Resource Document on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment.
Brief Background/Rationale for the work product:	At the Council's May 2014 meeting, there was discussion about the issue of mandatory outpatient treatment and the move to update the resource document from 1999 as there has been a great deal of work and research done in the last 15 years. The Council also felt that it might be good timing to create a position statement from the resource document and new literature. The Council formed a workgroup.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (workgroup to include: Dr. Marvin Swartz (Chair), Dr. Mardoche Sidor (fellow),

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

	Dr. Debra Pinals, Dr. Tiffani Bell (fellow), Dr. Elizabeth Ford, Dr. R. Scott Johnson (fellow), Dr. Eugene Lee (ECP and Guest), Dr. Grace Lee and Dr. Ken Hoge.)
Tasks:	To review and update the 1999 Mandatory Outpatient Treatment Resource Document and to create a position paper.
Timeline for Completion:	The resource document was passed by the JRC in October 2015 and the position paper was approved by the Assembly in November 2015 and passed by the BOT at their meeting in December 2015.

2015 ISSUE:	Patient Access to Electronic Mental Health Records
Work Product:	Proposed Position Statement on Patient Access to Electronic Mental Health Records
Brief Background/Rationale for the work product:	In November 2013, the Assembly passed and action paper titled Unsafe and Uncontrolled Access to Mental Health Records Affecting 21.5 Million Veterans which asks that the APA leadership immediately petition the VA to halt the online disclosure of mental health notes in absence of clinical oversight. The action paper was referred to the BOT in December 2013 and the BOT asked relevant bodies of the APA (Committee on Electronic Health Records, the Council on Psychiatry and the Law, the Ethics Committee and the Caucus of VA Psychiatrists) jointly study the issue. The Council on Psychiatry and Law took the lead on the project.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law (Workgroup on Patient Access to Electronic Mental Health Records chaired by Dr. Grace Lee and included Dr. Mark Komrad (Ethics Committee), Dr. Elizabeth Ford (Council on Psychiatry and Law), Dr. Richard Milone (Ethics Committee), Dr. Steven Daviss (Committee on Mental Health Information Technology), Dr. Jenny Boyer (Caucus of VA Psychiatrists) and Dr. Ken Hoge (Council on Psychiatry and Law))
Tasks:	The workgroup was tasked to develop an APA position statement on the appropriate disclosure of electronic mental health records to patients.
Timeline for Completion:	A proposed position statement was drafted and submitted to the JRC in October 2014 and referred to the Assembly in May 2015. The Assembly did not approve the proposed position statement and referred it back to the JRC. The Joint Reference Committee referred the paper back to the Council on Psychiatry and Law noting that the original intent of the action paper seemed to differ from the intent of the position statement drafted by the Council. The Council on Psychiatry and Law reworked the proposed position statement with help from the chair of the Committee on Mental Health Information Technology. The position paper was passed by the JRC in October 2015 and will be reviewed by the Assembly in May 2016.

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2015 ISSUE:	Trial and Sentencing of Juveniles in the Criminal Justice System
Work Product:	Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System (previously 2005 APA Position Statement on Adjudication of Youths as Adults in the Criminal Justice System)
Brief Background/Rationale for the work product:	Review 2005 APA Position Statement Adjudication of Youths as Adults in the Criminal Justice System. The Council on Psychiatry and Law reviewed the position paper and decided to revise the position paper.
Required resources:	n/a
Responsible Entities:	Council on Psychiatry and Law
Tasks:	Revise the 2005 position statement
Timeline for Completion:	The revised position statement was passed by the JRC in October and will be reviewed by the Assembly in May 2016.

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2016 Issues:

2016 ISSUE:	Location of Civil Commitment
Work Product:	The Council on Psychiatry and Law will develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings.
Brief Background/Rationale for the work product:	In May 2015, the Assembly passed an action paper on Location of Civil Commitment. The Council on Psychiatry and Law decided to form a workgroup to draft a position paper. The workgroup has already met by conference call and is in the process of developing a draft document.
Required resources:	Conference Call line, email distribution list
Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Elizabeth Ford)
Tasks:	To develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings.
Timeline for Completion:	The Council on Psychiatry and Law hopes to have a draft to the JRC for their meeting in June 2016.

2016 ISSUE:	Physicians Assistance with Dying
Work Product:	The Council on Psychiatry and Law discussed creating a Resource Document.
Brief Background/Rationale for the work product:	The Council on Psychiatry and Law held a joint meeting with the Committee on Judicial Action, the APA Ethics Committee, and the Council on Geriatric Psychiatry on physician assistance with dying at the September Component meeting. The subject of the meeting was triggered from multiple requests from District Branches asking APA for some guidance on the subject. The council formed a workgroup which is currently meeting by conference call.
Required resources:	Conference call line, email distribution list
Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Stuart Anfang)
Tasks:	The Council would like to create a resource document. For psychiatry, this topic raises concerns about competence evaluations and is becoming increasingly relevant as California has recently passed an ordinance

	permitting physician assisted death.
Timeline for Completion:	The Council on Psychiatry and Law hopes to have a draft to the JRC for their meeting in June 2016.

2016 ISSUE:	Physician Health Programs
Work Product:	There is still discussion with the Council on Addictions about creating a position paper and/or resource document.
Brief Background/Rationale for the work product:	Dr. Levin has asked Council on Psychiatry and Law and the Council on Addictions to address the subject of physician health programs. The APA has received several inquiries about resources available. The Council on Addiction and the Council on Psychiatry and Law have had a conference call to discuss next steps. In addition, the Council on Psychiatry and Law has created a workgroup.
Required resources:	Conference call, email
Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Patricia Recupero) and working with Council on Addictions
Tasks:	There is discussion about a position paper or resource document specific to psychiatry.
Timeline for Completion:	The estimated time frame to complete this project is summer of 2016.

The Council on Psychiatry and Law is charged with the following: The Council's principal responsibility is to evaluate legal developments of national significance, proposed legislation, regulations, and other government intervention that will affect the practice of psychiatry, including the subspecialty of forensic psychiatry. The council focuses on legislation, regulation, and case law that has the potential to influence the provision, quality or availability of mental health care and services, alter the psychiatrist-patient relationship, affect confidentiality or the rights of patients, or that will otherwise regulate the practice of psychiatry in the public or private sector. Additional areas of attention include child forensic psychiatry, corrections, assessment of violence risk, and psychiatric issues that reflect international concerns (e.g., abuse of psychiatry and psychiatrists, violence, terrorism, and human rights). In fulfillment of this charge, the Council is responsible for making recommendations concerning pending legislation that may affect effective psychiatric treatment, research and training; preparation of model statutes for district branch use; monitoring regulations (and other forms of implementation of legislation); and drafting appropriate statements, resource documents, and recommendations for APA policy. A function of the Council is to make recommendations to the Board of Trustees regarding appellate cases in which the APA should participate as amicus or support DB/SA participation as amicus, based on input from the Committee on Judicial Action. When there are time constraints, requests from the Committee on Judicial Action may go directly to the Board of Trustees after consultation with the chair of the Council on Psychiatry and Law. If an issue must be acted upon prior to the next meeting of the Board, the President may consider the issue through the Executive Committee.

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

The Council on Psychiatry and Law has several Committees besides their workgroups:

Committee on Judicial Action:
The Committee on Judicial Action function is to make recommendations to the Board of Trustees regarding appellate cases that the APA should participate as amicus or support DB/SA participation as amicus. The Committee on Judicial Action is chaired by Dr. Marvin Swartz and meets twice a year (Annual Meeting and September Component meeting).

Isaac Ray Awards Committee:
The Isaac Ray Award committee is charged with the selection of the recipient of Isaac Ray Award. Dr. Liza Gold is the current chair and the committee meets once a year. (Annual meeting)

Guttmacher Awards Committee:
The Guttmacher Awards Committee is charged with selecting the recipient of Manfred S. Guttmacher award. Dr. David Lowenthal is the current chair and the committee meets by conference call and email.

Additional Information:
The Council on Psychiatry and Law meets twice a year (Annual Meeting and September Components meeting). In between meetings, the Council conducts business through the email distribution list. The Council stays active through email and is constantly reviewing work products, providing feedback on legislation, and working with other Councils on an array of subject matters.

The Council members mentor RFM and ECP members by assigning mentors on the Council. In addition, the fellows are encouraged and often participate in the Council workgroups.

Appointment Year: June 1st to May 31st
Council: Council on Psychiatry and Law

Meetings – in person	Chairperson	Vice Chairperson	Members	Corresponding Mbrs	Consultants (Legal Advisor)	Fellows
Example: X of N	Yes	Yes	8 of 12	1 of 3	2 of 2	3 of 5
September Components - 2015	Yes	Yes	10 of 13	3 of 4	1 of 1	6 of 8
Annual Meeting – 2015	Yes	Yes	9 of 12	3 of 3	1 of 1	6 of 8
Other Meetings [specify]						
Conference Calls - Workgroups [specify dates; June to May]						
12/10/2015 – Workgroup on Physician Assisted Suicide	Yes	n/a	3		1	2
11/11/2015 – Workgroup on Civil Commitment	Yes	n/a	6		1	2
11/19/2015 – Workgroup on Physician Health Programs (with the Council on Addictions)	n/a	n/a	n/a	n/a	n/a	n/a
8/18/2015 –Physician Assisted Suicide prep for September Joint Meeting (Hoge, Swartz, Bonnie)			2		1	
7/30/2015 - Physician Assisted Suicide prep for September Joint Meeting (Hoge, Swartz, Bonnie)			2		1	

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2013 Issue:

2014 ISSUE:	Choosing Wisely List
Work Product:	Release of the APA copy righted Choosing Wisely List.
Brief Background/Rationale for the work product:	*Choosing Wisely* aims to promote conversations between clinicians and patients by helping patients choose care that is: • Supported by evidence • Not duplicative of other tests or procedures already received • Free from harm • Truly necessary In response to this challenge, national organizations representing medical specialists asked their providers to "choose wisely" by identifying tests or procedures commonly used in their field whose necessity should be questioned and discussed. The resulting lists of "Things Providers and Patients Should Question" will spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments. To help patients engage their health care provider in these conversations and empower them to ask questions about what tests and procedures are right for them, Consumer Reports has developed patient-friendly materials based on the specialty societies' lists of recommendations. These materials are disseminated through the campaign's consumer partners. For providers, a suite of communication education modules was created to help them engage in these conversations with their patients. A growing library of video resources also provides diverse perspectives on the campaign's impact and challenges.
Required resources:	APA Administration and sub-group of the Council on Quality Care
Responsible Entities:	Council on Quality Care subgroup (chaired by Joel Yager,MD; Greg Dallack, MD; Anothony Battista, MD.)
Tasks:	Reviewed a survey that identified expert consensus of over utilized medical practices in psychiatry. The work group developed statements based on this survey, reviewed and consulted these statements with the related

	APA Councils.
Timeline for Completion:	The process began in 2012 and completed upon release of the List in 9/2013.

2014 Issues:

2014 ISSUE:	Multiple Educational Efforts by the Workgroup on Patient Safety and the Workgroup on Standards and Surveys
Work Product:	Symposiums on Violence in Clinical Psychiatry, Over-bedding Problems, and Transition of Care at the APA 2014
Brief Background/Rationale for the work product:	The Council on Quality Care tasks both the Workgroup on Patient Safety and the Workgroup on Standards and Surveys (related to their unique subject matters) to help identify valuable areas of interest to APA members to assist in their various practice backgrounds. In order to best serve the membership, these groups have presented several times at the Annual Meeting
Required resources:	n/a
Responsible Entities:	Workgroup on Standards and Surveys (Yad Jarbarpour, MD) Workgroup on Patient Safety (Geetha Jayaram, MD)
Tasks:	The symposium was presented at the 2014 APA Annual Meeting: ***Violence in Clinical Psychiatry: Overcoming the Barriers to Improving Safety on the Unit*.** The topic drove discussion on this key quality and safety issue, which is also a concern for APA membership. The symposium allowed the APA to further discuss policy and standards development, including activities with *The Joint Commission*. The symposium was presented at the 2014 APA Annual Meeting focused on Over-bedding and Care Transitions. The topics drove discussion on this key quality and safety issue, which is also a concern for APA membership.
Timeline for Completion:	N/A

2014 ISSUE:	Resource Documents for the Treatment of Patients with Gender Dsyphoria
Work Product:	While not formal APA Guidelines on treating patients with Gender Dysphoria, these are resource documents

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

	to aid APA members.
Brief Background/Rationale for the work product:	Due to a dearth of materials in this area, the Council on Quality Care charged the Workgroup on Gender Dysphoria to develop resource materials.
Required resources:	n/a
Responsible Entities:	Council on Quality Care and Workgroup on Gender Dysphoria (Bill Byne, MD, workgroup chair)
Tasks:	The focus of the workgroup was to give guidance to mental health professionals working with patients with Gender Dysphoria
Timeline for Completion:	N/A

2014 ISSUE:	Registry Report
Work Product:	Recommendation Report providing advice on the direction the organization will take to consider a society-led registry.
Brief Background/Rationale for the work product:	Due to the changing face of quality reporting, many medical speciality societies have taken on the responsibility of supporting a society-led registry. This report was the APA's initial effort into this area.
Required resources:	Staff liaison assigment
Responsible Entities:	Council on Quality Care and Workgroup on Registries (Greg Dallack, MD, workgroup chair)
Tasks:	The focus of the workgroup was to research existing registries, and consider models that would work within various psychiatrist clinical settings, as well as incentives psychiatrists would have for reporting.
Timeline for Completion:	6 months.

2015 Issue:

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2015 ISSUE:	Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia
Work Product:	Development of standards for the treatment of this population.
Brief Background/Rationale for the work product:	Based on a broad systematic review completed by the AHRQ, Dr. Fochtmann (APA consultant) winnowed down the available material to this specific subject. From that, and the need for more specific guidance in this area, the effort to move forward with this guideline set occurred.
Required resources:	APA administration and consultant.
Responsible Entities:	Council on Quality Care, Steering Committee on Practice Guidelines, and the Guideline Writing Workgroup
Tasks:	To develop consensus standards (Delphi voting process) a writing group consisting of multi-stakeholders in the area of guideline writing and dementia care convened. Following IOM standards, this guideline set was approved by the BOT in 2015.
Timeline for Completion:	2 years

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

2016 Issues:

2016 ISSUE:	Location of Civil Commitment
Work Product:	The Council on Psychiatry and Law will develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings.
Brief Background/Rationale for the work product:	In May 2015, the Assembly passed an action paper on Location of Civil Commitment. The Council on Psychiatry and Law decided to form a workgroup to draft a position paper. The workgroup has already met by conference call and is in the process of developing a draft document.
Required resources:	Conference Call line, email distribution list
Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Elizabeth Ford)
Tasks:	To develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings.
Timeline for Completion:	The Council on Psychiatry and Law hopes to have a draft to the JRC for their meeting in June 2016.

2016 ISSUE:	Physicians Assistance with Dying
Work Product:	The Council on Psychiatry and Law discussed creating a Resource Document.
Brief Background/Rationale for the work product:	The Council on Psychiatry and Law held a joint meeting with the Committee on Judicial Action, the APA Ethics Committee, and the Council on Geriatric Psychiatry on physician assistance with dying at the September Component meeting. The subject of the meeting was triggered from multiple requests from District Branches asking APA for some guidance on the subject. The council formed a workgroup which is currently meeting by conference call.
Required resources:	Conference call line, email distribution list

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Stuart Anfang)
Tasks:	The Council would like to create a resource document. For psychiatry, this topic raises concerns about competence evaluations and is becoming increasingly relevant as California has recently passed an ordinance permitting physician assisted death.
Timeline for Completion:	The Council on Psychiatry and Law hopes to have a draft to the JRC for their meeting in June 2016.

2016 ISSUE:	Physician Health Programs
Work Product:	There is still discussion with the Council on Addictions about creating a position paper and/or resource document.
Brief Background/Rationale for the work product:	Dr. Levin has asked Council on Psychiatry and Law and the Council on Addictions to address the subject of physician health programs. The APA has received several inquiries about resources available. The Council on Addiction and the Council on Psychiatry and Law have had a conference call to discuss next steps. In addition, the Council on Psychiatry and Law has created a workgroup.
Required resources:	Conference call, email
Responsible Entities:	Council on Psychiatry and Law (workgroup chaired by Dr. Patricia Recupero) and working with Council on Addictions
Tasks:	There is discussion about a position paper or resource document specific to psychiatry.
Timeline for Completion:	The estimated time frame to complete this project is summer of 2016.

The Council on Psychiatry and Law is charged with the following: The Council's principal responsibility is to evaluate legal developments of national significance, proposed legislation, regulations, and other government intervention that will affect the practice of psychiatry, including the subspecialty of forensic psychiatry. The council focuses on legislation, regulation, and case law that has the potential to influence the provision, quality or availability of mental health care and services, alter the psychiatrist-patient relationship, affect confidentiality or the rights of patients, or that will otherwise regulate the practice of psychiatry in the public or private sector. Additional areas of attention include child forensic psychiatry, corrections, assessment of violence risk, and psychiatric issues that reflect international concerns (e.g., abuse of psychiatry and psychiatrists, violence, terrorism, and human rights). In fulfillment of this charge, the Council is responsible for making recommendations concerning pending legislation that may affect effective psychiatric treatment, research and training; preparation of model statutes for district branch use; monitoring regulations (and other forms of implementation of legislation); and drafting appropriate statements, resource documents, and recommendations for APA policy. A function of the Council is to make recommendations to the Board of Trustees regarding appellate cases in which the APA should participate as amicus or support DB/SA participation as amicus, based on input from the Committee on Judicial Action. When there are time constraints, requests from the Committee on Judicial

COUNCIL WORK PLAN TEMPLATE

Complete the Template for Current and Future Tasks

Action may go directly to the Board of Trustees after consultation with the chair of the Council on Psychiatry and Law. If an issue must be acted upon prior to the next meeting of the Board, the President may consider the issue through the Executive Committee.

The Council on Psychiatry and Law has several Committees besides their workgroups:

Committee on Judicial Action:
The Committee on Judicial Action function is to make recommendations to the Board of Trustees regarding appellate cases that the APA should participate as amicus or support DB/SA participation as amicus. The Committee on Judicial Action is chaired by Dr. Marvin Swartz and meets twice a year (Annual Meeting and September Component meeting).

Isaac Ray Awards Committee:
The Isaac Ray Award committee is charged with the selection of the recipient of Isaac Ray Award. Dr. Liza Gold is the current chair and the committee meets once a year. (Annual meeting)

Guttmacher Awards Committee:
The Guttmacher Awards Committee is charged with selecting the recipient of Manfred S. Guttmacher award. Dr. David Lowenthal is the current chair and the committee meets by conference call and email.

Additional Information:
The Council on Psychiatry and Law meets twice a year (Annual Meeting and September Components meeting). In between meetings, the Council conducts business through the email distribution list. The Council stays active through email and is constantly reviewing work products, providing feedback on legislation, and working with other Councils on an array of subject matters.

The Council members mentor RFM and ECP members by assigning mentors on the Council. In addition, the fellows are encouraged and often participate in the Council workgroups.

Appointment Year: June 1st to May 31st
Council: Council on Quality Care

Meetings – in person	Chairperson	Vice Chairperson	Members	Corresponding Mbrs	Consultants	Fellows
Example: X of N	Yes	Yes	8 of 12	1 of 3	2 of 2	3 of 5
September Components	Yes	Yes	7 of 11	1 of 1	1 of 1	4 of 4
Annual Meeting						
Other Meetings [specify]						
Conference Calls [specify dates; June to May]						
Liaison and Chair meet every other Thursday since June to date. (about 14 times)	Yes					
Council-wide Conference Call, 12/4/15	Yes	Yes	9/11	1 of 1	1 of 1	3 of 4

COUNCIL On QUALITY CARE

A meaningful component work plan should contain:

1) Clear statement of the issue and rationale for a given work product and its strategic utility
2) The work product defined for the given issue/topic. [e.g., position statement, resource document, curriculum, recommendations on policy]
3) Identification of the key resources needed to develop/implement the product (e.g. key components, administrative expertise, funding)
4) A specific plan for development and implementation of the work product. (i.e., tasks to be performed, assignment of responsibility for tasks, coordination of tasks with a defined completion timeline)
5) Plan to execute and monitor and evaluate

Please complete for each primary issue/topic of the Council and place in priority order.

ISSUE:	A. Strategies to assist members to adopt Technological Assistance • Develop a strategic plan to reach-out to other mental health organizations to collaborate on HIT. • Develop EHR/App requirements for web site (and work with APA staff to develop web site) • Identify current EHRs that support psychiatry • Develop criteria to review EHRs o Establish protocols to test these criteria B. EHR Improvement Consultants • Develop a database structure to store requirements, data elements, vendor information, and user comments • Develop a query mechanism for providers to be able to identify EHRs which satisfy their own requirements • Develop a mechanism for providing method to review and update requirements for EHRs
Work Product:	**Please see above**
Brief Background/Rationale for the work product:	**Due to a somewhat low EHR adoption rate, the work products identified by the Committee could help increase interest and ease into workflow this type of technology.**
Required resources:	**Continued APA administration (including APA IT staff) and expertise of committee members**
Responsible Entities:	**Council on Quality Care and Committee on Mental Health Information Technology**

COUNCIL On QUALITY CARE

Tasks:	**A. Develop strategic plan to reach-out to other mental health organizations to collaborate on HIT** • **February 2016 – Discuss strategic plan process and identify members of CMHIT to draft outline** • **March – Draft outline of strategic plan** • **April – Complete draft of strategic plan** • **May: Final strategic plan** **B. Develop EHR/App requirements for web site (and work with APA staff to develop web site)/Identify EHRs/Develop criteria & testing protocols** • **December 2015 – Initial consultation with web manager** • **January 2016 – Identify key CMHIT staff to work on EHR criteria development ; Meet with IT staff to outline needs** • **February 2016 – Develop mock-up of web site design; Meet with IT staff; Have members of CMHIT identify and review several EHRs and Apps for initial review according to criteria initially developed by CMHIT** • **March 2016 – Continue EHR review process; review February 2016's process for identifying and reviewing (protocols), change/update as needed; Provide IT with a working model for RDB needs (query mechanism, review and update electronic mechanism identified, etc.)** • **April 2016 – Continue EHR review process; meet with IT to review RDB needs** • **May 2016 – EHR/Apps RDB in beta?** • **June 2016 – EHR/Apps RDB in beta?** • **July 2016 – RDB soft release?** • **August 2016 – RDB launch?**
Timeline for Completion:	**The CMHIT's deliverables for much of 2016 will center around the development of a submission/review process for electronic health records (EHRs) and mobile applications (apps) for psychiatry. As the timeline progresses, members of the CMHIT will work with APA staff (i.e., HIT Specialist, IT staff, Communications) to provide the technological specifications based on the submission/review process in order to begin to develop a relational database (RDB) for EHRs and apps. The date for the launch of these products is tentative, as the CMHIT is just beginning the dialogue with APA Administration in order to articulate staff bandwidth on this very ambitious project.**

COUNCIL On QUALITY CARE

A meaningful component work plan should contain:

1) Clear statement of the issue and rationale for a given work product and its strategic utility
2) The work product defined for the given issue/topic. [e.g., position statement, resource document, curriculum, recommendations on policy]
3) Identification of the key resources needed to develop/implement the product (e.g. key components, administrative expertise, funding)
4) A specific plan for development and implementation of the work product. (i.e., tasks to be performed, assignment of responsibility for tasks, coordination of tasks with a defined completion timeline)
5) Plan to execute and monitor and evaluate

Please complete for each primary issue/topic of the Council and place in priority order.

ISSUE:	A. The Committee plans to develop two position statements on APA's role in measure development: 1) as experts, and 2) the existence in gaps in care. B. The Committee plans to determine the educational needs of its membership around the subject of performance measurement development, and performance measurement reporting.
Work Product:	Position Papers
Brief Background/Rationale for the work product:	Presently there is no identified role of the APA in performance measure development. The group plans to develop a unified strategy by which the organization can follow.
Required resources:	Continued work with the APA administration liaison. The development of "sub-committees" to address each goal, utilizing the committee's expertise most efficiently.
Responsible Entities:	Council on Quality Care and Committee on Performance Measurement
Tasks:	**For all projects, participate in an environmental scan of what currently exists in this area. Possibly reach out to the Councils on Research and the APA Research department to assist in the completion of this work.**
Timeline for Completion:	**A. 1 year** **B. 3 years**

COUNCIL On QUALITY CARE

A meaningful component work plan should contain:

1) Clear statement of the issue and rationale for a given work product and its strategic utility
2) The work product defined for the given issue/topic. [e.g., position statement, resource document, curriculum, recommendations on policy]
3) Identification of the key resources needed to develop/implement the product (e.g. key components, administrative expertise, funding)
4) A specific plan for development and implementation of the work product. (i.e., tasks to be performed, assignment of responsibility for tasks, coordination of tasks with a defined completion timeline)
5) Plan to execute and monitor and evaluate

Please complete for each primary issue/topic of the Council and place in priority order.

ISSUE:	**Improved Topic Selection for Clinical Practice Guideline Development Selection**
Work Product:	Develop a standard process for selecting topics for guideline development based on: degree of public importance, relevance to psychiatric practice, availability of evidence, likelihood of guideline improve practice and patient care, and potential quality gaps.
Brief Background/Rationale for the work product:	Presently the Steering Committee on Practice Guidelines works to influence the AHRQ on what topics to accept for systematic review. In addition, the committee might consider development of other documents with a more limited focused on a specific treatment issue, rather than guidelines that cover broad topics, that would allow for more expedient development.
Required resources:	In order to increase the current rate at which guidelines are developed, the APA would need more internal methodological and scientific writing expertise. Of note, the American Psychological Association has started developing guidelines and has three topics that are in various stages of development. In additional to standing committees and writing panels, they have several staff members across various directorates that work on guideline develop and have devoted financial resources to the outsourcing of systematic reviews for topics they deem to be of greatest importance.
Responsible Entities:	**Council on Quality Care and Committee on Practice Guidelines**
Tasks:	The Executive Committee on Practice Guidelines is in the process of reviewing past guideline topics as well as topics identified via a survey of the Assembly to prioritize topics for guideline development, and to identify which topics should be nominated to AHRQ for possible systematic review and which systematic reviews could be done in-house.
Timeline for Completion:	**On going**

Council on Addiction Psychiatry: Yearly Assessment: 2015

1. Councils' top 3 activities from the previous year

- **Workgroup on Tobacco Use Disorder:**

In January 2015, the APA, with the Workgroup's leadership, submitted a proposal for external funding to the Robert Wood Johnson Foundation's Smoking Cessation Leadership Council (SCLC). The grant was funded and supported the development of an APA strategic plan and the implementation of several of the plan's initial steps. In 2015, the workgroup: (1) completed the strategic plan; (2) developed an APA position statement on Tobacco Use Disorders, (3) conducted a pilot survey of a group of APA members to assess current practice; and (4) presented training workshops at the APA Annual Meeting and the Annual Meeting of the American Academy of Addiction Psychiatry.

- **Developed APA Position Statements:**

Position Statements and accompanying resource documents were developed and have now been approved by the Board of Trustees. They are: **(1)** Position Statement and Resource Document on Tobacco Use Disorder; **(2)** Position Statement and Resource Document on Substance Use Disorders in Older Adults; and **(3)** Joint APA/AAAP Position Statement on Opioid Overdose Education and Naloxone Distribution. With mentorship of members of the Council, Resident Fellows developed additional statements and resource documents that are in the final review process. Topics are: **(1)** Equitable Access to Quality Medical Care for Persons with Substance Related Disorders; **(2)** Adolescent Substance Use; **(3)** Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone with that of Co-Occurring Mental Illnesses; **(4)** Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder; and **(5)** Treatment of Substance Use Disorders in the Criminal Justice System.

- **Special Projects: Substance Use Disorder Curriculum and Physicians' Health Programs:**

The Council sought a received a contract from NIDA to identify and assess the scope and quality of existing open-source SUD curriculum; design and implement mechanisms to make the curriculum available to all residency training programs; execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors; identify gaps in the existing curriculum with the goal of developing curriculum to address them in a future initiative; and develop and implement mechanisms to evaluate the project. This project will be undertaken collaboratively by the Council on Addiction Psychiatry and the Council on Medical Education and Lifelong Learning, with representation from other organizations (e.g., ACGME, RRC, AADPRT, AAAP).

Additionally, the council is working collaboratively with the Council on Psychiatry and Law to develop policy and/or a resource document that will address Physicians' Health Programs and address evidence-based practices and due process.

2. Tangible work products –

Psychiatrists' Undertaking Freedom From Smoking (PUFFS), a strategic plan to address Tobacco Use Disorder; three approved position statements; and five position statements in various stages of APA review.

3. Work priorities for the coming year

The Council will make significant progress in advancing the curriculum project, produce a position statement and/or resource document on Physicians' Health Programs, advise and oversee APA's

contributions to the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment and the Providers' Clinical Support System for Opioid Therapies, and establish a Tobacco Use Disorder Champions Program in collaboration with several APA State Associations.

4. Assess the participation of Council members
The Council is fortunate to have very committed members.

5. Mentoring of RFM/ECP members
Council members actively mentor RFM's and include them in the activities of the council. Every RFM has been involved in developing position statements and contribute to invitations for input on a variety of issues.

6. **Please attach a copy of the charge to the council. (found in the APA Operations Manual)**

The Council on Addiction Psychiatry is charged with the following:

- Liaison with the American Academy of Addiction Psychiatry (AAAP) to address mutual interests and priorities and advance shared goals
- Providing psychiatric leadership in the growing field of prevention and treatment of addictive disorders;
- Developing and clarifying the role of the psychiatrist in the prevention and treatment of addictive disorders;
- Formulating policy recommendations related to prevention, education, treatment, and research in addictive disorders;
- Considering important developments in basic knowledge, treatment, methodology, treatment systems, and related matters in the field of addictive disorders, and dissemination of that knowledge;
- In cooperation with other appropriate APA components, enhancing the quality and quantity of medical education in addictive disorders, at all educational levels, including undergraduate, residency, fellowship, and continuing medical education;
- Providing additional liaison to medical, educational, consumer interest, and governmental organizations interested in alcohol and other drug problems;
- Collaborating with other councils and components of the APA on common issues related to the role of psychiatry in addictive disorders; for example, to improve the quality of care and risk management for addictive disorders, to foster adequate research efforts and funding, and to foster adequate reimbursement for treatment.

Scope of work and work product: It is expected that a newly constituted Council will continue the work of its predecessor council and expand on it. It will maintain active communication and collaboration with Federal agencies and offices (i.e., ONDCP, NIDA, NIAAA, CSAT/SAMHSA; (2) provide ongoing consultation to initiatives to train and provide clinical mentorship to physicians who treat opioid dependence in their offices, (3) consult with the Department of Government Relations on legislative and policy initiatives that impact education, research, and clinical care; (4) maintain ongoing collaboration with components focused on other psychiatric subspecialties and seek opportunities to join together in efforts to strengthen the respective fields; (5) work closely and collaboratively with the American Academy of Addiction Psychiatry.

Item JRC #8.A
Joint Reference Committee
January 24-25, 2016

Summary
Council on Addiction Psychiatry

Action Items:

- Will the Joint Reference Committee recommend that the Assembly approve the **Position Statement on Equitable Access to Quality Medical Care for Substance Related Disorders**? Attachment #1

- Will the Joint Reference Committee recommend that the Assembly approve the **Position Statement on Integrating Opioid Use Disorders Treatment with Buprenorphine and Naltrexone With That Of Co-occurring Mental Illnesses?** Attachment #2

Information Items:

- In response to the JRC's suggestion, the **Position Statement on Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder** is being reformatted. It will be submitted for approval by the Joint Reference Committee in June 2016.

- A **Position Statement on Adolescent Substance Abuse** was developed by the Council and forwarded to the Council on Children, Adolescents, and Their Families for their review and input. It will be submitted for approval by the Joint Reference Committee in June 2016

- A workgroup of members of the Council on Addiction Psychiatry and the Council on Psychiatry and Law has been formed to focus on Physicians' Health Programs. The group intends to develop a position statement and/or resource document that will address issues related to due process and evidence-based treatment.

- The National Institute on Drug Abuse is organizing a featured research track for the 2016 APA Annual Meeting. It will include eight symposia, a workshop, and a panel discussion on the prescription drug and heroin epidemic. Leaders of the National Institute on Drug Abuse, White House Office of National Drug Control Policy, Centers for Disease Control, and the Surgeon General have been invited to participate.

- The current contract for the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment will end in July 2016. APA will again partner with the American Academy of Addiction Psychiatry and several other organizations to submit an application for a three-year contract renewal. SAMHSA's decision is likely to be announced in the next few months.

- APA submitted a grant proposal to SAMHSA for the purpose of updating its online waiver-eligible buprenorphine course. A funding decision has not been made as yet.

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.
- 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 is opposed.
- Access to effective prevention and treatment for substance related disorders, including medication assisted treatment, must be expanded. Other chronic illnesses such as heart disease, diabetes, and asthma, among others, are not subject to the same restricted limits on access to and coverage of care as are substance related disorders.
- The exclusion of substance related disorder diagnoses and patients with these diagnoses, as well as limitations to access to effective behavioral and medication assisted treatments, is discriminatory and contrary to the scientific findings of the clinical, research, health economics, and policy communities.

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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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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COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:

The Council on Advocacy and Government Relations continues to serve as APA's principle coordinating component for all legislative and regulatory activities involving the federal and state governments.

Specifically, the Council has provided recommendations and counsel to APA's Department of Government Relations on several key areas, including:

- Comprehensive Mental Health Reform legislation in both the U.S. House and Senate
- APA's Unsafe Prescribing Toolkit (scope of practice advocacy publication)
- State Battles related to Psychologists Seeking Prescribing Privileges (e.g., Idaho, Hawaii)
- Psychiatric workforce efforts, including Expanding the Conrad 30 J-1 Visa Waiver Program
- 2015's successful State Advocacy Leadership Conference
- Workshop on the Elements for Effective Advocacy for the Profession of Psychiatry

The draft minutes from the Council's monthly conference calls are attached.
(Attachment #1 and Attachment #2)

ACTION ITEM(S):

The Council brings the following Action Items to the Joint Reference Committee

1. **JRC REFERRAL: Any Willing Physician**
   The Council on Advocacy and Government Relations reviewed the Position Statement, "Any Willing Physician" as directed by the JRC. The Council discussed the Position Statement in length, taking in consideration the statement was originally approved in 1995 (reaffirmed 2007). Members agreed the intent of the statement is applicable to current issues concerning workforce and scope of practice. Through unanimous consent, the Council recommends the Position Statement be retained as written. (Attachment #3)

   Will the Joint Reference Committee recommend that the Board of Trustees accept the Council on Advocacy and Government Relations' recommendation to retain APA's 1995 Position Statement "Any Willing Physician"?

2. **JRC REFERRAL: Timely Reimbursement for Psychiatric Treatment**
   The Council on Advocacy and Government Relations discussed the JRC referral of Action Paper, "Timely Reimbursement for Psychiatric Treatment" (ASMMAY1512.G). The Council examined the correlation of the timeliness of payment systems and increased participation in plans by psychiatrists, as presented in the Action Paper. Members offered feedback related to reimbursement systems and relative practicality in solo/private practices compared to larger healthcare settings. The Council—agreeing with the comments from the Council on Healthcare Systems and Financing—found the Action Paper does not clearly define its objective or provide a clearly understood outcome for resolution. Through unanimous consent, the Council seconded the recommendation of the Council on Healthcare Systems and Financing and recommended the Action Paper be returned to the authors for further clarification. (Attachment #4)

   Will the Joint Reference Committee accept the Council on Advocacy and Government Relations' recommendation to return the Action Paper on "Timely Reimbursement for Psychiatric Treatment" to the author for clarification, including a definition of the problem that is being addressed?

INFORMATIONAL ITEM(S):
The Council brings the following Informational Items to the Joint Reference Committee:

1. **ACTION PAPER: Emergency Department Boarding of Individuals with Psychiatric Disorders**
   The workgroup of the Council on Psychosomatic Medicine presented a draft of a position statement—developed from the action paper (ASMMAY1512.S; JRCJUN156.13)—to the Council on Advocacy and Government Relations soliciting review and feedback. By way of conference call, the Council discussed the significance the position paper holds in emphasizing the necessity of appropriate services in emergency settings for individuals with acute mental illness. The Council members agreed the document addresses unintentional consequences associated with boarding these patients without access to adequate care. Through unanimous consent, the Council supported the position statement as written. The Council has shared their feedback with the Council on Psychosomatic Medicine, and recommended the work group consult with the APA's Department of Government Relations – Office of State Affairs in developing DB/SA outreach and state-based advocacy efforts surrounding state mental health budgets and implications for access to psychiatric hospitalization. Those efforts are currently underway.

Council on Advocacy and Government Relations

Conference Call – October 15, 2015

Attendance (present)

Barry Perlman
John Bailey
Jenny L. Boyer
David A. Lowenthal
David Pickar
Charles S Price
Altha J. Stewart.
Craig Zarling
Debra Koss
Nicole Wimberger
Michael Hann
Morgan Medlock

Members (absent)

Brenda Jensen
Katherine Gershman Kennedy (schedule conflict)
Matthew Erlich
Cassandra F. Newkirk
Napoleon Higgins (schedule conflict)
Joshua Berezin
Jacob Izenberg
Bem Atim
Wilsa Charles Malveaux

(Barry Perlman – Council Chair)
Welcome and overview
Official roll call

Political Environment on the Hill – Comprehensive Mental Health Reform

(Jeff Regan)
Currently there are House Speaker conflicts amongst Republican members.
(Matt Sturm)
There is movement in the House on Comprehensive Mental Health Reform. A number of committee hearings. However there is an obvious battle amongst parties.
(Regan)
The Senate has a companion bill to the House legislation on Comprehensive Mental Health Reform, with minimal variations in the provisions to its companion.
(Charles Price)
The PAC has improved in numbers; since the introduction of both the House and Senate legislation, there has been more activity for the PAC.

Comprehensive Addiction and Recovery Act of 2015

(Regan)

The legislation would authorize a half-billion dollars to combat the national heroin crisis. Considered a strong bill in the MH/SUD community, the provisions promote treatment and recovery and recovery services. The legislation falls under the authority of the Dept. of Justice. This was an intentional action by Sen. Portman, taking key agencies in consideration. The Dept. of Justice and the other key agencies would be the main authorizes accountable for carrying out chief responsibilities.
(Perlman)
What are the areas of reservation?
(Regan)
We have a comprehensive bill with positive impacts but there are issues that give us pause. Albeit minors. The Council on Addiction has reviewed the legislation and expressed concerns with making sure the treatment efforts are explicitly evidence-based. When writing the letter to Congress, we will be sure to incorporate these suggestions in order to strengthen the bill.
(John Bailey)
In the section on best practices panel, it looks like an opportunity to have psychiatrists involved, especially as it targets pain management clinics. It is important to include psychiatric involvement. This panel can inform practices well into the next decade.
(Craig Zarling)
It gives us a chance to offer ourselves as a resource for those that shape this legislation.
(Perlman)
Is there any thought of assigning to CSAT rather than SAMHSA, because of SAMHSA's feeling towards medical practitioners?
(Regan)
The bill requires to consult with SAMHSA, this means CSAT and they will be responsible for these enacted these actions.
(Jenny Boyer)
In my observation, if we are trying to get this passed in conservative arenas, I would recognize the stigma associated with heroin and label it as prescription abuse.
(Morgan Medlock)
I am intrigued by section 201, in terms of the jail diversion initiatives. The question I have is do they specify in the criteria for diversion initiatives? Is it broad regardless of the drug of choice or the offense? I am asking in terms of the background of knowing there are sentencing disparities in terms of heroin, specifically crack-cocaine. As well as in the understanding that for minority communities, many have felt that these have been race related in sentencing disparities. I am specifically curious to whether the criteria for the diversion initiatives are broad and do they represent parity specifically for minority individuals?
(Regan)
I don't recall it being drug or demographic specific.
(Sturm)
I will ask for our policy team to research this and provide a response to your concerns.

Scope of Practice Report: APA Administration Visit to Hawaii
Brian Smith provided an overview of the meetings and activity that took place during APA's visit to address the volatile situation of increasing the number of prescribing psychologists in the state.

APA 2015 State Advocacy Conference
Smith remained members of the Council who will be attending the State Conference in Florida later in the month. He provided a summary of the agenda for the meeting.

Report from CAGR Work Group: ***Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights***

Dr. Bailey provided an abbreviated report to the Council members on the activity of the work group. The work group has scheduled a conference call next month to discuss the revisions that members have compiled.

(Perlman)

Call wrap-up. The chair announced that the Council will have another scheduled conference call after the Thanksgiving holiday.

Council on Advocacy and Government Relations

Conference call – December 1, 2015

Attendance (present)

Barry Perlman
John Bailey
Jenny Boyer
Napoleon Higgins
Katherine Gershman Kennedy
Altha Stewart.
Craig Zarling
Debra Koss
David Pickar
Morgan Medlock
Michael Hahn
Charles Price
Steve Koh
Wilsa Charles Malveaux

(Perlman)
Welcome and overview

Report by Council Work Group

<u>Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights</u>

(Perlman)
As all may recall, the Council discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." During the May 2015 meeting, the Council moved to form a work group led by Dr. Bailey and joined by the Council on Health Care Systems and Financing. That Council advised the JRC to retire the position statement. However, the recent JRC directive was for CAGR to continue the joint Council work group, revising the position statement. Thanked Dr. Bailey and the other CAGR members that assisted in the current drafted revision of the position statement, Drs. Boyer, Higgins and Medlock.
(Bailey)
The Group divided the position statement into four sections. DGR staff forwarded a markup copy that is an agglomeration everyone's work. This past September, he marked up the document, sharing with the Work Group. The Group discussed to continue calling the document a "Bill of Rights," and landed on the suggestion of a title change. The reason to change the title, a Bill of Rights gives people a legal standing. APA does not have the right to guarantee anyone's legal standing. Patients who pay insurance premiums should have a right to know their basic privileges and that is what we are trying to say here.
(Boyer)
Responsible for sections 1 thru 3, I thought we are trying to keep the integrity of the original position statement. My intent was to keep it less specific and more general, addressing some of the recent concerns and changes in national policy.
(Bailey)
The edited changes provided were developed with the thought that everyone agreed the document should be tossed. But it was returned to the Council by the JRC, because they believe there is utility in

having a document like this. The JRC directed us to move forward in revising it. Is there is any feelings about the change to the title to include 3rd party contractors?
(Zarling)
Most risk is in respect to third party payers, particularly that applicable to patients as well as providers. In the discussion of pushing back on these third party payers, this is where most of the action is.
(Stewart)
I am not in opposition of the document—even if we agree in principle—do we need something in design as specific as this? Or rather a statement of the principle and let that drive activity with respective to what providers experience in their states? In a few years' time this could easily become obsolete.
(Bailey)
This makes it a good argument for retiring it. The skeleton of it, that has been modified, contained many specifics that were obsolete. It cannot be everything to everyone but there is something specific to third party payers. Compared to other policy this can be considered rather general.
(Bailey)
In doing edits, we understood there is a market for our services.
(Perlman)
In respective to parity, it has a place in out-of-network discussions.
(Bailey)
That is huge in state legislatures, out of plan payments for emergency situations. States are pinning set fees on doctors when they are not part of the insurer. It wasn't added here [in the position statement].
(Medlock)
I was responsible for sections 4 thru 6. I came from a doctor's perspective. And I pulled language from APA policy in revising the section on appeals and grievance. For the section on confidentiality, I included language about telemedicine, also using existing APA policy and position statements. I added language about HIPAA because this is an issue that has become important in healthcare since the document was instated. Under the section on Choice, I didn't feel there was much to change.
(Perlman)
Thank you for addressing telemedicine. We haven't heard anything from APA's taskforce on tele-psychiatry since the September Component Meeting. I expect that there will be a report.
(Bailey)
Thank you Dr. Medlock for your work because it has been left broad without including telemedicine. This is important because there are many variables left open.
(Perlman)
Both Murphy bills have been under attack because of proposed changes to HIPAA.
(Bailey)
Dr. Higgins was responsible for the following sections. There weren't much to change in these sections.
(Bailey)
Under the section of treatment review, Dr. Higgins wanted to include language that identified APA members.
(Perlman)
The retrospective review, how does APA not recognize and tell patients that they shouldn't deal with retrospective review?
(Bailey)
It's not to say that isn't happening, but to take a position on this. Meaning, that it is not being compliant and consolatory position that has be destructive on psychiatry across the country.
(Perlman)
The question is, as a bill of rights, do we want this is be a position for patients, or for doctors to use in their office as a resource? Despite our feelings, how do we separate this out?

(Boyer)
I currently am sitting on the JRC. I am not sure that we are asking for specifics. But as a provider, we should be able to look it up and offer it to the patient as a reference.
(Perlman)
I think the JRC wanted us to update it, to make it current.
(Kennedy)
Looking at the document, it is being changed to what APA advocates for rather than empowering the patient to ask for certain things. There is a change in the voice throughout the document. However, the ideas are great.
(Higgins)
The document has been changed from being patient focus to an APA position on the issue. The section under Treatment Review, the language on "its members," I thought about "its members" referring to all doctors.
(Perlman)
Anyone enrolled in the plan should expect availability of mental health providers, including access to psychiatrists. This is up to the state insurance boards that they have adequate panels. This would not go in a patient's bill of rights.
(Higgins)
Going from section to section, it is unclear what the document is for.
(Perlman)
I am going with Boyer, in not rewriting [the position statement] but update it as it relates to the changes in the health care.
(Stewart)
Should we be doing a bill of rights? We don't have a singular document, to address these things. Is this a position statement for APA that attends to all the things going on? Is this the approach we should be going in?
(Perlman)
Taking what the committee has done, we should take these constructs and build them back into a patient document. Where, it is a more modern version, and doctors can use for a patient resource.
(Boyer)
I believe that we should either ask Laurie McQueen, JRC staff liaisons; or Maria Oquendo, what is the meaning of the directive?
(Perlman)
Read the JRC directive
(Perlman)
I would like to take another swap at this, looking at this and modernize in a coherent way.
FINAL ACTION
The council agreed to move forward and get something back to the group.

Other JRC Directive for Council
Action Paper on *Timely Reimbursement for Psychiatric Treatment*
(Perlman)
He read comments forwarded from members via email prior to the conference call.
(Perlman)
There is skepticism of the action paper as it is written. Should the council support it as written?
(Matt Sturm)
He read the Council of HCSF statement to the JRC.
FINAL ACTION

The Council agreed with the Council on HSCF's comments. And will send the action paper back to the author for further clarification. The action paper should not move forward.

Position Statement on *Any Willing Physician*
(Perlman)
He read comments forwarded from members via email prior to the conference call.
(Bailey)
This issue will become important with workforce and scope issues. Doctors need to be included on these panels. We have to take in consideration what states are doing on this.
(Perlman)
You don't have to join any panel; it is up to the state. This is APA's aspirational position. Should this be continued [retained] or retired?
(Higgins)
When we bring on new doctors, they refuse to put on panels. I am in agreement with the position statement.
(Perlman)
So is there a consensus?
FINAL ACTION
Retain.

APA Position Statement on *Emergency Department Boarding of Patients with Acute Mental Illness*
(Perlman)
Our tasks include, 1) look at the document that Council on Psychosomatic Medicine wrote up; 2) APA's Division on State Affairs will be made available to work with state legislatures.
(Bailey)
It addresses the unintentional consequences that we oppose in boarding, regardless. There were concerns stated earlier that we oppose boarding under any circumstances.
(Perlman)
If there is no boarding it could place our members in danger and where they could possibly be forced to treatment these patients.
(Koss)
The document is well written. I am remembering what happen in the state of Washington, and ensuring that we capture lessons learned.
(Perlman)
CAGR supports the position paper. Report back on specifics on DGR outreach to the states.
FINAL ACTION
Support as written. Follow-up by DGR State Affairs in outreach efforts

Update on Congressional Activity
(Jeff Regan)
Ryan was elected speaker of the house.
The omnibus deadline is approaching.
There are discussions of a potential government shutdown.
The Energy and Commerce Subcommittee on Health hearing to markup of Murphy/Johnson legislation
(Bailey)
What is the discussion surrounding the HIPAA provisions
(Jeff Regan)
There are three senate bills in play

1) S.1893 – Mental Health Awareness and Improvement (Sen. Lamar Alex), authorizes GAO reports
2) S.1945 – Mental Health Reform Act of 2015 (Sens. Cassidy and Murphy), companion bill of House Murphy/Johnson bill
3) S.2002 – Mental Health and Safe Communities Act of 2015 (Sen. John Cornyn), referred to the judiciary committee

(Rodger Currie)

While Speaker of the House, Boehner was supportive of Murphy legislation.

The current Speaker Paul Ryan was recently on 60 minutes, in which he came out in support of Murphy legislation.

We do not expect any health legislation to get through in 2015, and possibly not until after the 2016 election.

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.

Item 2015A1 12.G
Assembly
May 15-17, 2015

ACTION PAPER
FINAL

TITLE: Timely Reimbursement for Psychiatric Treatment

WHEREAS:
Whereas the APA and its members strive to improve quality and efficiency and reduce costs without reducing access to care;

Whereas the APA seeks to support the concept of statewide and nationwide voluntary systems of immediate, electronic health claims filing, adjudication, and payment;

Whereas inefficiency within the healthcare financing and payment system contributes to the fact that half of psychiatrists choose to not participate in health insurance; therefore

BE IT RESOLVED:
That the APA Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance-paneled psychiatrists (and patients of psychiatrists who have opted out of third party payors excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and
That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.

AUTHORS:
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Robert Roca, M.D., MPH, Representative, Maryland Psychiatric Society
Bruce Taylor, M.D., APA Member
Ronald Taylor, M.D., APA Member
Kim Jones-Fearing, M.D., APA Member

ESTIMATED COST:
Author: $0
APA: $11,027.69

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 3 Council; Maryland Psychiatric Society
KEY WORDS: insurance, claims, EHR

APA STRATEGIC GOAL: Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT:

EXECUTIVE SUMMARY
Council on Children, Adolescents and Their Families

Council Overview

The work of the Council is directed toward maximizing the effectiveness of APA in addressing the mental health needs of children, adolescents, and their families. Its charge is primarily carried out through workshops, position statements, and liaison with allied children and adolescent organizations.

Action Items

- **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the revised Position Statement on Psychiatric Hospitalization of Children and Adolescents?** Attachment A

- **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Parent Medication Guide on Autism***?* Attachment B
  Parent medication guides, jointly produced by APA and the American Academy of Child and Adolescent Psychiatrists, are resources to help parents understand medication safety issues. The autism guide is the latest in the series, which include guides on ADHD, bipolar disorder in children and adolescents, and childhood and adolescent depression. The entire collection is available at http://parentsmedguide.org.

JRC Referrals

- In October 2015 JRC instructed council to incorporate the issue of mental health leave in colleges in the Position Statement on College Mental Health. The council halted work on the position statement in view of the Council on Psychiatry and the Law's (CPL) preceding rewrite of the document. The council therefore has determined that the CPL version effectively addresses the concerns of college mental health leave. CPL has been notified of the endorsement.

Information Items

- The council has resolved to draft a position statement encouraging high-caliber clinical research and funding within child and adolescent psychiatric populations. The decision to do so stems from the removal of that recommendation from the revised Position Statement on Patient Access to Treatments Prescribed by Their Physicians put forth by the Council on Healthcare Systems and Financing.

Attachments

- December 16, 2015 conference call minutes (Attachment C)
- November 9, 2016 conference Call Minutes (Attachment D)
- Yearly Assessment (Attachment E)

Attachment A

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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Attachment B

Parent Medication Guide

Autism Spectrum Disorder

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Introduction

What is ASD? Autism Spectrum Disorder (ASD) is a developmental disorder defined by major impairment in social communication combined with unusual fixations, interests, repetitive behaviors, or abnormal sensory responsiveness. Communication problems include difficulty understanding and responding to social cues and nonverbal communication, which results in challenges in making or keeping friends. Although people with ASD may want to connect with peers, difficulties in understanding social norms or correctly interpreting facial expressions can get in the way.

In recent years, it has become clear that individuals with ASD, despite sharing some behavioral challenges, can be quite different from one another. Some people with ASD may be quite intelligent, while others may have cognitive challenges. Some may have advanced vocabularies and others may not have any functional speech. Previous attempts to subdivide the population on the basis of language and cognitive ability have not been supported by research. Thus, people with autism in the same family, or who share the same genetic risk factor(s), can end up with very different symptoms and outcomes.

Why consider medication in ASD? People with ASD often experience a host of difficulties that can be as problematic as the symptoms of ASD itself. Anxiety, mood instability, impulsivity, hyperactivity, sleep problems, and even aggression and self-injurious behavior can occur in some people. Just as for other children, treatment of these issues may include the use of medication. The use of medication is more often aimed at treating the symptoms of these associated conditions, which we can characterize as emotional and behavioral challenges, than for core symptoms of ASD itself, as no medications have shown clear benefit for social communication impairment or restricted, repetitive behaviors.

Sitting down with an expert to discuss whether it is a good idea to try medication for certain troublesome symptoms in your child with ASD is never a bad idea. Sometimes, although the best approach to addressing those symptoms may not be medication-based, it can be helpful to learn about various options or begin to gather information on the frequency and intensity of behaviors that may ultimately be targets for medication treatment.

Assessment of the Child with ASD experiencing emotional or behavioral problems

When a challenge presents itself, it is time for an assessment. The first step in helping a child with ASD to get assistance with an emotional or behavioral challenge is to have him or her evaluated by an expert or team of experts. Since many factors may contribute to emotional and behavioral problems in a child with ASD, it is ideal to have the child assessed by a team whose members can consider different causes and approaches. In reality, most children will only have access to a single provider, or the child's emotional or behavioral problems are severe enough that there is a need to act quickly. Even in these situations, it is important for the clinician who evaluates the child to consider multiple sources for the problem, and refer the child for further assessment if needed.

A thorough assessment of emotional or behavioral problems will take into account the possible role of communication, family functioning, factors that maintain or reinforce the behavior, physical health, co-existing

mental health disorders, sensory factors, and daily living skills. The child's ability to communicate should be considered and a speech therapist can perform more formal assessments of language and social communication abilities. Mental health providers can assess the functioning of the family and how family relationships could relate to problems, and evaluate for co-existing mental health disorders in the child such as anxiety or ADHD. Psychologists and other experts in behavior can assess factors that may maintain or reinforce the problem behavior(s), and can use applied behavioral analysis techniques, as outlined below. The possibility of a medical issue underlying the emotional or behavioral symptoms can be assessed by a physician or other medical provider. Finally, occupational therapists can assess the role of hyper- or hypo-sensitivities and challenges in daily living skills.

Primary non-medication treatment strategies for emotional and behavioral challenges

Applied Behavioral Analysis (ABA)

Applied Behavioral Analysis (ABA) has been shown to be effective for addressing challenging behaviors, as well as teaching many skills, in well-designed research studies. Parents frequently have questions about how ABA works and how it will help their child.

Children with ASD often have difficulty learning. Applied Behavior Analysis (ABA) is an educational and therapeutic approach which involves encouraging, shaping, and reinforcing functional behaviors and discouraging harmful or disruptive behaviors. ABA focuses on the relationship between a certain behavior, the factors that were present before the behavior ("antecedents") and the results of the behavior. ABA has been successful in helping children with ASD improve communication, academic performance, social behavior, and adaptive living skills as well as addressing specific problem behaviors.[1]

Communication supports

While speech is generally the preferred method of communication in our society, not all children with ASD can use speech effectively. For children who have limited or no verbal ability, alternative methods of communicating have been developed to improve communication.

Communication supports are tools to help children with ASD communicate. A non-electronic method that has been shown to increase communication in children with ASD is the Picture Exchange Communication System (PECS), where the child uses pictures to communicate. [2]Electronic assisted communication devices include speech generating devices (SGD), which can produce an electronic voice that communicates words. These SGDs come in two main forms, dedicated devices (e.g. DynaVox, AlphaSmart, DynaWriter) or software (e.g. Proloquo2Go or Touchchat) that can be used on personal computers, tablets, or mobile phones.

Speech-language pathologists can recommend an assistive communication system after a careful evaluation of the unique abilities, needs, and communication goals of the child. Preliminary studies have shown that assistive

communication devices are generally liked by users and may improve functional communication in children with ASD. [3]

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is a type of psychotherapy in which a person's negative thoughts are challenged in order to reduce associated troubling emotions and behaviors. CBT is "problem-based," meaning that it is used to address the specific concerns of a patient. CBT has been shown to be an effective treatment for anxiety in individuals with high functioning ASD (HF-ASD), and it may also be helpful in addressing disruptive behaviors, like aggression, and in improving social and communication skills. [4] CBT is typically administered by a therapist, but parents and teachers may also access books or web-based CBT guides.

Social Skills/Social Cognitive Training

Social skills are verbal and non-verbal behaviors necessary for positive and effective social interactions, and include eye contact, smiling, and asking and responding to questions. The value of developed social skills is well-documented, and can boost academic performance, mental health, and positive developmental outcomes. [5] Social skills training programs are designed to teach the skills necessary to navigate social environments. [6] There is also preliminary evidence supporting programs that address social cognitive impairments, such as helping children develop the skill of understanding the perspective of others. [7]

Life Skills

The countless tasks of daily living—including dressing, bathing, mealtimes, homework, free time, toileting, and waiting — present many opportunities for challenging behavior each day. As children become adolescents and young adults, new tasks to learn include keeping their own schedules or appointments, asking for help, caring for their own belongings, preparing meals, navigating transportation, and learning a trade. An occupational therapist and other providers can help establish routines and teach these life skills. By breaking tasks into parts, making visual charts outlining steps, presenting rewards for step completion, and implementing this plan consistently, caregivers can teach life skills to children with ASD. Before trying to manage problem behaviors through other means, consideration should be given to whether the child has adequate support to meet the goals being set for them.

Sensory Interventions

One of the possible causes of challenging behavior in a child with ASD are abnormal sensory responses. Children may at times either seek or avoid sensory input, including textures, bodily movement, deep pressure, noises, or visual patterns. Preventing a child's sensory-seeking or sensory-avoiding behaviors can cause distress and/or tantrums. Interventions for sensory-related problems include weighted vests, swinging or jumping or bouncing, and deep pressure. The evidence for such interventions is weak, due to problems with study methods thus far. Occupational therapists can assess the child's sensory system and direct these interventions to help address sensory factors.

Treatment of Medical Problems

Prior to starting any therapy for a behavioral or emotional problem in ASD, consideration should be given to a possible medical cause. The extent of a medical evaluation should be decided in collaboration with an experienced medical provider. A sudden or drastic change in behavior may warrant a more thorough evaluation. The medical problems mentioned here are not an exhaustive list, but are often causes of behavioral problems in children with ASD.

- ***Sleep problems*** are present in many children with ASD. Inadequate sleep can certainly contribute to behavioral problems and should be considered prior to more rare causes. Poor sleep patterns should be initially addressed with good sleep hygiene, such as removing television and video screens from the bedroom, having a set bed time and a bedtime routine, and learning to fall asleep without a parent present.
- ***Medications*** themselves can contribute to problem behaviors. Possible medication side-effects include changes in sleep, sedation, cloudiness of thinking, constipation, and agitation, among others.
- When a child experiences ***pain***, yet is unable to express clearly the nature or source of the pain, behavioral changes may result. For instance, headaches may cause head banging or hitting. Dental problems may go unnoticed if the child will not allow examination of his or her teeth. Bodily injuries can result from a high level of activity and a low pain threshold.
- ***Gastrointestinal discomfort*** may be caused by constipation or diarrhea, acid reflux, food allergies or inflammatory bowel diseases. Constipation is by far the most common gastrointestinal problem in children with ASD and should always be considered as a possible source of problems.
- ***Seizures*** are more prevalent in children with ASD than in the general population. Symptoms of seizures can include staring spells, involuntary movements, confusion, or headaches. Less common features are sleep changes, behavioral problems, or otherwise unexplained emotional changes or severe emotional shifts.

Family Interventions

Raising a child with ASD can be an overwhelming experience that can negatively impact the health and well-being of parents and families. Interventions intended to provide support and education for families of children with ASD can provide valuable stress reduction to reduce tension in the home environment, which in turn positively impacts the behavioral functioning of the child. [8]

Comprehensive treatment should attend to the well-being and functioning of the family. Parent and sibling support groups can help family members feel less alone. Supportive therapy for parents or families can address the challenge of raising a child with special needs. Family therapy aims to create new interactions or awareness that highlight the family's strengths and successes. At the same time, family therapy changes the interactions between family members that may accidentally encourage unwanted behaviors.

The most researched parent interventions are those that help parents to manage the child's behavior (e.g. parent management training (PMT) and those that enhance skill-based therapies (e.g. parent ABA training). Although less researched than PMT or ABA, there are also treatments that foster parent-child emotional connections in order to improve communication, skills, and emotional balance. Families should be encouraged

to talk with other families and their providers about different treatment options. They should also consider the first meeting with a new therapist as an evaluation in which they learn what can be offered and whether there is a good fit between the family's difficulties and the therapist's skills.

Medication as a Treatment Tool for Emotional or Behavioral Challenges

In addition to the interventions outlined above, medication is another tool that may play a role in the treatment of the child with ASD. It is important to recognize, however, that the medications currently used to treat symptoms and behaviors associated with ASD have not at this point in time been shown to improve the core features of autism. In other words, there is no medication to treat the autism itself.

Medication may be recommended due to the presence of an emotional or behavioral disorder in a child with ASD. These co-occurring disorders are more common than once thought, and include ADHD, anxiety and depression, among others. The symptoms and findings that lead to these diagnoses are the same as those for children without ASD, but may require a provider with experience in ASD to recognize them.

Armed with this knowledge, it may be easier to understand some of the reasons for use of medication in children with ASD. Use of medication in ASD is common, but the number of children with ASD that are prescribed medications has also raised concerns among some doctors and parents. A study in 2013[9] reported that nearly two out of three children with ASD had been prescribed a psychoactive medication during the three-year study period, and one in seven children had been treated with three or more medications at the same time.

Appropriate use of medication requires an ongoing trusting relationship between parents and providers, and clear information about when to use and not use medication for symptoms in children with ASD. When parents have questions about medication use in their children, they should seek the advice of a professional with training in ASD. Board certified pediatricians and family physicians often see many children with ASD, and many times can appropriately recommend a medication for symptoms. Others with more specialized training include child and adolescent psychiatrists, child neurologists, and developmental-behavioral pediatricians. Parents should feel free to ask doctors about their level of training and experience with patients with ASD, and if they feel comfortable prescribing medication, or if they prefer to seek consultation from more specialized or experienced providers.

Important Factors to Consider for Medication Treatment

- **Informed consent.** A clear and thorough discussion between the parent or guardian and the prescriber should outline the diagnosis, symptoms, non-medication treatment options, and expected duration of treatment. For the child or adolescent taking medication who is able, the provider can obtain his/her assent by offering information about why they are taking medication and the symptoms that the medication is meant to treat. These discussions should take place not just at the beginning of medication treatment, but be ongoing, so that as issues arise and symptoms change, treatment can be modified to meet the child's needs.

- **Risks and expected benefits**. Risks include the known side-effects from the product label (if studied in children and adolescents), adult use side-effects (may have different side-effects than in youth), published research, and the experience of the treating clinician with the medication. Expected benefits would be to reduce the target symptoms. If the medication is effective in reducing target symptoms, other benefits may arise, including improved functioning in school, with peers, and at home.

- **Which medication will work?** Medication trials are exactly that - trials. Prescribers do not have good enough information to predict which medication will be the best option for each individual child. A medication trial is a time-limited period of testing a medication for the individual child. Most clinicians start at a low dose to minimize side effects and increase slowly to a target dose based on the child's age, weight, and his/her response. Once on the target or maximum tolerated dose, for many medications, the prescriber will then wait four to eight weeks for the full benefit to take effect. If a child does not benefit after that time period, it is time to reassess the situation, taper off the ineffective medication, and consider starting the child on an alternate medication.

- **Level of evidence supporting the use of a particular medication for a particular problem.** When considering which medication to use for a particular set of symptoms, clinicians and families can refer to several sources of information about effectiveness, including the table provided at the end of this guide. Two medications are approved by the Food and Drug Administration (FDA) to treat irritability in autism: aripiprazole and risperidone. Other medications may have been originally studied in youth or adults without autism.

- **Understanding "off-label" uses of medication.** When the FDA approves a medication, it allows a pharmaceutical company to advertise that medication for a specific purpose. When a medication is not FDA-approved for a particular clinical purpose, it is termed "off-label." There are numerous off-label medications that physicians use to treat problems associated with ASD. The provider should explain to a parent or guardian whether or not a medication is off-label. This does not mean the medication should not be prescribed to the child with ASD. The decision to use a certain medication should be based on available research, but when research is limited, it may be based on evidence from studies on children or adults without ASD and clinical judgment.

- **Adequate dose and length of medication trial.** It is important to speak with your child's provider about how long to stay on a medication. Some medications may take effect sooner than others. For example, stimulant medications like methylphenidate may take effect very quickly compared to selective serotonin reuptake inhibitors (SSRIs) like citalopram, fluoxetine, or sertraline, which may take several weeks to take effect. While it can be difficult to predict

the duration of treatment needed, addressing this topic can be informative and build an understanding between prescriber and family.

- **Understanding placebo effects.** In general, prescribers, families whose child is being treating with a medication, and often the patients themselves would like medications to be helpful and have a positive response. This is a natural reaction. It is important to understand that even in large, well-designed drug studies where families and prescribers do not know if the child is receiving an active drug or a placebo (inactive sugar pill), one in three or four of those receiving placebo will report significant treatment-associated improvement. Clearly, this placebo effect can make it more difficult to understand if a drug is truly providing clinical benefit. Given this fact, it is important to try to be as objective as possible when assessing the impact of a drug on your child. Sometimes it can be helpful to receive input from others who know your child, such as teachers, therapists, or other family members. Families will sometimes ask if they should inform school administrators or teachers about a medication change. This common question is designed to increase the strength of objective or unbiased assessment. Depending on the drug and the need to have others observe the child for adverse effects, this option can be considered.

- **When to stop a medication.** First, it is generally a good idea to discuss stopping a medication with the prescriber before doing so. This is important because some medications may require lowering the dose in gradual steps to avoid potential withdrawal effects. It is also important to have an open dialogue with your prescriber about what criteria will be used to determine success and when to stop a medication. Prior to starting a new drug it is important for families to understand what symptoms and/or behaviors the prescriber is hoping to alleviate with the medication. Families can take an individual approach to defining "success" in response to the medication, and discuss this with the prescriber at the time the medication is started and at follow-up visits.

  There can be many reasons for stopping a medication: the medication may have adverse effects on the child, the child's symptoms may not respond to the medication, or the child's family may not be able to pay for the medication. Stopping a medication is a personal decision best made in consultation with the prescriber.

- **Combining medication treatment with other forms of treatment.** We know that combining medication for behavioral issues with interventions such as occupational, speech, physical, and behavioral therapies may provide the best chance for some patients and families to achieve the best outcomes. It would be rare to find that use of a medication completely replaces the need for other types of therapies. In many instances, effective medication use may maximize the benefits patients with ASD receive from other types of therapy.

- **It is important to share information about the use of all natural remedies and/or alternative treatments with your child's clinician.** Certain supplements and alternative treatments can interact with prescription medicines. For instance, St. John's Wort, which some people take as a natural treatment to alleviate depression symptoms, may have a negative interaction with prescribed selective serotonin reuptake inhibitor (SSRI) drugs. Given this fact, it is imperative to provide a complete list of supplements and other alternative treatments your child may be receiving to his or her treating clinician to increase safety and effectiveness.

What if medications fail? ASD is a complex disorder that can be difficult to treat. If a medication fails, it is time to reassess the problem and see if an alternate explanation, therapy, or medication may be helpful. If the child's symptoms do not improve after multiple medication and other treatment trials, other options may be considered, particularly if severe aggressive and/or self-injurious behaviors pose a threat to the child or others.

- There are approximately 10 *specialized child psychiatry hospital units* in the U.S. These specialized psychiatric units for children and adolescents with developmental disabilities typically use a multi-modal approach that combines medication and behavioral treatment with communication and occupational therapy strategies. Although waiting lists for these units may be long, there is preliminary evidence that such an intensive approach can be helpful. [10] There are also many day treatment, specialized school, and residential treatment programs that focus on children with developmental disabilities and emotional and behavioral challenges. While evidence for the effectiveness of these programs is generally not available, programs that use evidence-based practices, such as applied behavioral analysis (ABA), and that take a multi-disciplinary approach are more likely to be beneficial.

- *Electroconvulsive therapy (ECT)* In rare instances, ECT can be considered in the treatment of patients who have very severe aggressive and/or self-injurious behaviors that do not respond to other interventions and are driven by a co-existing psychiatric condition, such as a mood disorder or catatonia (a state of muscle rigidity and stupor or great excitability). While there is no controlled evidence, several case studies have reported ECT to be helpful in a few such individuals, though common side-effects of ECT include headache and nausea, and short-term memory loss during the initial course of treatment.

Are there treatments that should not be used? Approximately three-quarters of children with autism have been given alternative or off-label treatments. Although there is little evidence supporting the vast majority of alternative therapies (with the exception of melatonin for sleep), many of these popular remedies, such as diet or vitamins, are relatively harmless. It should be noted, however, that any treatment always requires effort and expense, consuming resources that could be used for more evidence-based treatments. There are some treatments, however, that parents should not consider. These treatments not only do not work and are expensive, but may pose serious health risks to the child.

- **Chelation** removes toxic metals from the blood and is used to treat cases of severe lead poisoning and elevated iron associated with particular blood disorders. Scientific tests of chelation as a treatment for ASD have not shown it to be effective and the procedure can have dangerous side-

effects, including kidney and liver failure, cardiac arrest, and has even resulted in the deaths of at least two children with autism.

- **Hyperbaric oxygen treatment** (HBOT) is the administration of oxygen to a patient in a pressurized chamber, and is used for a handful of conditions, including decompression sickness and different types of soft tissue damage. There is a lack of scientific evidence for using this costly procedure in children with autism, which can cause lung, vision, and sinus damage, as well as rupture of the middle ear.
- **Secretin** is the most studied medication in children with autism, and has been repeatedly shown in multiple scientific studies to have no effect**.** Side-effects can include diarrhea, vomiting, fever and blood clots.
- **Stem cell re-implantation** is a potentially promising therapy for many diseases, however, experts have cautioned that the field is at least a decade away from the development of effective treatments. There is no scientific evidence for the use of stem cell procedures in autism, costs can exceed six figures, and injecting dead or deteriorating stem cells into a person can cause potentially fatal side effects, including stroke and brain inflammation.

Symptoms and Medications

Medications can be used to target a wide range of specific symptoms in children and adolescents with ASD, some of which are listed below. A table summarizing the controlled research evidence for medications in children with autism is located at the end of this guide.

- **Irritability, tantrums, and aggression**

Irritability, tantrums and aggression are common reasons for families to seek treatment for their child with ASD. Children who are irritable are prone to become upset or angry easily, sometimes leading to tantrums, property destruction, or aggression. Irritability can range from mild, where the only noticeable problem is that a child cries more easily than peers when frustrated; to severe, where a child may be so prone to aggression that they need to be hospitalized. Addressing symptoms when a child is young may prevent them from worsening as a child gets older and physically larger. Clinicians should evaluate the potential contributing factors to irritability and aggression in a particular child before prescribing medication, as detailed in the assessment section of this guide.

Medication can be considered to treat irritability and aggression when contributing factors do not appear to explain the symptoms or these contributing factors have been addressed without resolving the problem. Two anti-psychotic medications, risperidone (Risperdal) and aripiprazole (Abilify) have been shown to reduce tantrums and aggression in multiple large controlled studies in children with ASD, but each of them can also lead to significant side effects, including increased appetite and weight gain, changes in cholesterol, sedation, and movement disorders. Haloperidol (Haldol), another anti-psychotic, also has evidence of benefit for irritability and aggression, suggesting that this general class of medications may be helpful in children with ASD. Little evidence supports other types of medications; although the side- effects associated with antipsychotics can lead parents and physicians

to try medications that have single controlled studies to support their use, including clonidine or guanfacine (Tenex or Intuniv).

- **Self-injurious behavior (SIB)** can be a significant and distressing problem for children and their families. Almost 11% of children with ASD in a community survey were stated to have SIB, including hitting, biting, or scratching directed at themselves.[11] SIB can range from mild to very severe. Some children will engage in a mild self-injurious behavior, such as lightly hitting their chin, but may do it so often that over time they eventually produce an injury. Other children may only occasionally engage in self-injury, such as banging their head on an object, but may do it with such force, that even a single episode could cause serious injury. Self-injury that is part of a suicidal episode (such as cutting one's wrists) is less common in children with ASD, though some higher-functioning individuals may engage in suicidal actions.

  The best evidence for effective treatment of SIB is with applied behavioral analysis (ABA). In this method, the provider performs an analysis to try to determine the source of the SIB, which is typically escaping from demands, accessing preferred items or activities, attention-seeking or changing sensory input or pain.[12] Functional communication strategies have also been shown to reduce problem behaviors in ASD, including self-injury.[13] Medication may play a role in addressing SIB, particularly if the SIB is determined to be related to other mental health problems, such as anxiety or depression.

  The atypical anti-psychotics, risperidone and aripiprazole, have been studied for treatment of irritability in children with ASD, which can include self-injury.[14,15]

- **Inattention, Hyperactivity, and Impulsivity**, the cluster of symptoms referred to as attention deficit-hyperactivity disorder (ADHD), are common in children with ASD and can be a treatable source of challenges. Most recent surveys have identified ADHD symptoms in 30-60% of children with autism. [16] While reduced interest and attention to the social environment is a typical feature of ASD, significant inability to focus on tasks, or high levels of motor activity that are present across different settings, such as school and home, are not typical of ASD and could indicate the presence of ADHD.

There are a number of reasons a child could be very hyperactive, impulsive or inattentive across settings besides ADHD. Hyperactivity or impulsivity may occur in younger children who do not have enough structure in their day, or do not have a functional means of communication. Inattention may occur in children who are highly anxious and distracted by their worries or are overly sensitive to stimuli in the environment. In these cases, structuring the environment, providing visual and positive behavior supports, and addressing anxiety may reduce ADHD-like symptoms. As always, a careful consideration of why the child may be hyperactive, impulsive, or inattentive should precede treatment.

For children with inattention, hyperactivity, or impulsivity that do not respond to environmental and/or behavioral approaches, methylphenidate (Ritalin and similar forms) has been shown to be effective in approximately half of children with autism and ADHD.[17] Appetite suppression is common, and headaches, insomnia, or irritability can occur. While it has not been specifically tested in children with autism, a similar type of medication, amphetamine salts (Adderall and similar forms), has been shown to be

effective for ADHD in children without ASD, and may be helpful if methylphenidate is ineffective.[18] Atomoxetine (Strattera) has also been researched in controlled studies for treatment of ADHD in children with autism, and showed some improvements, particularly for hyperactivity and impulsivity,[19] and common side-effects were nausea and vomiting, decreased appetite, and drowsiness. In small single studies of children with autism, guanfacine[20] and naltrexone[21] showed some benefit for ADHD symptoms, and clonidine[22] did not.

- **Repetitive behavior and insistence on sameness -** In their play activities and daily routines, children with (ASD) may display repetitive behaviors and insistence on sameness. These behaviors can manifest as:
    - Repeated motor mannerisms (such as hand flapping)
    - Atypical sensory interests (manifested as touching or rubbing certain textures)
    - Complex body movements
    - Repeating a sound, word, or phrase many times

Interruption of these repetitive patterns or the daily environments of children with autism may cause anxiety or even aggression due to their insistence on sameness and inflexible adherence to specific routines.

It is important to note that repetitive behaviors vary greatly among children with autism, in both types and frequency of behaviors, and while some individuals only engage in repetitive behaviors when feeling anxious, others may do so constantly. Therefore, when considering medication treatment, it is essential to determine whether these behavioral patterns are a problem or not. Repetitive behaviors can be unobtrusive or even adaptive (for example, obsessing about model airplanes and developing a passionate interest in learning how to build them), or can be interruptive and cause difficulties for academic and social functioning.

Because selective serotonin reuptake inhibitor (SSRI) medications have been successful in improving repetitive symptoms of Obsessive Compulsive Disorder (OCD) in children without ASD, clinicians have attempted to treat repetitive behaviors in ASD with SSRIs. However, controlled studies of SSRIs—including fluoxetine, fluvoxamine, and citalopram—have shown little or no benefit in improving repetitive behaviors in ASD.[23-25] The atypical antipsychotics, risperidone and aripiprazole, have shown limited evidence of reducing repetitive behavior in children with ASD.

- There are a number of other areas that can be a focus of clinical concern in children with ASD, and practitioners and families may consider medication, though there is little or no controlled evidence for effectiveness. These areas include **Anxiety and Depression, Inappropriate Sexualized Behavior, Insomnia, Pica, Psychosis, and Social Communication.**
    - **Anxiety** or **depression** can occur in children with ASD, and cognitive behavioral therapy has been shown to be helpful for high-functioning children with ASD and anxiety. While no medication has been directly studied for anxiety or depression in ASD, most practitioners will consider the use of an SSRI, such as fluoxetine or sertraline, both of which have strong

evidence for reducing anxiety and depression in children without ASD. As part of assessing anxiety, the possibility of post-traumatic stress should be considered.

- **Inappropriate sexualized behavior:** (ISB) When a person does not follow recognized social rules, socially unacceptable behaviors often occur, and sometimes this includes disinhibited or inappropriate sexualized behavior (ISB). Adolescents with ASD are often discouraged from expressing their sexuality and many are deprived of adequate sexual education. It is also important to note that people with developmental disabilities are particularly vulnerable to abuse, and ISB can be a possible indicator of child sexual abuse.[26] To treat ISB, most clinicians recommend starting with educational or behavioral approaches.[27] There are case reports describing use of mirtazapine (Remeron) to treat ISB in adolescents with ASD, though there is no controlled evidence.[28-30] Medications such as antidepressants (SSRIs) or antipsychotics may decrease libido, which could be helpful, though this is untested.[31,32] Leuprolide was described in one case report to reduce ISB in a young adult male with ASD,[33] but has potential side-effects of depression, seizures, and anaphylaxis, as well as ethical considerations.
- **Insomnia (sleep problems)** appear to be prevalent in children with ASD and should be first addressed by removing electronics and other stimulating activities from the bedroom, developing a consistent bedtime routine, and addressing bed-wetting if needed. For children who continue to have trouble falling or staying asleep, melatonin has been shown in a number of controlled studies to improve sleep in some children with ASD.
- **Social communication** is a core deficit area in ASD and a number of psychosocial treatments have been developed to address this area. Medication is limited to the possible use of methylphenidate, which was shown in one study to potentially improve social communication, perhaps by increasing attention and focus.
- **Pica** is the eating of non-nutritive substances and can have serious medical consequences. Although historically attributed to nutritional deficiencies, many people with pica do not have demonstrable vitamin or mineral deficits, though they are typically evaluated. Nevertheless, iron-deficiency is the most common cause of pica, and pica behaviors usually disappear once the deficiency is corrected.[34] Applied behavior analysis (ABA) continues to have the strongest evidence for treatment of PICA.
- **Bruxism** is the repetitive clenching and grinding of teeth, often occurs during sleep, and appears to be more frequent in patients with developmental delays, including ASD. [35] To date, behavioral interventions remain the mainstay of treatment.
- **Psychosis** (the loss of reality-based, organized thinking) can occur rarely in children with ASD. Antipsychotic medications that have evidence of benefit in children without ASD are typically used in these cases.

- **Resource links:**
  - AACAP practice parameter http://www.jaacap.com/article/S0890-8567%2813%2900819-8/pdf
  - Autism speaks https://www.autismspeaks.org/

- CDC website http://www.cdc.gov/ncbddd/autism/index.html
- Others

  ChildTrends http://www.childtrends.org/?indicators=autism-spectrum-disorders

  NIMH http://www.nimh.nih.gov/health/publications/a-parents-guide-to-autism-spectrum-disorder/index.shtml

- ATN tool kits https://www.autismspeaks.org/family-services/tool-kits
  - Autism speaks challenging behaviors toolkit https://www.autismspeaks.org/family-services/tool-kits/challenging-behaviors-tool-kit

- Author disclosures

CONTROLLED MEDICATION STUDIES IN ASD

Medication			Participants		Dose (mg/day)	Treatment Response	Side-effects Associated with Study Medication		FDA Approval Status
Target Symptom(s)	Generic Name (Trade Name)	Controlled Trial in ASD	Age Range (years)	Study Duration	Mean Dose (Dose Range)	Target symptom	Side-Effects (SEs)	Serious SEs	A=Approved in autism, B=Approved in youth
	Serotonin Reuptake Inhibitor								
Repetitive behaviors	Fluoxetine (Prozac)	Hollander et al., 2005	Youth (5-16)	Short-term (8-week)	10mg ±4 (2.5 – 20) [once a day]	YES	None (AEs were *less* likely on fluoxetine than placebo)	None	B Major Depressive Disorder (≥8) - OCD (≥7)
Repetitive behaviors	Citalopram (Celexa)	King et al., 2009	Youth (5-17)	Short-term (12-week)	16.5mg ±6.5 (2.5 – 20) [once a day]	NO (Irritability)	97% on study medication experienced AEs: - Insomnia (38%) - Increased energy (38%) - Diarrhea (26%) - Nausea/Vomiting (19%) - Impulsivity (19%) - Hyperactivity (12%) - Stereotypy (11%) - Nightmares (7%)	12% (N=9) on study medication terminated treatment due to AEs: - Seizures (N=2)	
Repetitive behaviors	Clomipramine (Anafranil)	Gordon et al., 1993	Youth (6-18)	Short-term (10-week)	152mg ±56 25-250 [in 2 divided doses a day]	YES- -Irritability Hyperactivity	- Insomnia (29%) - Constipation (25%) - Sedation (25%) - Twitching (21%) - Tremor (17%) - Flushing (17%) - Dry mouth (13%) - Decreased appetite (13%)	- Seizure (4%; N=1)	B OCD (≥10)
Autism		Remington et al., 2001	Youth + Adults (10-36) Youth [10-18] =27/36	Short-term (7-week)	128mg (100-150) [in 2 or 3 divided doses a day]	NO	NR	38% (N=12) on study medication terminated treatment due to AEs: - Lethargy (13%) - Tremors (6%) - Tachycardia (3%) - Insomnia (3%) - Diaphoresis (3%) - Nausea/vomiting (3%) - Anorexia (3%)	
	Typical Antipsychotic Agents								

CONTROLLED MEDICATION STUDIES IN ASD

Medication			Participants		Dose (mg/day)	Treatment Response	Side-effects Associated with Study Medication		FDA Approval Status	
Target Symptom(s)	Generic Name (Trade Name)	Controlled Trial in ASD	Age Range (years)	Study Duration	Mean Dose (Dose Range)	Target symptom	Side-Effects (SEs)	Serious SEs		A=Approved in autism, B=Approved in youth
ASD	Haloperidol (Haldol)	Anderson et al., 1984	Children (2-6)	Short-term (14-week) [4-week on study medication]	1mg (0.5 – 3) [in 2 divided doses a day]	YES - Withdrawal - Stereotypies - Relatedness -Hyperactivity - Temper tantrums	- Sedation (78%) - Irritability (28%) - EPS (>25%)	None		B - Psychosis - Tourette's Disorder (both ≥3)
		Anderson et al., 1989	Children (2-7)	Short-term (14-week) [4-week on study medication]	0.8 ±0.6mg (0.25 – 4) [in 2 divided doses a day]	YES - Withdrawal - Stereotypies - Relatedness - Hyperactivity - Temper tantrums	- Sedation - EPS	None		
	Atypical Antipsychotic Agents									
Irritability**	Risperidone (Risperdal)	RUPP, 2002	Youth (5-17)	Short-term (8-week)	1.8 ±0.7mg (0.5 - 3.5) [in 2 divided doses a day]	YES -Hyperactivity - Stereotypies - Repetitive behaviors	- Increased appetite (73%) - Fatigue (59%) - Sedation (49%) - Drooling (27%) - Dizziness (16%) - Weight gain	None	A Irritability (5-17)	B Schizophrenia (≥13) - Bipolar Disorder (≥10)
		Shea et al., 2004	Children (5-12)	Short-term (8-week)	1.2mg [once a day]	YES - Anxiety - Hyperactivity - Inappropriate speech - Social withdrawal - Stereotypies	All participants (100%) on study medication experienced AEs: - Somnolence (73%) - EPS (28%) - Increased appetite (23%) - Headache (13%) - Constipation (13%) - Weight gain (10%)	None		
		RUPP Open-label Continuation Trial								
		RUPP, 2005		Long-term (6-month)	2.1 ±0.8mg (up to 4.5)	YES - Repetitive behaviors - Stereotypies - Affectual reaction - Sensory response	- Increased appetite (6%) - Drowsiness (2%) - Weight gain (2%)	- Constipation (N=1)		
		McDougle et al., 2005								
		Williams et al., 2006				-Adaptive behaviors: - Socialization -Communication - Daily living skills				

CONTROLLED MEDICATION STUDIES IN ASD

Medication			Participants		Dose (mg/day)	Treatment Response	Side-effects Associated with Study Medication		FDA Approval Status	
Target Symptom(s)	Generic Name (Trade Name)	Controlled Trial in ASD	Age Range (years)	Study Duration	Mean Dose (Dose Range)	Target symptom	Side-Effects (SEs)	Serious SEs		A=Approved in autism, B=Approved in youth
Irritability**	Aripiprazole (Abilify)	Marcus et al., 2009	Youth (6-17)	Short-term (8-week)	5 – 15mg	YES - Hyperactivity - Stereotypies At higher dose (15 mg/day): - Inappropriate speech - Repetitive behaviors	88% on study medication experienced AEs: - Sedation (24%) - Fatigue (15%) - Vomiting (13%) - Increased appetite (12%) - Tremors (10%) - Drooling (9%) - EPS (7%) - Weight gain (4%)	10% on study medication terminated treatment due to AEs: - Sedation (N=7) - Drooling (N=4) - Tremor (N=4)	A Irritability (6-17)	B Schizophrenia (≥13) - Bipolar Disorder (≥10) - Tourette's Disorder (6-18)
		Owen et al., 2009	Youth (6-17)	Short-term (8-week)	8.5mg (2 – 15)	YES - Hyperactivity - Inappropriate speech - Stereotypies - Repetitive behaviors	- Weight gain (29%) - Fatigue (21%) - Somnolence (17%) - Vomiting (15%) - EPS (15%) - Increased appetite (15%) - Sedation (11%) - Drooling (9%) - Diarrhea (9%) - Pyrexia (9%)	11% on study medication terminated treatment due to AEs: - Fatigue - Vomiting - Weight gain - SIB - Agitation		
		Marcus et al., 2011a Marcus et al., 2011b		Long-term (52-week)	10mg (1 – 15)	YES- Hyperactivity - Inappropriate speech - Stereotypies - Repetitive behaviors	87% on study medication experienced AEs: - Decrease in BP (33%) - Weight gain (23%) - Vomiting (19%) - EPS (15%) - Increased appetite (13%) - Pyrexia (12%) - URI (12%) - Insomnia 10%)	11% on study medication terminated treatment due to AEs: - Aggression (2%) - Weight gain (2%) - Suicidal ideation (N=1)		
ASD	Olanzapine (Zyprexa)	Hollander et al., 2006	Children (6-14)	Short-term (8-week)	10 ±2mg (7.5 – 12.5)	YES (in Global functioning)	- Sedation (67%) - Weight gain (67%) - Increased appetite (50%) - Constipation (50%)	None		B Schizophrenia - Bipolar Disorder (both ≥13)
	Anti-ADHD Agents									B
Hyperactivity / Impulsivity	Methylphenidate (Ritalin)	RUPP, 2005	Children (5-14)	Short-term (4-week)	7.5 – 50mg [in 3 divided doses a day]	YES	- Decreased appetite (18%) - Insomnia (15%) - Irritability (10%) - Emotional outbursts (10%)	18% on study medication terminated treatment due to AEs: - Irritability (8%)		ADHD (≥6)
				Long-term (8-week)		YES		1 participant discontinued study medication due to AE		

CONTROLLED MEDICATION STUDIES IN ASD

	Medication		Participants			Dose (mg/day)	Treatment Response	Side-effects Associated with Study Medication		FDA Approval Status
Target Symptom(s)	Generic Name (Trade Name)	Controlled Trial in ASD	Age Range (years)		Study Duration	Mean Dose (Dose Range)	Target symptom	Side-Effects (SEs)	Serious SEs	A=Approved in autism, B=Approved in youth
		Ghuman et al., 2009	Pre-schoolers (3-6)		Short-term (1+2-week)	14 ± 4mg (5 – 20) [in 2 divided doses a day]	YES	50% on study medication experienced AEs: - Increased stereotypy (21%) - Upset stomach (21%) - Sleep difficulties (14%) - Emotional lability (7%)	- Dysphoria (N=1)	
ADHD	Atomoxetine (Strattera)	Harfterkamp et al., 2012	Youth (6-17)		Short-term (8-week)	20 – 100mg (1.2 mg/kg/day) [in 2 divided doses a day]	YES	81% on study medication experienced AEs: - Nausea/vomiting (29%) - Decreased appetite (27%) - Fatigue (23%) - Early morning awakening (10%)	- Fatigue (N=1)	B ADHD (≥6)
ADHD	Guanfacine (Tenex)	Handen et al., 2008	Children (5-8)		Short-term (4-week)	2.8mg (2 – 3) [in 3 divided doses a day]	YES	- Drowsiness (50%) - Enuresis (14%)	None	B ADHD (6-17)
ADHD symptoms	Clonidine (Catapres)	Jaselskis et al., 1992	Children (5-13)		Short-term (6-week)	0.15-0.20mg (4-10 micro-gm/kg/day) [in 3 divided doses a day]	NO - Irritability	- Drowsiness (38%) - Hypotension (25%) - Decreased activity	None	B ADHD (6-17)
	Anticonvulsants / Mood Stabilizers									B
Repetitive behaviors	Divalproex sodium (Depakote)	Hollander et al., 2005	Youth (5-17)	Included participants with ID	Short-term (8-week)	823 ±326mg (500-1500)	YES	77% on study medication experienced side-effects: - Irritability (33%) - Weight gain (22%) - Aggression (11%) - Anxiety (11%)	None	Seizure Disorder (≥10)
Irritability/ Aggression		Hollander et al., 2010	Youth (4-15)	Majority	Short-term (12-week)	≥500 (dosed to mean serum level of 90 mg/mL) [in 2 divided doses a day]	YES	- Agitation (13%) - Skin rash (13%) - Polyuria (13%) - Weight gain (6%)	- Irritability & insomnia (N=1)	
Autism	Lamotrigine (Lamictal)	Belsito et al., 2001	Children (3-11)	NR	Short-term (18-week) [12-week on study drug]	60 – 200mg (5 mg/kg/day)	NO	- Insomnia - Hyperactivity	- Insomnia (N=2) - Insomnia+ Aggression (N=1) - Stereotypy (N=1)	B Seizure Disorder (≥2)

CONTROLLED MEDICATION STUDIES IN ASD

Medication			Participants			Dose (mg/day)	Treatment Response		Side-effects Associated with Study Medication		FDA Approval Status
Target Symptom(s)	Generic Name (Trade Name)	Controlled Trial in ASD	Age Range (years)		Study Duration	Mean Dose (Dose Range)	Target symptom		Side-Effects (SEs)	Serious SEs	A=Approved in autism, B=Approved in youth
ASD	Levetiracetam (Keppra)	Wasserman et al., 2006	Children (5-10)	Majority	Short-term (10-week)	863 ±279 mg(350-2500) 20-30 mg/kg/day	NO		- Agitation/Aggression (30%)	None	B Seizure Disorder (≥1)
	Cholinergic Agents										
Irritability	Galantamine (Razadyne)	Niederhofer et al., 2002	Children (7.4 ± 3.2)	Majority	Short-term (Duration NR)	NR	YES	Parent-rated (and not Clinician-rated) improvement in: - Hyperactivity - Social withdrawal - Inappropriate speech	None	None	
Core Symptoms	Donepezil (Aricept)	Chez et al., 2003	Children (2-10)	NR	Short-term (6-week)	1.25 – 2.5mg	NO (Refer to comments)		- Irritability (22%) - Diarrhea (11%)	- Irritability (N=4) - Diarrhea (N=2)	
Core Symptoms	Mecamylamine (Inversine)	Arnold et al., 2012	Children (4-12)		Short-term (14-week)	0.5 – 5mg	NO		- Constipation 50%	None	
	Glutamate Modulating Agents										B
Irritability + Hyperactivity	Amantadine (Symmetrel)	King et al., 2001	Youth (5-15)		Short-term (4-week)	168mg (90-200) [5 mg/kg/day] [in 2 divided doses a day]	NO	Clinician-rated (and not Parent-rated) improvement in: - Hyperactivity - Inappropriate speech	74% on study medication experienced AEs: - Insomnia (21%) - Somnolence (11%)	None	Flu (≥1)
Irritability	N-acetylcysteine (Mucomyst, Acetadote)	Hardan et al., 2012	Children (3-10)		Short-term (12-week)	900-2700mg (900 mg once, twice, or thrice a day for 4-week each)	YES	- Stereotypies - Social cognition - Social motivation	- Nausea/vomiting (43%) - Constipation (21%) - Diarrhea (21%)	- Irritability (N=1)	
	GABAergic Agents										
Core Symptoms	Bumetanide (Bumex)	Lemonnier et al., 2012	Children (3-11)		Short-term (12-week)	1mg	YES		- Hypokalemia (22%)	- Enuresis (N=1) - Hypokalemia (N=1)	
	Miscellaneous Agents										
Core Symptoms	L-Carnitine (Carnitor)	Geier et al., 2011	Children (3-10)		Short-term (12-week)	50 mg/kg/day	YES		- Irritability - Stomach discomfort	1 participant discontinued study medication due to AE	
Insomnia	Melatonin	Cortesi et al., 2012	Children (4-10)		Short-term (12-week)	3mg (Controlled-release formulation)	YES		None	None	

*Intellectual Disability=IQ<70; **Behaviors under irritability include aggression, deliberate self-injury, and temper tantrums; NR=Not Reported; AEs=Adverse Effects; OCD=Obsessive-compulsive Disorder; EPS=Extra-pyramidal Symptoms; SIB=Self Injurious Behaviors; URI=Upper respiratory tract infection; LDL=Low-density lipoprotein; HDL= High- density lipoprotein; TG=Triglycerides; MPH=Methylphenidate;

Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

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ATTACHMENT C

Council on Children, Adolescents and Their Families
December 16, 2015, 7PM, Conference Call
MINUTES

Present: Drs. Joseph Penn (chairperson), Amy Ursano, Anish Dube, Gabrielle Shapiro, Jean Thomas, Karen Pierce, Mary Ann Schaepper, Louis Kraus, and Steven Adelsheim. Fellows: Misty Richards , Raj Loungani and Swathi Krishna,.
APA Administration: Drs. Ranna Parekh and Philip Wang, Alison Bondurant
Excused: Drs. Albert Sargent, Christopher Kratochvil, Eraka Bath. Fellows: Isheeta Zalpuri, Megan Baker, Maria Lisotto
Unexcused: Drs. Andres Martin, Caitlin Costello, John Walkup, Kim Gordon, Michael Houston, Sarah Bougary. Fellows: Drs. Barbra Robles, Caroline Brozyna, James Murphy, Yetunde Atkins, and Yang Xu.

1. **Position Statement on Psychiatric Hospitalization of Children and Adolescents**. There was consensus to accept the position statement. Dr. Penn thanked Dr. Swathi for taking the lead in its rewrite.

2. **Position Statement on College Mental Health**. Dr. Dube proposed support of the Council on Psychiatry and Law's (CPL) redraft of the position statement, citing that passage #7 within the document effectively decries the practice of requiring students with mental health problems to take a medical leave. Callers agreed. Dr. Penn resolved to convey the council's endorsement to Dr. Hoge, CPL chairperson.

3. **Support Alliance Network (SAN)/Advocacy through collaboration work group.** Drs. Shapiro recommended that the council work to ensure that child/adolescent psychiatrists are among those trained through APA's quality improvement training initiative made possible by the SAN grant awarded by the Centers for Medicare/Medicaid Services. Dr. Shapiro further reported that she will convene the advocacy work group to take up this issue and related others. Dr. Penn invited others to work with Drs. Shapiro and Pierce on these matters.

4. **Clinical research in child and adolescent mental health disorders.** Dr. Penn reported that Drs. Kratochvil and Walkup have agreed to develop a position statement on this subject.

5. **Work group on at-risk children.** Ms. Bondurant noted that the work group, chaired by Dr. Lisotto, recently met by conference call with the parallel work group from the Council on Minority Mental Health and Health Disparities. The two groups plan to reach out to organizers of the April 2016 Stepping Up Summit to encourage the inclusion of youth-related issues on the agenda. The summit's focus is reducing the number of people with mental illness in jails.

6. **Parent Medication Guides (PMG).** Participants on the call highly praised the draft Parent Medication Guide on Autism Disorders and commended Dr. Kraus for his service on the writing team. Some felt that because the document addressed non-medication treatments as well, it should be retitled as a "comprehensive treatment manual." There was consensus to approve the document as is but to pass along that friendly suggestion to AACAP, co-sponsor of the PMG series. Dr. Penn agreed to follow-up with Heidi Fordi, AACAP Executive Director.

Dr. Wang noted that consideration is being given to create a parent medical guide on disruptive mood disregulation disorders. Many on the call felt that because this disorder is a new diagnosis and there is limited trial data, developing a comprehensive document would be difficult. There was strong support for a workshop on the diagnosis. Drs. Shapiro and Thomas volunteered to work with Dr. Wang to build upon this idea.

7. **Action paper on intellectual disabilities.** Dr. Schaepper asked for council's assistance in refining her draft action paper addressing the unwillingness of ER units to deal with adolescents and young adults with intellectual impairments who are in crisis and/or presenting with behavioral disturbances. This subject will be discussed at the next council meeting.

8. **Next Call.** Another conference call will be scheduled for mid-February.

The call adjourned at 8pm

ATTACHMENT D

Council on Children, Adolescents and Their Families
November 9, 2015, 7PM, Conference Call
MINUTES

Present: Drs. Penn (chairperson),Costello, Gordon, Kraus, Schaepper, Shapiro, Adelsheim, Dube, and Pierce. Fellows – Drs. Brozyna, Xu, Baker, Krishna, Lisotto
APA Administration: Dr. Parekh and Ms. Bondurant
Excused: Drs. Sargent, Houston, Kratochvil, Ursano, Bath; and Thomas. Fellows – Drs Zalpuri, Richards
Not Excused: Drs. Bougary, Martin, Thomas, and Walkup; Fellows – Drs. Murphy, Loungani, Akins, Robles

1. **Work group on collaboration with Council on Minority Mental Health/Disparities.** Dr. Lisotto reported that the work group is still brainstorming on ways in which to partner with that council on at-risk youth. Given the breadth of that topic, Dr. Gordon, who is also on the workgroup, suggested a guide for parents to help their kids deal with having an incarcerated parent, not distrust police or the judicial system. Drs. Shapiro, Costello and Xu volunteered to work with Drs. Lisotto and Gordon to expand upon that idea. Dr. Lisotto will confer with Dr. Ruiz**,** chair of the counterpart Council on Minority Mental Health/Disparities work group.
2. **College mental health position statement.** Dr. Dube reported that the Council on Psychiatry and Law (CPL) did a nice job of revising the existing position statement which referenced the issue of mental health leave in colleges. Dr. Dube will send the CPL version for review.
3. **Position Statement on Hospitalization of Children and Adolescents.** Dr. Krishna reported that she updated the draft to include edits previously suggested by council and will send the final edited version to the council by the end of this week.
4. **Action Paper on Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior.** Council concurred that the topic is broad. There was agreement that if the council were to tackle this action paper it would be valuable to focus on one or two toxins, including vaccines. Dr. Kraus noted that the AMA is developing a paper on the importance of vaccines. Dr. Penn advocated for involving other groups, such as AACAP, AMA and American Academy of Pediatrics, for a stronger voice.
5. **Clinical research in child/adolescent disorders**. Dr. Penn raised the question of whether or not the council should tackle creation of a separate position statement encouraging clinical research in child and adolescent psychiatry in view of the decision by the Council on Healthcare System's removal of that viewpoint in the Patient Access to Treatments Prescribed by Their Physicians position statement. The council resolved to consult with Drs. Kratochvil and Walkup before January in order to state its decision to JRC at that time.
6. **Council work plan.** Dr. Penn reported that the JRC expects a council work plan over the course of the coming year. He encouraged members to mull over potential topics and burning issues. Drs. Shapiro, Dube and Pierce volunteered to flesh out a project around state advocacy involving among other things: parity for child and adolescent services, expanding access to children and family services, extenders not infringing on practice. Collaborative care was suggested as a worthy topic

for the council. Dr. Shapiro pointed out that the Centers for Medicare and Medicaid Services (CMS) has awarded APA a Support Alliance Networks grant that will enable APA to train psychiatrists to expand their quality improvement capacity and clinical skills related to evidence-based integrated care consultation. This effort is a good opportunity for child and adolescent psychiatrists given integrated care is AACAP's presidential theme this year. Dr. Parekh will reach out to Kristin Kroeger for more information and ideas on how the council can have influence in the SAN training modules.

7. **RAISE**. Dr. Adelsheim called attention to the NIMH Recovery After an Initial Schizophrenia Episode (RAISE) research initiative. Its aim is to develop, test, and implement coordinated Specialty Care (CSC) programs for first episode psychosis in young people in "real world" community clinics. He inquired how the council can play a role in helping to promote the program. He also mentioned that PEPNet is a system for enhancing the quality of programs that link young people (ages 12 to 25) to work and education in order to promote a successful transition to adulthood through Communities of Practice.
8. **Next meeting.** Council agreed upon the usual meeting date/time – on the Monday of the Annual Meeting, May 16, 1pm – 4pm.
9. **Next conference call.** Mid-December at 7pm Eastern.

   The call adjourned at 8pm.

Attachment E
Yearly Assessment of the Council on Children, Adolescents and Their Families
January 2016

- **Councils' top 3 activities from the previous year**
  - Assessed existing APA policy statements related to children and adolescents, including *Corporal Punishment* and *Reactive Attachment/Disinhibited Social Engagement Disorder;* provided input to the Council on Healthcare Systems and Financing regarding the position statement on *Access to Treatments Prescribed by Their Physicians* and to the Council on Psychiatry and Law related to the position statements on *Segregation of Juveniles with SMI in Correctional Facilities* and *College Mental Health*. Commented on NIDA's draft strategic plan which was integrated into APA's overall feedback to NIDA per the agency's Request for Information.
  - Reviewed and approved the Parent Medication Guide on Autism Disorders. Dr. Kraus represented the council and APA on the guide's planning and writing committee, comprised of AACAP representatives and consultants from varied parent and autism groups.
  - Formed work groups to develop council initiatives relating to at-risk youth, collaborative care, and advocacy for child and adolescent services. A work group was also established to develop an education program on disruptive mood disregulation disorders.

- **Tangible work product**
  - 2015 Annual Meeting session on *Prescribing Food: Can Diet Interventions Reduce Symptoms in Children With Mental Illness*
  - Revision of position statement on hospitalization of children and adolescents

- **Work priorities for the coming year**
  - Continue collaboration with the Council on Minority Mental Health and Health Disparities to develop project(s) on at-risk minority youth
  - Create a position statement supporting more clinical research on child/adolescents mental health;
  - Develop initiatives around:
    - Collaborative care
    - Teen suicide
    - Gender dysphoria
    - Guidance for adult psychiatrists who treat adults with autism
    - State advocacy involving parity for child/adolescent services, expanding access to kids and families

- **Assess the participation of Council members**
  - The majority of members of the council are keenly committed to the mission of the council and consistently and thoughtfully contribute to council deliberations; however, there are two members who have been completely absent.

- **Mentoring of RFM/ECP members**
  - Oriented and provided guidance to fellows on submitting abstracts for the Annual Meeting; critiqued fellows' submissions for the 2016 Annual Meeting

Charge:

The Council on Children, Adolescents and their Families is charged with the following:

- Work to advance issues related to the diagnoses and treatment of mental health needs of children and adolescents with special attention to vulnerable populations.
- Keeps psychiatric issues involving children, adolescents, and their families in the forefront of APA policy
- Works to assist general psychiatrists in learning more about the diagnoses & treatment of mental illness and the effects of physical illness on mental health in children & adolescents.
- Works with other APA components to advise & assist on matters that impact the emotional lives of children & adolescents such as substance abuse & matters related to juvenile justice
- Works to help maintain effective communication and collaboration between the APA & the American Academy of Child & Adolescent Psychiatry
- Addresses the clinical care & provision of services of children and adolescents with developmental disabilities including autistic spectrum disorders & intellectual disabilities.
- Works to increase the awareness of the prevalence & promote the prevention of all types of violence including the physical & sexual abuse of children and spouse as well as other types of domestic abuse.
- Works to promote policies aimed at improving the awareness of mental health issues and the effectiveness of school based treatments within schools across all age ranges & settings.
- Helps promote the identification, treatment, and prevention of mental health issues of infants, toddlers, and preschool aged children in collaboration with other professional organizations and related programs.
- Oversees the activities of the Blanche F. Ittleson Research Award Committee.
- Oversees the activities of Agnes Purcell McGavin Awards Selection Committee.
- Oversees the activities of the Council-appointed Child & Adolescent Fellowship Program Work Group

Executive Summary

Council on Geriatric Psychiatry

Description of the Council:

The Council supports the APA in its work on behalf of older adults and the psychiatrists who care for them. To this end, the Council develops Position Statements and Resource Documents on important issues in geriatric psychiatry, thereby providing the APA with background information essential for advocacy efforts and interactions with the media. The Council also works collaboratively with other professional groups to develop best practices in geriatric psychiatry, to promote research, and to provide education and training to psychiatrists, other physicians, residents, medical students, and allied mental health professionals.

Information Items:

- The entire Council is meeting at least monthly via conference call; minutes of the meetings attached
- Subgroups of the Council are working on the following two position statements via email and conference calls
    a. Role of Psychiatrists in Long-term Care Settings
    b. Role of Psychiatrists in Palliative Care

Referral Updates:

- Revision of Position Statement: Principles of End-of-Life Care for Psychiatry (2001) [JRCJAN158.E.3] : The Council is working on this project with the Council on Psychosomatic Medicine. The creation of the first draft was delayed due to the illnesses of several members of the workgroup. As of this writing, a conference call is planned for January to move this project forward.

Action Items:

- Will the Joint Reference Committee recommend that the Assembly approve the position statement on Role of Psychiatrists in Assessing Driving Ability? (JRCJAN158.E.2; ASMMAY154.B.8) (Attachment#1)
    - The most recent draft of this position statement revision was created with input from the Council on Psychiatry and the Law. When last reviewed by the JRC, it was suggested that reformatting might be in order. As of this writing, we are trying to determine if this has been accomplished.

Review of the Practice Guideline on the Use of Antipsychotics to treat agitation and psychosis in patients with dementia:

The Council reviewed the final draft of the Guidelines and provided comments to the Steering Committee. The Council members have a few concerns that were not addressed in the document. Since the Guidelines have been approved by the Assembly and the Board, the Council is considering how best to proceed to ensure that our members have the support they need to treat these challenging conditions.

Position Statements:

Role of Psychiatrists in Long-term Care Settings- The JRC asked the Council to review an existing position statement entitled "Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia". A workgroup has been formed, and a first draft of a revised position statement has been created. The Council hopes to have a final product for presentation to the JRC in the spring of 2016.

Role of Psychiatrists in Palliative Care: A workgroup consisting of volunteers from the Council on Geriatric Psychiatry and the Council on Psychosomatic Medicine has started working on the statement. The workgroup discussed the primary details in a conference call in October. Two members of the workgroup are working on a draft statement which will be presented to both councils for their review soon.

Workgroup on Telepsychiatry:

The Council reached out to Dr. Jay Shore, with an offer to schedule a phone meeting to explore the possibilities of collaboration between the Council and the telepsychiatry taskforce to develop resources on the use of technology in geriatric psychiatry. The Council is planning to put a workgroup together to get started on this project.

Attachment: 1

Position Statement on the Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8)

The presence of a mental or neurocognitive disorder per se does not imply impaired driving capacity. Nonetheless, persons suffering from mental disorders may experience symptoms that can 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

1. When appropriate, psychiatrists should discuss with the patient, caregivers, and family members symptoms of the patient's mental disorders that may substantially impair their driving ability.

2. Physicians should warn their patients about the possible effects of medications, including psychotropic medications, on alertness and coordination.

3. When clinically appropriate, medications 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 the 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.

Council on Geriatric Psychiatry
October 14, 2015 8-8.45pm

1. Maureen Nash, MD
2. Marilyn Price, MD
3. Pachida Lo,MD
4. Paul Kirwin, MD
5. Susan Schultz, MD
6. Robert Roca, MD
7. Brent Forester, MD
8. Ipsit Vahia, MD
9. Marsden McGuire, MD
10. Seon Kum, MD
11. Peter Ureste, MD

Position Statement: The Use of Antipsychotic Medications for the Treatment of Behavioral Disturbances in Persons with Dementia

Dr. Roca will check with the JRC to see if we should wait to work on this statement until the practice guidelines are out and approved. We can discuss this further in the next conference call. We will have feedback from Assembly by that time.

Position Statement on Long-term care settings

The Council was asked to review an old position statement - Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia. There was a consensus that the statement was outdated and not useful. The council agreed to create a new position statement that is relevant today and can be useful for the APA leadership, especially when they want to issue advocacy statements. The statement should include new regulatory requirements for antipsychotics. The PS will have background information and reference document attached to it.

Working with the APA Workgroup on Telepsychiatry

Dr. Jay Shore invited the council to collaborate with the workgroup to create educational products related to geriatric psychiatry. The council agreed to create a toolkit for psychiatrist to help them set up tele-psychiatry for LTC settings. Dr. McGuire, Dr. Seon Kum and Dr. Kirwin agreed to join the workgroup. Dr. McGuire will reach out to Dr. Lind Godleski who is considered an expert in telepsychiatry to see if she can provide some guidance. Dr. Peter Ureste will find out more about the GENESIS program at UCLA and share the information with the group.

Update: Sejal has sent an email last week to Dr. Jay Shore to set up a tele-meeting.

Requirement from the JRC:

The JRC has asked the council to submit their 1-year and 3-yaer plan. Dr. Roca asked the group to share their thoughts and ideas. The plan should feature the list of products and activities that council is planning to undertake. The group shared ideas in the call as well as via emails.

Brent Forester, MD:

- APA could help support recruitment into geriatric psychiatry through the annual meeting (i.e. a Scholars program for the APA) or other brainstorm other ideas.
- Topic area of interest: Integrated Care (Geriatric Mental Health in Primary Care). White paper on this topic and set up best practices for this…geriatric depression well studied (IMPACT) but what about dementia care management in primary care.

Susan Schultz, MD

- Increase interest in trainees and young members to join the field of geriatric psychiatry
- Enhance the skills & knowledge of our general APA members who are in general practice but want skills in elder care.
- Increase the APA reach as the source of knowledge in primary care and interprofessional settings on aging and mental health.

Ipsit Vahia, MD

- Geriatric psychiatrists increasingly have deal with issues related to aging in place. Integral to this is the use of various types of technology for monitoring, communication, assessment and even treatment. This is an area poised for rapid growth
- Currently, most technology is being marketed directly to seniors with no evidence for safety, efficacy, reliability or validity. The industry has tended to exclude healthcare providers from the process of technology development
- It is critical that mental health practitioners have input on some of these issues. The APA may be poised to a leading role in steering on how to incorporate technology into care, especially for older adults with dementia. There is a strong need to for guidelines and structure in this area.
- It would be important for the council include this area in its mission - working with interest groups withing the APA to identify how technology may best be applied for mental health care, but also for promotion of general well being and quality of life in older adults.
- Deliverables may include position statements, white papers, and potentially a forum for dialog and networking to generate multi site evidence or qualitative/quantitative evidence to guide technology use by physicians. The council may also serve as a point of liaison with the industry, as needed.

Paul Kirwin, MD

Perhaps we can base our goals for the next 1-3 years on key recommendations in the 2012 comprehensive IOM report: The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? –A study that Congress funded.

The scope of these recommendations is far beyond what the Council can accomplish, but perhaps we select 2-3 major topics, i.e. strategic ways to address critical Geriatric mental health workforce shortages (as Brent and Susan have already suggested).

The Council can also encourage the governance arm of the APA to carefully examine these recommendations, and evaluate where they might press for change—ideally with the cooperation of the AAGP, AGS, etc. As you know, many of the nation's experts in Geriatric Psychiatry sat on the IOM Committee, led by Dan Blazer. Could we work from their blueprint and capitalize on their thoughtful expertise?

The report begins with defining the scope of the issue. Perhaps part of our role on the Council is to inform the general membership of this scope, and follow the IOM's recommendations to begin to address it:

"The committee conservatively estimated that between 5.6 million and 8 million older Americans -- 14 percent to 20 percent of the nation's overall elderly population -- have one or more mental health conditions or problems stemming from substance misuse orabuse. Depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent. Rates of accidental and intentional misuse of prescription medications are increasing. Although the rate of illicit drug use among older individuals is low, studies indicate that it will likely increase as the baby boomers age. " IOM press release

The report ends with 5 general recommendations, each having bulleted details, for example, recommendation 1:

"RECOMMENDATION 1: Congress should direct the Secretary of Health and Human Services (HHS) to designate a responsible entity for coordinating federal efforts to develop and strengthen the nation's geriatric mental health and substance use (MH/SU) workforce.

- The committee urges Congress to fund the already authorized National Health Care Workforce Commission to serve in this capacity. In the absence of congressional action, the Secretary of HHS should act as soon as possible to designate an alternative body.
- The coordinating body should have the following priorities with respect to the geriatric MH/SU workforce:
- Identification, development, and refinement of methods for improving

recruitment and retention of geriatric MH/SU personnel, including ways to build

a workforce that reflects the increasingly diverse older adult population.

- Promotion and support of wide-scale implementation of evidence-based models of geriatric MH/SU care that effectively deploy personnel.
- Identification, development, and refinement of model curriculums and curriculum development tools in geriatric MH/SU, including effective models of training for integrated rehabilitation, health promotion, health care, and social services for older adults with serious mental illness.
- Identification, development, and refinement of core competencies in geriatric

MH/SU for the entire spectrum of personnel who care for older adults, including direct care workers, peer support specialists, primary care physicians, nurses (at all levels), physician assistants, substance use counselors, social workers, psychologists, rehabilitation counselors, and marriage and family therapists.

- Evaluation and dissemination of all of the above. "

Other ideas:

- We need to find a way to get funds for the Jack Weinberg Award.
- Submit more educational programs at the national meetings.
- Develop a model curriculum for medical school in geriatric psychiatry.

Council on Geriatric Psychiatry
November 17, 2015/8:00-8:45pm

Minutes of Meeting

Participants:

1. Robert Roca, MD
2. Susan Schultz, MD
3. Brent Forester, MD
4. Marsden McGuire, MD
5. Ipsit Vahia, MD
6. Paul Kirwin, MD
7. Olivia Okereke, MD

Minutes of October Meeting:

The participants reviewed the minutes of minutes and passed it without any changes.

Review current version of the practice guidelines on use of antipsychotics

Members raised a few concerns in the practice guidelines that are approved by the Assembly.

Statement 12. APA recommends that in patients with dementia who show adequate response of behavioral/psychological symptoms to treatment with an antipsychotic drug, an attempt to taper and withdraw the drug should be made within 4 months of initiation, unless the patient experienced a recurrence of symptoms with prior attempts at tapering of antipsychotic medication. (1C) – Members questioned the use of specific duration – 4months. It seems an arbitrary number. Rather it should be something like "within a reasonable period of stability after initiation". It should be a choice of physician.

In the September meeting in the DC, the council suggested to add a list of unresolved issues that are clinically important and not covered in the guideline due to lack of evidence. That seems to be not incorporated; we should check the draft to reconfirm.

Statement 10. APA recommends that in patients with dementia with agitation or psychosis, if there is no clinically significant response after a 4 week trial of an adequate dose of an antipsychotic drug, the medication should be tapered and withdrawn. (1B)- This is not supported scientifically; no clear evidence for what the adequate dose is.

Statement 3. APA recommends that in patients with dementia with agitation or psychosis, response to treatment be assessed with a quantitative measure. (1C)- Most clinicians don't utilize quantitative tool. Rather it should be something like – "gold standard quantitative measure that everybody should be using."

There is a scope to propose a position statement that helps deal with some of the practical issues that these guidelines may present in the field. The council will discuss the scope of the position statement in December call.

PS on Long –term Care

The workgroup came up with the following statements.

1. The widening scope of mental health problems in LTC includes severe cognitive impairment, behavioral dysregulation, intellectual disabilities, neuropsychiatric symptoms of dementia, mood disorders and chronic mental illnesses such as schizophrenia. *Consequently pharmacologic management that includes appropriate use of antipsychotics, antidepressants, etc, is an inherent part of quality LTC services.*

2. Optimizing the appropriate use of psychotropic medication in LTC is most likely to be achieved through a psychiatric consultant, although additional training or continuing education in geriatric-specific psychiatry practices is ideal. – Need to tweak language here about additional training or continuing education

3. Interprofessional collaboration with the LTC medical director or other primary care provider in a systematic way offers the best likelihood of high quality patient-centered care. – Add a point on – in addition to managing appropriate use of antipsychotics, geriatric psychiatrists have a role in assessing the problem. This could be an additional statement.

PS on Palliative Care (Summary of the first call attached)

The workgroup had its first call and some primary discussions. Dr. Buxton (Council on Psychosomatic Medicine) and Dr. Maureen Nash are working on the first draft.

Reminder about the Open Comment Period APA/AAN Dementia Measures

Dr. Roca encourage the council to submit comments on the APA/AAN Dementia Measures

Council on Geriatric Psychiatry
December Phone Meeting
December 15, 2015 8pm-8:45pm

Participants:

1. Robert Roca, MD
2. Brent Forester, MD
3. Susan Schultz, MD
4. Maureen Nash, MD
5. Marilyn Price, MD
6. Marsden McGuire, MD
7. Olivia Okereke, MD
8. Susan Schultz, MD
9. Elisabeth Santos, MD
10. Ipsit Vahia, MD
11. Seon Kum ,MD
12. Peter Ureste, MD
13. James Wilkins, MD
14. Ranna Parekh, MD (APA Staff)
15. Sejal Patel (APA Staff)

Position Statement in LTC:

The workgroup presented a revised draft of the position statement on Long-term Care. Members agreed that this is an opportunity for the APA to make a statement about what psychiatrists bring to the table in long term care settings. Dr. Roca suggested to expand the statement by considering the role of psychiatrists in comprehensive assessment and diagnostic skills. The statement should be relevant for all psychiatrists, and not just geriatric psychiatrists. Dr. Roca will send some edits in the statement.

Position Statement on Palliative Care

The workgroup couldn't meet last month as Dr. David Buxton became ill. Since he is one of the main authors of the first draft, the call has been moved to January. Even Dr. Maureen Nash was not well so she couldn't work on the draft.

Practice Guidelines on Use of Antipsychotics in patients with Dementia:

After the November call meeting, the council shared a few concerns about the practice guidelines with Dr. Laura Fochtmann. She responded with following comments:

Thanks for getting in touch with us. As you may already know, the guideline was approved by the Board of Trustees this past weekend so we are not able to make any changes in content at this point.

Based on the input from the Council, we did make significant changes to the document between the September Components meetings and the distribution of the document in advance of the Assembly meeting. Additional modifications addressed input that we received from other experts as part of the draft review process.

In particular, we greatly expanded the section on "Balancing of Benefits and Harms in Rating the Strength of Recommendations" to describe the rationale behind each of the statements. In accord with the new development process, the deliberations of the writing group focused on weighing the benefits and harms of a specific recommendation as informed by the research evidence. If no direct research evidence was available, we incorporated indirect inference from the research evidence or used consensus based information from the expert survey and comments on the draft guideline. In the section on "Balancing of Benefits and Harms in Rating the Strength of Recommendations", the final document also describes differences in opinion for statements where comments showed particular variation.

We tried to make each of the recommendations as clear as possible, but we agree that terms such as "adequate dose" will always have some degree of imprecision. Consequently, in the revised document, we made a concerted effort to define such terms in the glossary.

The document that was approved by the Assembly and the Board also includes a new section titled "Limitations of the Evidence in Assessing Benefits and Harms". This section was intended to describe the limitations of the research evidence and also to identify gaps in the available research as was discussed at the Council meeting in September. The limitations of existing quantitative measures are one of a number of topics that we review in this section. In addition, further discussion of quantitative measures was added to the section on Implementation.

Since the guidelines are approved by the Board, these concerns may not be addressed in the guidelines. The council is concerned about the misuse or misinterpretation of the guidelines in the field. The council is considering releasing a statement/commentary in the American Journal of Psychiatry or American Journal of geriatric Psychiatry. The council may consider posting an opinion on APA Blog or LinkedIn groups.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

Report of the
Council on Healthcare Systems and Financing
Harsh K. Trivedi, MD, MBA, Chair
Executive Summary

The Council on Healthcare Systems and Financing has focused their efforts on the priority items identified in their work plan which includes items referred to the CHSF from the Assembly via the JRC. We asking the JRC to review and approve three position statements (Attachments 1-5): a new statement on integrated care; and two statements that are major revisions to existing APA position statements on off-label prescribing and care of the seriously mentally ill. The revisions to the existing position statements were so significant that we did not include a document with the changes tracked; rather we have included a copy of the existing position statement as well as the proposed position statement. Attachments 6 and 7 provide brief updates on activities related to the CHSF work plan, including items referred to the CHSF by the JRC.

Action Item: Position Statement on Integrated Care

Background: It is a given that integrated care delivery policy initiatives are fundamental to help both public and private payers in pursuing better quality care and desired cost efficiencies. The APA has been in the forefront of placing emphasis on the essential role the treatment of behavioral conditions has in respect to these objectives. However, the APA does not have a current position statement that sets forth the principles it thinks should guide payor initiatives. Drs. Lori Rainey and Eliot Sorel were the primary authors of the proposed position statement with members of the Council on Healthcare Systems and Financing and its Workgroup on Integrated Care and the Council on Psychosomatic Medicine, providing input. The Council on Healthcare Systems and Financing reviewed and approved the proposed position statement on their December 2015 conference call.

ACTION #1: Will the Joint Reference Committee recommend that the Assembly vote to approve the Position Statement on Integrated Care? (Attachment 1)

Action Item: Proposed Position Statement on Off-Label Treatments and Position Statement on Patient Access to Treatments Prescribed by Their Physicians

Background: Members of the CHSF had reviewed and recommended retaining a revised/updated version of the position statement "Patient Access to Treatments Prescribed by Their Physicians" (Attachment X), which is based on existing AMA policy on this issue. The JRC referred the revised position statement back to the CHSF for additional work. The JRC "felt that the title of the position statement should reflect the key message and that the statement itself be succinct and on point." Members of the CHSF reviewed the document again and determined that the statement is primarily aimed at addressing issues that arise when prescribing "off-label" treatments. They recommended revising the existing statement to focus on that issue and recommended that the Council on Children, Adolescents and their Families review the section on encouraging clinical research in the area of child and adolescent psychiatry to determine if a separate statement on that issue was necessary. The Council on Children reviewed that section and recommends that a separate statement be developed. They will be developing a statement for the JRC to review at a later time. As part of the review process, the JRC asked the CHSF to seek input on the suggested revisions from the Council on Advocacy and Government Relations (CAGR). CAGR reviewed and approved the revised language put forward in this report. The Council on Healthcare Systems and Financing reviewed and approved the proposed position statement at their May 2015 meeting.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

ACTION#2: Will the Joint Reference Committee recommend that the Assembly vote to approve the Position Statement *on Off-Label Treatments*? (Attachment 2)

If action #2 is approved,

ACTION #3: Will the Joint Reference Committee recommend that the Assembly vote to retire the 2007 position statement on *Patient Access to Treatments Prescribed by Their Physicians*? (Attachment 3)

Action Item: 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)
Background: As part of the routine review of position statement the CHSF was asked to review and make recommendations on the 1978 position statement *A Call to Action for the Chronic Mental Patient*. The CHSF believed strongly that a statement with regard to the care of the seriously mentally ill was needed. They recommended revising the dated position statement. The JRC asked that the Assembly Committee on Public and Community Psychiatry be involved in the process. Led by Drs. Larry Miller and Isabel Norian, immediate past chair and current chair of the Assembly Committee on Public Psychiatry, the Assembly Committee drafted the proposed statement. They sought and received input from a number of components including the Council on Healthcare Systems and Financing, the CHSF Workgroup in Integrated Care, the APA BOT Workgroup on Healthcare Reform, and members of the American Association of Community Psychiatrists. The Council on Healthcare Systems review and approved the position statement on their December 2015 conference call.

ACTION#4: Will the Joint Reference Committee recommend that the Assembly vote to approve the position statement *The Call to Action: Accountability for Persons with Serious Mental Illness*? (Attachment 4)

If action #4 is approved,

ACTION #5: Will the Joint Reference Committee recommend that the Assembly vote to retire the 1978 position statement A Call to Action for the Chronic Mental Patient? (Attachment 5)

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

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

[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

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.
- 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:

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

American Psychiatric Association

[Proposed] Position Statement on Off-Label Treatments

January 2016

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, 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.

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.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

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

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, 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.

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-

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.*

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Topic/Issue	Product	Background	Key Tasks	Timeline	Update
1.Integrated/ Collaborative care	a) Development of an APA position statement	It is a given that integrated care delivery policy initiatives are fundamental to help both public and private payers in pursuing better quality care and desired cost efficiencies. The APA has been in the forefront of placing emphasis on the essential role the treatment of behavioral conditions has in respect to these objectives. However, the APA does not have a current position statement that sets forth the principles it thinks should guide payor initiatives. The Council will undertake a lead role in the development of a position statement to be processed through appropriate APA channels.	1. To immediately begin drafting a position statement that articulates APA principles with input from other key stakeholders within the APA. 2. Secure JRC approval to begin to process this through governance quickly for eventual final approval of an APA Position Statement.	1 to 6 Months (depending on approval process)	Position statement moving forward to the JRC in January
	b) Development of specific coding and valuation amounts for the evidence based collaborative care model for persons with behavioral conditions in primary care settings to enable sustainable reimbursement	The problem of access to psychiatric services in primary care settings has been well documented. Care models to improve access in primary care settings have been developed and tested over time. The most prominent evidence-based collaborative care model is the one that the AIMS Center at the University of Washington has stewarded over time. The key barrier to the proliferation of the model has been payment for the essential functions of the model. CMS announced in July 2015 that it intends to move to coverage of, or further demonstration of, this evidence based model, and specifically intends to address how to appropriately reimburse for it. The Council will work to develop and advocate for a specific coding proposal with CMS. This will be done primarily through the Committee on RBRVS, Codes, and Reimbursement.	There are many, many decision points in the following tasks that cannot be specified at this time. 1. Key CPT and RUC representatives will be assessing our options for playing this through given the many stakeholders involved. 2. Designation of a workgroup to begin to draft the required specifications for code development for CPT. 3. Convening a teleconference with APA experts for other medical specialties to explain the model and its requirements. 4. Convening meetings with CMS to provide additional information to the comments APA submitted Sept 2015 on CMS request for information. 5. Developing the content and strategy for when a proposal is submitted to CPT and/or the development of a G code by CMS. This may require two concurrent paths of actions with CPT and CMS. 6. Key tasks that follow from point 5 can only be delineated once we have a more defined pathway which should emerge by December 2015.	The foregoing will occur over the next 18 to 24 months. The timelines that the AMA CPT and RUC work on and that of CMS are complex with respect to completion dates for codes to be considered for Medicare rule-making. However, CMS's announced target for coverage is January 2017. It should be noted that target does not mean that we will not be involved with CPT and RUC after that deadline for refinements in evaluation of the eventual codes.	We have completed tasks 1-5 and are in the process of assembling the necessary information. A two-prong approach is occurring with regard to the development of a reimbursement mechanism for collaborative care: A CPT coding proposal has been submitted for consideration by the AMA CPT Editorial Panel at their February 2016 meeting. We will also be engaged in supplying CMS with key pieces of information with regard to the description of work, associated costs and level of complexity as it relates to existing services. This information will be helpful should CMS consider the development of HCPCS codes which could be billed starting as early as January 2017 (CPT codes would not go into effect until 2018 at the earliest). A work plan based on the outcome of the February meeting will be formulated.
	c) Convening an expert workgroup of psychiatrists	Accountable Care Organizations (ACOs), medical and health homes, and efforts by CMHCs to secure better access for physical	1. Develop an outreach plan throughout the existing APA structure, including the Assembly, to identify psychiatrists who are involved in	The plan to identify individuals involved and/or interested parties should be developed by	The new office of practice management will coordinate this effort. A new director is

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	involved in new care models, e.g. ACOs and health homes (and working with public and private payers around issues for psychiatry in the new care models)	health services for the SMI population permeate the landscape. There are stellar examples of achievement--e.g., the Montefiore Pioneer ACO--where the successful integration of treating individuals with behavioral conditions has led to overall success. There are also examples in the health home world where sophisticated approaches to treating behavioral conditions in primary care settings have been successful. There are also a number of CMHC efforts that have been successful. However, the overall penetration of psychiatry in these models has been highly variable as documented in the literature. There is a need to draw on the experience of psychiatrists who have been involved to understand the elements necessary for success and barriers to successful integration. There is also a need to better understand the payer perspective on barriers to the implementation of better care models for behavioral conditions.	these alternative arrangements. 2. Establish an outreach effort with commercial and public payers to begin discussions. Note that a meeting has already been had with Aetna. 3. Identify existing APA meetings (e.g., area council meetings, the annual meeting and IPS) to convene forums on these issues.	December 2015. It should be noted that the APA has received notice that it is the recipient of a major Support Availability Network (SAN) grant from CMS. The general purpose of this grant is to provide education for psychiatrists working in collaborative care situations as well as to bring training opportunities to primary care practices. We think this will be a major vehicle to identify and coalesce the community of psychiatrists involved or interested in these models and to conduct important outreach with the primary care and payer communities.. The timeline for a potential working group summit for psychiatrists and payers would be spring 2016.	slated to start January 5, 2016. This will be integrated into the ongoing work relating to the SAN grant from CMS.
2) Coding and Payment Issues (separate from those for the CoCM model)	a)Working to enable payment for the interprofessional consultation codes and/or the possible development of new EM add-on codes for cognitive work, new or revised care coordination codes for all physician specialties and improvement in coverage for telepsychiatry.	Independent of a specific coding proposal for the CoCM model noted above , there are a number of coding issues that are relevant for all physician specialties in the new healthcare delivery environment. Psychiatry has specific interest in the development of any of these new codes as well as payment for existing codes. We think there are special issues that need to be addressed to expand coverage and payment for telepsychiatry. CHSF, through the Committee on RBRVS, Codes and Reimbursement and with input from the BOT Workgroup on Telepsychiatry, will be actively working on each of these as agenda items.	1. To monitor strategies along with other medical groups to persuade CMS to pay for the existing interprofessional consultation codes (CPT XXXXX to XXXXX). 2. To continue and ensure psychiatry's participation with key coalition groups that have emerged to expand recognition for essential cognitive work and care collaboration and potential new add on codes to the EM CPT codes. 3. Work with the BOT workgroup on telepsychiatry to identify key coverage and payment issues for telepsychiatry and develop an advocacy agenda based on them.	Activities around this have already commenced and given prior experience we expect that they will continue actively throughout the next 12 to 18 months.	APA has been a participant in the Multispecialty Coalition which is made up of medical specialty organizations interested in securing reimbursement for work not currently described within CPT or HCPCs codes. APA will be commenting and working with interested parties on several relevant CPT coding proposals moving forward beginning with the February 2016 CPT Editorial Panel Meeting.
	b) Production of a background paper on the feasibility of alternative payment models for psychiatric/SUD care across all levels of care and payers	Numerous proposals (e.g., value-based payment, bundled payment, episodes of care, and so on) are emerging from both public and private payers as alternatives to fee for service. The feasibility of these alternatives for psychiatric care has not been systematically reviewed. There are many technical issues involved in alternative payment methods (e.g.,	1. Assemble a group with the requisite expertise to begin to develop the necessary background paper/resource document. 2. Convene the group to begin to identify the essential review and analysis tasks that need to be undertaken to produce a definitive paper/resource document 3. Implement and coordinate the	We will begin exploring establishment of this group in October and develop an appropriate timetable to produce the needed resource document. At a minimum, in order to be timely with Medicare's objectives, we	The new office of reimbursement will coordinate this effort. A new director has been engaged and is slated to begin February 1, 2016. We expect Medicare to provide essential clarification on the APM issue through regulation

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		the cost basis for the unit of payment, however defined; how it is risk adjusted for case mix; how to define the beginning and end points for what triggers an end to an episode and payment for same; and so on). The long-standing APA experience with prospective payment for inpatient care under Medicare, for instance, bears out that this is an extremely complex task. There are also distinct subset issue with other specialty APMs with respect to how psychiatry should be included for essential consultation functions. Before proceeding to specific proposals the Council thinks it is essential that the APA fully analyze the issues. Even if a way to design an alternative payment model(s) (APM) for psychiatry cannot be found, this effort will assist in defining why these approaches are not appropriate, which may prove to be important in itself in advocating with payers as to how to appropriately deal with psychiatric care. Note that the development of APMs under Medicare is in some respects a special case because of to be stipulated CMS criteria and will be included in the initial work.	development of the document. 4. Ongoing collaboration with other medical associations regarding Medicare APMs.	believe we need a resource paper/document by spring of 2016.	in the spring of 2016.
	c) Optimizing payment for psychiatry under the new MIPS formula for Medicare (which cuts across quality, education, and HIT especially) including establishing appropriate exemption thresholds for practicing psychiatrists.	SGR reform (i.e., MACRA) has reconfigured how much physicians will be paid or not paid depending upon how they interact with the various programs and alternative options established under the reform legislation. There are four potential paths that psychiatrists can occupy under MACRA, with each having different physician reporting, risk taking, and bonus/penalty implications. Psychiatrists can choose to: 1. Opt out of Medicare entirely; 2. Participate through the to-be-established MIPS payment formula; 3. Participate and be part of an alternative payment method and potentially be exempt from the MIPS payment formula; or 4. They can participate and be exempt from the MIPS payment formula if they fall under yet-to-be-	1. Develop materials that fully explain options and implications for APA members; 2. Develop proposals that make it feasible for psychiatrists to meaningfully participate in the MIPS formula (this includes quality measures, meaningful use, and recognized clinical practice improvement activities and appropriate patient attribution methodology) and advocate for same with CMS; 3. Develop a background paper and work with other appropriate medical professional societies to explore the feasibility of an APM for psychiatry consistent with the yet to be developed criteria from CMS; and 4. Develop a specific low-volume threshold exemption for psychiatrist participating in Medicare.	A timeline for this will be more fully mapped out once CMS has provided more clarity about its own timeline for development of essential regulations in this arena.	See above re federal rulemaking.

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		established low-volume thresholds that exempt physicians from MIPS.			
3) Mental health /SUD parity MHPAEA took more than a decade to come to fruition. It is a complex and not well understood statute and regulations. Currently all individual DBs and State Associations are dealing with MHPAEA issues on their own. APA deals with member issues directly with insurance plans and with the federal government and brings in DBs when possible. It is a patchwork approach that is not strategic. To successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before healthcare reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join	a) Continuation of current plan of action to secure network adequacy and reimbursement equity for psychiatry	Under MHPAEA network adequacy and reimbursement parity are closely related non-quantitative treatment limitations (NQTLs). It is critical for the APA to successfully engage employers as purchaser and regulators as enforcers to move on the issue of network adequacy for psychiatrists, which is a well-documented problem. There have been many ongoing activities by OHSF staff in conjunction with the APA's General Counsel to pursue this, and there are indications that there is a beginning understanding by purchasers and regulators that network inadequacy is a parity violation. Moreover payment equity is fundamental to this. [Mention Parity and Medicaid Managed Care and Exchange Plans]	1. Building on the current work plan, we need to finalize a letter, which has been prepared, that will go from the New England Business Group on Health to numerous major insurers requesting specific data and documentation about the status of their psychiatric networks. 2. District Branches need to be educated on the issues and provided with the tools needed to address network adequacy at the state level with legislators and regulators. A series of materials are being finalized to be presented at the state legislative conference in October in Florida. A plan for follow-up with the District Branches will be executed at this meeting. 3. Other outreach efforts on network the adequacy issue as a parity problem need to be made to state insurance commissioners, attorney generals, and others. 4. Develop an appropriate internal and external communications plan around these issues.	These efforts have been ongoing and will continue aggressively over the next twelve months.	A comprehensive work plan for parity has been developed and will involve numerous other APA offices.

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forces in a coordinated fashion nationwide. Key elements of where we are headed are described below.					
	b) Development of education/action materials for APA state affiliates to identify and act on parity issues under health plans	Many district branches have indicated a desire to move forward on mental health parity issues, but some do not understand the intricacies of the statutes, the enforcement scheme, or the insurance industry. There is need for a coordinated strategy between the APA and its DBs regarding dealing with all relevant stakeholders around the parity issue. The enforcement authorities and the insurance industry do not distinguish the APA from its district branches and our credibility is tied together.	1. Work with DBs to identify and define the educational materials most needed to proceed on a local basis regarding parity issues. Some of the needed materials have already been identified, e.g., understanding the enforcement scheme under MHPAEA, and will be disseminated at the October state conference. 2. To prepare other materials needed by the DBs 3. To develop educational opportunities for DBs or other state entities such as in-person meetings or webinar/go-to-meeting events 4. Develop a communications strategy to engage and sustain DB activities on parity with the central office.	These activities have been ongoing and there will be scheduled events prior to the May 2016 Annual Meeting.	Part of the above-mentioned work plan.
	c) Release of resource document on disclosure and transparency re MHPAEA compliance with model recommendations for state advocates	A fundamental issue regarding MHPAEA compliance and enforcement is the virtual total lack of disclosure by health plans and insurers on details that would permit evaluation of compliance with the statute. Disclosure is essential to transparency, and without real transparency there can be no assurances that plans have a legitimate basis for their assertions of parity compliance. An extensive resource document on disclosure under MHPAEA has been prepared and will be reviewed by the Council. A series of recommendations with model disclosure requests will be prepared for advocates at the state or individual level (should we link or attach the paper?).	1. Review by Counsel and discussion with staff 2. Approval of recommendations and disclosure templates to be distributed 3. Develop and launch an implementation plan to engage APA affiliates on this important issue.	The bulk of the work has already been done and we will target a launch for winter 2016.	The materials are in development and will be integrated with the above noted work plan.
4) Development of communications/marketing materials that illustrate psychiatry's value proposition for healthcare reform care delivery and payment initiatives		APA has asserted that psychiatry has a direct value proposition of health reform and the many health systems and payers involved. For example, it has produced the Milliman report (title) which illustrates the extent of the behavioral health problem, its total impact, and psychiatry's potential contribution to ameliorate it. The relevance of psychiatry's value proposition varies from audience to audience.	1. CHSF and staff will first survey and inventory the research literature relevant to this as well as materials that have already been developed (such as those from the Academy of Psychosomatic Medicine) 2. Convene a conference call with all necessary parties to develop an appropriate message platform and identify materials for internal and external audiences. This would	The target deadline for these materials would be the 2016 Annual Meeting. Consultation with the Division of Communications will commence as soon as practicable and will include specifics of a work plan timeline to achieve the May target	The new office of practice management will coordinate this effort. A new director is slated to start January 5, 2016.

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		However, we have not effectively communicated this. CHSF will work with the councils on communications and psychosomatic medicine to develop a set of communications/marketing materials and a dissemination strategy.	include materials that would be available to members for use on a local basis. 3. Request that the Council on Communications draft and finalize, with review by CHSF, the needed communications materials 4. Request that the Council on Communications develop a distribution plan for the materials and execute it	deadline.	
5) Pharmacy Benefit Management issues	a) Execute a survey of APA members on current PBM issues, produce a background document on current issues and options for APA advocacy	The presence of PBMs is not new but the tremendous increase in micromanagement of pharmacy requests and the associated time burden is. There are many variations in the types of barriers or hurdles PBMs put in place, from securing approval for on or off-label use, to demanding justifications for why step therapy protocols are not in order or why patients who switch plans should be grandfathered on their effective drugs. The volume of complaints coming from members has increased as has the number of action papers from the Assembly on various aspects of this issue. This problem is not limited to psychiatry. We are aware of many other physician specialties that have voiced similar concerns. The council will explore and potentially recommend a plan of action for resolving this managed care problem.	1. Execution of a member survey on a wide variety of PBM issues to enable better definition and identification of what should be considered priority areas. This will also enable better identification of what if any parity issues may be embedded in current practices. 2. Due diligence with other medical associations and the PBM industry to identify potential collaboration and potential points of intervention. 3. The development of a draft action plan for APA for review and consideration by relevant components and governance. 4. Pending consensus on and action plan, implementation of same.	We expect to complete tasks 1 and 2 shortly. The survey instrument has been finalized and mechanisms for distribution have been worked out. Explorations with other medical societies and key players in the PBM world will begin this fall.	The new office of practice management will coordinate this effort. A new director is slated to start January 5, 2016. Task 1 has been completed and Task 2 is in process.
6) Continued processing of action items referred to the Council with priority attention given to those which fall within the above mentioned categories		CHSF continually receives requests to act on Action Papers and/or Position Statements and other documents. This is an ongoing process and function of the Council. We would note that material triaged to CHSF and timelines assigned should fully consider where a particular matter fits in terms of the APA's priorities.	The Council reviewed several Action Papers referred to it concerning the development of an Access to Care Toolkit. The Council agreed with these Action Papers that such a toolkit would be useful and will begin to develop it with a target date of May 2016. The toolkit will include a compendium of access to care Action Papers and Position Statements as well as an Access to Care Survey, based on one utilized by Area 6, that can be employed by other state associations.		See attachment 7 of the JRC report.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

Updates on JRC/Assembly items from the CHSF are in the last column on the right.

Oct Agenda Item #	Action	Comments/Recommendation	Administration Responsible	Referral/Follow-up/Update (in bold)
8.B.6	Referral Update Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights (JRCOCT148.G.17) The Council on Advocacy and Government Relations discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." Following the May 2015 meeting, the Council moved to form a work group led by Drs. Bailey and Badaracco (Council on Health Care Systems and Financing). DGR staff worked with other council staff liaisons to gather facts on the use of the current Bill of Rights and made inquiries with APA Administration policy staff to best inform deliberation by the work group. The Council members, being advised of the CHSF initial recommendation to retire the paper and the ongoing deliberation by the joint Council work group, voted the following recommendations, while the work group continues their work: a) Retire the position statement (originated 1996, reaffirmed 2007); b) Notify signatories and other components; c) The joint Council work group will review existing APA policies to see if said policies satisfy the need of members with regards to having an organizational statement of a patient's bill of rights. d) Based on their evaluation, the joint Council work group will determine the potential need, recommending whether or not the drafting of a new bill of rights is essential. Contingent on the results of reviewing APA policies and if determined as necessary, the Council instructed the work group to craft a new APA document which would address the rights of patients, revised to reflect developments in law and policy over the past 15 years. Additional members of the Council volunteered to serve on the work group: Drs. Jenny Boyer, Napoleon Higgins, and Morgan Melock (RFM).	The Joint Reference Committee thanked the Council for the update. While the joint council work group deliberates, the JRC thought it best not to retire the position statement. To kick start the functioning of joint work group, the JRC transferred 'ownership' of the work group from the Council on Advocacy and Government Relations to the Council on Healthcare Systems and Financing. A conference call of the work group was requested within the next month. The JRC would like the position statement revised as it would be useful from both a member and advocacy standpoint.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Joint Reference Committee January 2016 (deadline: 1/6/2016) CHSF Member point person: Mary Anne Badaracco Staff will work with Dr. Badaracco and the existing work group from the Council on Advocacy and Govt Relations on the development of a position statement. The CAGR based work group is in the process of revising the draft document which will be sent to the CHSF for review on a future call. We anticipate forwarding this to the JRC in June pending review and approval by CHSF.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

8.G.3	Referral Update Access to Care Related Action Papers Developing an Access to Care Toolkit (ASMMAY1512.C) Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D Access to Care Survey (ASMMAY1512.E) The Council on Healthcare Systems and Financing reviewed the three access to care related items at their September meeting. The Council supported the actions and will incorporate this work into its work plan. It was felt that the survey would provide data that will be necessary to advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will lead the project.	The Joint Reference Committee thanked the Council for the update and noted that the Council on Communications and the Division of Communications should be utilized in the development of a communications plan. The JRC requested that a timeline of the work and communications plans be forwarded to the JRC not later than its January Meeting.	Kristin Kroeger Becky Yowell Jason Young	Joint Reference Committee January 2016 (Deadline: 1/6/2016) CHSF member point person: Joe Mawhinney OHSF staff attended a forum (led by Dr. Mawhinney) held by the Assembly Access to Care Workgroup in November, and Dr. Mawhinney has further defined the scope of work. We have begun to compile the relevant materials. Outreach to the Office of Communications has occurred re the development of a communications plan. Timeline: The timeline will be dependent on the scope of work; we anticipate having a web-presence within the first quarter.
8.G.8	Referral Update Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W) CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar id spent on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.	The Joint Reference Committee thanked the Council for the update and referred the action paper back to the Council for review and feedback. The JRC noted that once approved by the Assembly, the action paper is a product of the Assembly.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Joint Reference Committee January 2016 (Deadline: 1/6/2016) CHSF member point person: Jim Dilley A conference call will be held with Dr. Dilley, APA staff and the action paper author (Jonathan Weker MD) to get a better understanding of the action.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

8.G.9	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by their Physicians (JRCOCT148.G.19) The CHSF was advised of the CAGR recommendation to maintain the existing position statement. A subsequent discussion with CAGR resulted in CAGR endorsing our support for the revised statement. It was reiterated that members of the CHSF thought that the original statement combined too many issues, and lacked clarity for that reason. The Councils on Government Relations and Research support the revised position statement as proposed by the CHSF. The Council on Children has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was needed.	The Joint Reference Committee thanked the Council for the update and looks forward to receiving the proposed position statement on *Patient Access to Treatments Prescribed by their Physicians* once it has been vetted by the Council on Children, Adolescents and Their Families.	Kristin Kroeger Becky Yowell Ranna Parekh, MD, MPH Allison Bondurant	Council on Healthcare Systems and Financing (LEAD) Council on Children, Adolescents and Their Families Joint Reference Committee January 2016 (Deadline: 1/6/2016) CHSF member point people: Sue McLeer and Joe Mawhinney The CHSF has asked the JRC to review and approve the revised position statement at their January meeting. The Council on Children has decided to write a separate position statement encouraging clinical research in child and adolescent psychiatry.
8.G.10	Referral Update (see also 8.B.5) Multiple Co-payments Charged for Single Prescriptions (ASMMAY1412.A) The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's work plan for the next 12 months.	The Joint Reference Committee thanked the Council for the update and requested a timeline for the dissemination of the survey.	Kristin Kroeger Becky Yowell	Report to JRC on timeline by November 25, 2015 CHSF member point person: Larry Miller In lieu of a survey, APA staff have developed a portal to collect information on pharmacy benefit issues via a form on the APA website: http://www.psychiatry.org/psychiatrists/practice/practice-management/pharmacy-benefits-complaints A subsequent work plan will be developed based on the information gathered.

DRAFT SUMMARY OF ACTIONS (Oct 2015 JRC)
Council on Healthcare Systems and Financing (updates as of 12/31/2015)

8.G.11	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers (ASMNOV1412.D) The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers, but also the Indian Health Service, Veterans Administration, and other federal programs. General consensus is that this is an issue in other areas also. CHSF does not think there are any current APA position statements that speak to the issue of compensation. The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back on what kinds of salary income data we are able to discover.	The Joint Reference Committee thanked the Council for the update and requests a progress report and timeline from the Council as part of its report to the JRC in January 2016.	Kristin Kroeger Becky Yowell	Joint Reference Committee January 2016 (Deadline: 1/6/2016) CHSF member point person: Harsh Trivedi APA staff will work with Dr. Trivedi to review the data and move this forward.

Council on International Psychiatry

The Council on International Psychiatry is focused on increasing international membership by working cross-collaboratively with individuals and organizations to identify and develop benefits that support the education and training of psychiatrists inside and outside the United States.

Education & Training

The Council's submission for the 2016 Annual Meeting was accepted by the Scientific Program Committee and will focus on the training of psychiatrists in the United States as global mental health investigators, implementers, and collaborators in order to identify best practices.

> ***Training American Psychiatrists as Global Mental Health Investigators, Implementers and Partners: What Have We Learned That Can Inform Best Practices?***
> Monday, May 16, 2016, 9:00 AM – 10:30 AM
> Georgia World Congress Center, Building A, Level 3, Room A304

The Council is also working with staff to identify other sessions accepted by the Scientific Programs Committee for Atlanta which fall under the topic of "Global Mental Health and International Psychiatry." A preliminary review identified a session by the Advisor to the APA on the United Nations, which now reports to the Council, and by the Arab American Psychiatric Association on the practice of psychiatry in the Middle East and Africa.

Membership

The Council identified several special interest psychiatric organizations operating in the United States, and their current respective leadership, to connect with to identify overlaps in membership and benefits and potential opportunities for collaboration.

- **China**: Association of Chinese American Psychiatrists: Edmond Pi, MD
- **Greece**: Hellenic American Psychiatric Association: Philip J. Candilis, MD
- **Haiti**: Haitian American Psychiatric Association: Frantz Lubin, MD
- **India**: Indo American Psychiatric Association: Ashwin Patkar, MD
- **Iran**: Society of Iranian Psychiatrists in North America: Mohammad Ali Shamie, MD
- **Korea (Republic of)**: Association of Korean American Psychiatrists: Jaesu Han, MD
- **Nigeria**: Nigerian American Psychiatrists Association: Charles C. Dike, MD, MPH
- **Philippines**: Philippine Psychiatrists in America: Maria I. Lapid, MD
- **Turkey**: Turkish American Neuropsychiatric Association: Erol Ucer, MD, Nevzat Tarhan, MD
- **Arab**: Arab American Psychiatric Association: Abdel Amin, MD, MPH
- **Hispanic**: American Society of Hispanic Psychiatry: Mauricio Tohen, MD, DrPH, MBA

It should be noted that many of these organizations typically meet annually during the APA Annual Meeting and several are scheduled to meet in Atlanta. Staff is currently developing a schedule of the

dates, times, and agendas of these organizations' meetings in Atlanta for distribution to Council members.

Referral Update

The Impact of Global Climate Change on Mental Health (ASMMAY1512.L)

The Council forwarded the following feedback to the lead reviewing Council, the Council on Minority Mental Health and Health Disparities, to include in their report to the JRC:

> The Council identified a need for more information on the impact of global climate change on mental health for specific populations, including minority, under-represented and under-served populations. The Council focused on populations residing near geographic areas most impacted by climate change. It was noted that these areas may include island nations and territories (including those in the Caribbean Sea and the Pacific Ocean) and countries with populations residing near Arctic territories (including the U.S. and Canada). Additionally, the Council introduced the consideration of reviewing reports of increased suicide rates in populations residing in areas impacted by climate change, specifically Alaska and the Northwest Territories of Canada.

Position Statements

The Council is continuing to review the following APA position statements to determine if they are in need of updating and whether the APA should reaffirm them as policy or not.

- ***Use of Psychiatric Institutions for the Commitment of Political Dissenters:*** This position statement was last approved by the Board of Trustees and Assembly in 1994.
- ***Identification of Abuse and Misuse of Psychiatry:*** This position statement was last approved by the Board of Trustees in 1998 and was developed by the sunset components the Committee on Abuse and Misuse in Psychiatry in the U.S. and the Committee on the International Abuse of Psychiatry and Psychiatrists.
- ***Abuse and Misuse of Psychiatry:*** This position statement was last approved by the Board of Trustees and Assembly in 1994 and reaffirmed in 2007. It was developed by the following sunset components: Committee on Abuse and Misuse of Psychiatry in the U.S., Council on National Affairs.
- ***Resolution Condemning the Role of Psychiatrist Radovan Karadazic in Human Rights Abuse in the Former Yugoslavia:*** This position statement was last approved by the Board of Trustees in March 1993 and reaffirmed in 2007. It was developed by the following sunset components: Committee on Human Rights, Council on International Affairs.

ATTACHMENT 1: COUNCIL MINUTES – OCTOBER 2015

Council Name: Council on International Psychiatry
Date: October 23, 2015
Time: 4:00 PM – 5:00 PM
Location: Conference Call

Council Members Present: M. Riba, D. Jeste, K. Busch, J. Griffith, E. Pi, U.K. Quang Dang, P. Ruiz, B. Acharya, J. McIntyre, S. Rataemane, E. Sorel, M. Morse, J. Severe, A. Sabur

Council Members with Excused Absences: D. Baron, A. Becker, N. Juthani, S. Okpaku, A. Tasman, G. Raviola, M. Soliman, J. Srinivasaraghavan (Dr. Van), R. Winer, N. Natala, S. Jani, V. Tate, C. White, J. Iluonakhamhe, D. Loo, M. Agbonyitor

Council Members with Unexcused Absences: None

Guests in Attendance: None

Staff in Attendance: R. Juarez

Summary

The Council discussed a proposal for a new caucus and received updates, reports, and announcements from Council members regarding the approval of the 2016 APA Human Rights Award, the World Federation for Mental Health Mental Health Day, the World Association of Social Psychiatry June World Congress.

Minutes

The Council approved the minutes of the September 11, 2015 conference call.

Council Business

Joint Reference Committee (JRC) Update

Dr. Busch provided an update on the Council's report to the JRC which included the approval of Dr. David Satcher to receive the 2016 APA Human Rights Award. The JRC will forward this action to the December Board of Trustees (BOT) for review and approval. Dr. Busch also reported that the JRC inquired as to how often the Council was meeting and what products the Council was producing. Dr. Busch reported that the Council meets monthly via conference calls and that there were several work groups established during the Council's September meeting.

Council Work Group Updates

It was noted that Dr. Pi and Dr. Loo coordinated to develop a list of questions to use when reaching out to the special interest psychiatric groups identified at the Council's September meeting. Staff provided this work group with a template to use to record the contact information for each of the groups.

Proposal for APA Caucus on Positive Psychiatry

Dr. Jeste discussed his proposal for the establishment of a Section on Positive Psychiatry in the World Psychiatric Association (WPA) and a Caucus for Positive Psychiatry in the APA with oversight by the Council on International Psychiatry. Dr. Jeste described an increasing need for this in the APA due to the positive reception received following presentations on the subject at the APA Annual Meeting in Toronto and other meetings which lead to several pages of individuals indicating their desire for the establishment of a component on Positive Psychiatry. It was recommended that Dr. Jeste develop and submit a proposal to Dr. Afzal Javed, WPA Secretary for Sections, to establish a WPA Section and coordinate with APA Staff to develop and submit a proposal for the establishment of a Caucus for review by the JRC and BOT.

Announcements

2015 World Federation for Mental Health (WFMH) Mental Health Day

Dr. Sorel reported that the theme of the 2015 WFMH Mental Health Day was "Dignity and Mental Health" which was also confirmed by Dr. Riba as the WFMH President's them for Dr. Gabriel Ivbijaro.

2016 World Association of Social Psychiatry (WASP) World Congress

Dr. Sorel reported that the June 2016 WASP triennial congress theme is "Social Psychiatry in a Changing World." It is anticipated that 1,000-2,000 people will attend. It was noted that there will be an opportunity for scholarships funds that Dr. Sorel will update the Council with when there is more information. It was also noted that the current WASP President is Dr. Thomas Craig, the President-Elect is Dr. Roy Kallivayalil and the WASP secretariat is located in London. WASP is a member organization for organizations and includes the American Association of Social Psychiatry whose current President is Dr. Andres Pumariega.

USNS Comfort Global Health/MH

Dr. Sorel reported on an event being held by the Washington Psychiatric Society during the October APA Assembly meeting in Washington, DC by Lt. Miguel Alampay, MD regarding his experiences with humanitarian assistance mental health serving on the USNS Comfort

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING REPORT TO THE JOINT REFERENCE COMMITTEE

The Council's purview covers issues affecting the continuum of medical education in psychiatry—from undergraduate medical education to lifelong learning and professional development of practicing physicians. The Council is a convening body for the allied educational organizations, including AADPRT, ADMSEP, AAP and the ABPN.

EXECUTIVE SUMMARY

Since the Council's last report to the JRC, the Council has met twice by phone. The Council is planning several educational activities for the Annual Meeting, including a panel discussion on issues related to faculty development. At the request of the Board of Trustees, the Council has also provided significant input to the Division of Education about the creation of a pilot program that would expand the services offered through the existing CME Joint Sponsorship Program. More information is included below. The Council also provided feedback to Bea Eld, Associate Director for Addiction Psychiatry in Division of Education, about ways in which buprenorphine training can be better incorporated into residency training and discussed ways in which they can support the dissemination of training related to collaborative care and the CMS SANS grant. The Council approved the Vestermark Award winners selected by the Vestermark Award committee and put those names forward to the APAF Board for formal approval. A subcommittee of CMELL fellows who would like to be more involved in medical student recruitment was formed, and they are working with PsychSIGN and the Council on Communications to develop social media items that highlight the diversity of work that psychiatrists engage in on a day to day basis. The Council is currently generating comments regarding the ACGME's proposed changes to the duty hour rules.

Information Items

1. **APA Joint Sponsorship Program Expansion 12-Month Pilot Program** – At the request of the Board of Trustees, the Council provided input on the Division of Education's proposal to expand the Joint Sponsorship Program. The Council discussed this plan in detail during its December conference call. The Council is supportive of this plan and feels that it will enhance the educational benefit provided by the APA. The details of this plan are outlined in the enclosed attachment. The Council will report back to the Board of Trustees with this information during the March 2016 BOT meeting.

ATTACHMENTS:

Attachment 1: APA Joint Sponsorship Program Expansion 12-Month Pilot Program

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APA Joint Sponsorship Program Expansion
12-Month Pilot Program

This document is compiled by the APA Division of Education and the Council on Medical Education and Lifelong Learning (CMELL).

Objective
Joint Sponsorship Program expansion will increase APA's educational offerings by partnering with non-ACCME-accredited district branches and affiliates to develop live and enduring education through Joint Sponsorship.

Goals of the Joint Sponsorship Program
- Acquire additional novel revenue by partnering with affiliates and outside organizations seeking CME accreditation for their educational programs in psychiatry. Additional funds will be used to offset cuts made to the Division of Education's FY2016 budget.
- Engage nonmembers who may be in an affiliate organization or outside organization in the APA Education ecosystem.
- Provide additional avenues for district branches to offer accreditation for their programs.
- Provide added value to education initiatives impacting psychiatry and enhance professional reputations of District Branches and APA Affiliates.
- Utilize the prestige of APA's accreditation with commendation to elevate the mission of advancing mental health, overcoming mental illness and eliminating stigma through Joint Sponsorship relationships.

What is Joint Sponsorship?
Within the framework of the Accreditation Council for Continuing Medical Education (ACCME) requirements, there is an opportunity for ACCME-accredited providers such as the APA to plan and implement CME activities with organizations that are not accredited by ACCME. This approach, called "joint providership," accounts for a sizable portion of the CME conducted annually by ACCME-accredited providers.

What does the current APA Joint Sponsorship offer?

	District Branches	APA Affiliates	Outside Groups*
Live Programs	YES	NO	NO
Online Programs	NO	NO	NO

* Outside groups must meet the requirements noted below.

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What would the proposed APA Joint Sponsorship expansion offer?
CMELL and the APA Division of Education are proposing to the APA Board of Trustees a 12-month pilot program in which the services of the existing Joint Sponsorship Program are expanded. The pilot program would allow for district branches to seek accreditation for up to 20 online activities, up to 10 programs submitted to APA-affiliated organizations and up to five outside programs approved by CMELL.

	District Branches	APA Affiliates	Outside Groups*
Live Programs	YES	YES	YES
Online Programs	YES	YES	YES

* Outside groups must meet the requirements noted below and must be approved by CMELL.

Do district branches and other groups want additional services from the Joint Sponsorship Program?
In December 2015, we surveyed the current members of the Joint Sponsorship (JS) Program to learn if the program is beneficial and to assess if there would be an interest in providing accreditation for enduring activities. Twenty-nine district branches (DBs) participated in the survey. Ninety-six percent of the district branches polled strongly agreed or agreed that the APA Joint Sponsorship Program provided exceptional value. Of the responses, 52% are immediately interested in developing enduring material for CME through the APA Joint Sponsorship Program; 45% voted that they may be interested in the opportunity and would like to know more. Aggregation of the data shows a 95% confidence level in the proposed JS Program expansion.

Additionally, we received high ratings and positive feedback about the current program and strong interest in expanding the program to include online CME activities. Overall, the DBs felt that the JS program “is a core and valued member benefit that offers evidence of value for member recruitment and retention. ... Taking this online elevates that value.” DBs also commented on the growing expense of live CME and the lack of revenue generated from it. It would, therefore, be a valued asset if we were able to provide online educational opportunities.

Are APA accreditation prices competitive?
Yes. Below, you will find examples of APA’s proposed fee structure, which was approved by the Budget and Finance Committee in 2015. Additionally, the Joint Sponsorship fees of other ACCME providers are listed below for comparison. These fees generally exceed APA’s fee structure.

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APA Proposed 2016 Live Activity Fees

CREDITS	APA District Branch (current)	APA District Branch (new)	APA Affiliate	Outside Entity Without Commercial Support
1-3.75	$250	$250	$500	$1,000
4-5.75	$250	$500	$1,000	$2,000
6-7.75	$500	$500	$1,000	$2,000
8-11.75	$500	$750	$1,500	$3,000
12-16	negotiated	negotiated	negotiated	negotiated

APA Proposed 2016 Online Activity Fees

CREDITS	APA District Branch	APA Affiliate	Outside Entity Without Commercial Support
0.25-1	$250	$500	$1,000
1.25-3	$500	$1,000	$2,000
3.25-5	$750	$1,500	$3,000
5+	negotiated	negotiated	negotiated

American Association of Neurological Surgeons

50 attendees and under	$2,300
51 – 100 attendees	$2,500
101 – 200 attendees	$3,000
201+ attendees	$3,250

American Academy of Ophthalmology

Application form	$150 nonrefundable fee
JS fee	$1,000, plus $15 per CME request form

ACCP

100 attendees and under	$1,500
101 – 300	$2,500
300 – 499	$3,000

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NY Medical College

0 – 5 credits	$1,500 + $15 per credit certificate
6 – 9 credits	$2,500 + $15 per credit certificate
10 – 12 credits	$4,000 + $15 per credit certificate

University of Cincinnati

Live activity joint sponsorship for nonprofit entities	$1,500
Per person credit fee (RSS) for societies	$4
Physician reviewer	$150 per hour
Processing UC letter of agreement	$50
Processing commercial entity letter of agreement	$100
LOA rush fee	$50
Processing grant proposals	$100 per grant application

Massachusetts Medical Society

Base fee	$3,000 + additional fees based on “complexity”

Annenberg Center for Health Sciences

Live activity with PPTs and event	$2,800
Multi-day symposium and meetings	$7,000
Online activity with 1 – 3 modules/cases	$2,050
Online activity with 4 – 6 modules/cases	$1,050
Online activity with 7 – 9 module/cases	$1,050
Grant submission fee	$1,000
Certificate fee	$15 per certificate

How were the APA fees determined?

The fees charged to **district branches** represent the amount of staff effort required to process and reconcile an activity. A one- to four-hour live program requires approximately eight hours of staff time to process. Using the standard APA budget estimating template, this translates to $287. Online activities require more review of the content and additional web-related work to host the program. A two-hour online activity requires approximately 16 hours worth of work to process, build, test, deploy and reconcile. This translates to a staff cost of approximately $574.

For **APA affiliates** and **outside organizations**, the Division of Education calculated higher fees. These higher fees represent the additional work required to orient them into the Joint Sponsorship Program and the need to generate additional revenue for the Division of Education. The APA affiliates are still receiving accreditation services below market-rate. Outside organizations would receive rates that are comparable to other accreditors.

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What are the costs associated with running this program?
There are fixed costs associated with being an ACCME accreditor, which cover all accreditation activities. The ACCME does not charge additional fees for APA to offer Joint Sponsorship. There are incremental costs associated with each activity, primarily related to staff hours required to review applications, review materials, set up online registration and evaluations, reconcile program outcomes, and report activity data to the ACCME.

What is the current revenue generated by this program? What is the potential additional revenue from this expansion pilot project?
In 2015, APA generated $18,500 from the Joint Sponsorship program. We do not believe that this amount covers the staff costs associated with covering the program. Program expansion will allow us to bring in additional revenue (at cost to DBs) and some additional margin from affiliate and outside organizations. We have a revenue target of $40,000 in FY2016. Results of the pilot would inform projects for FY2017.

Are DBs required to use APA for accreditation?
No, district branches can continue to use any accreditor they chose. Many district branches have relationships with state medical societies or professional association management companies who can provide CME. District branches can continue to work with them.

Who would be eligible to apply for participation in the additional services provided through the Joint Sponsorship Program during the 12-month pilot expansion?
District branches and APA affiliates would be able to submit a Joint Sponsorship application. During the 12-month pilot, we will approve up to 10 programs from APA affiliates. Outside organizations may also apply, but their applications must be approved by the CMELL. During the 12-month pilot, we will approve up to five programs from outside organizations.

What is involved in becoming a participant in the Joint Sponsorship Program? In the pilot program?
Currently, district branches wishing to participate in the Joint Sponsorship Program must complete the following steps:

1. The district branch completes the Joint Sponsorship application.
2. The Joint Sponsorship application must be approved by CMELL Chair.
3. An APA member from the applying organization commits to serving on the APA. Subcommittee on Joint Sponsorship, a subcommittee of CMELL, and must attend annual Joint Sponsorship meeting/webinars.

4. Joint Sponsorship Program members and staff participate in the planning, implementation and evaluation of any APA jointly sponsored activity.

The process will be similar for all participants in the proposed program expansion.

Who would not be eligible to participate in the expansion pilot?
Organizations who submit programs that are unrelated to psychiatry, neurology and mental health. Outside programs, in which the educational portion of the meeting is funded by commercial support as defined by the ACCME, would also be excluded from this pilot program.

Does the APA education staff have the bandwidth to take on the additional work associated with the expansion pilot?
During the course of the 12-month pilot, the Joint Sponsorship Program expansion will utilize a LEAN process model for streamlining. The pilot will allow us to identify the needs of the DBs, enhance current practices and incorporate continuous improvements into our processes. We would also identify opportunities for streamlining work through online submissions and evaluation collection and reduce staffing effort for processing and reconciling programs. Upon completion of the pilot, we will have developed a formal set of guidelines for managing accreditation for the Joint Sponsorship Program, which will be incorporated within the APA operations manual.

Time-zero (t0) workflow for start of process improvement cycle:

- DB to complete CME proposal form requesting accreditation of educational program
- Internal proposal review
- APA to review faculty paperwork
- DB to develop content
- APA to review content for scientific accuracy, bias or commercial interest
- APA to manage the transfer of content into the LMS
- APA to collect evaluation data and report
- APA to issue certificates through the LMS

How might expansion of the Joint Sponsorship Program impact our accreditation status?
The APA has obtained ACCME Accreditation with Commendation status because it has been able to demonstrate superior competence in its ability to manage programs in a compliant fashion. With the implementation of new technologies and program management workflows that provide considerable checks and balances, the downside to the program expansion is unsubstantial.

Additionally, as we look toward our next ACCME audit, a consideration of commendation status includes new initiatives an organization has undertaken that enhance the overall value of medical education. Expansion of the Joint Sponsorship Program in a manner consistent with the objective noted above increases our chances of being awarded commendation in future ACCME reviews, particularly as we engage new groups and new types of learners.

Who will provides oversight of this pilot program?
The APA Subcommittee on Joint Sponsorship and the Council on Medical Education and Lifelong Learning both oversee the Joint Sponsorship program. They receive updates during face-to-face meetings on the status of the program. ACCME compliance and implementation is maintained by APA staff. CMELL, the Subcommittee on Joint Sponsorship and APA staff will work together to evaluate this expansion pilot. Program submissions of questionable integrity can be reviewed and rejected by APA staff and CMELL.

What are some sample scenarios that would be allowed (and not allowed) under this pilot project?

Scenario 1: The Minnesota District Branch has an interest in expanding their live meeting content into the development of interactive online presentations and case vignettes. Would they be eligible to participate in this pilot?

> Answer: The Minnesota DB is already part of the Joint Sponsorship Program, and APA has accredited a number of their live activities. In this pilot project, their online activity would be eligible for accreditation.

Scenario 2: The Indian Psychiatric Association (IPA) is interested in providing a four-hour educational program for its members attending the APA Annual Meeting.

> Answer: Currently, the IPA is not eligible for accreditation because they are not a district branch. In this pilot program, their activity would be eligible for accreditation as long as it is not commercially funded.

Scenario 3: The Center for Health Care Services Texas, a federally funded quality improvement organization (QIO), has an interest in developing education for family physicians around the collaborative care impact model. The program would be a live activity with no commercial funding. The course director is a psychiatrist and an APA member.

> Answer: This program would be eligible to participate in the JS Program pending approval by CMELL and completion of the Joint Sponsorship application.

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Arlington, VA 22209

Scenario 4: A mental health study section at the United Nations is seeking accreditation for a four-hour symposium with no commercial support, which they are hosting for physicians. The course director is a psychiatrist and APA member.

> Answer: This program would be eligible to participate in the JS Program pending approval by CMELL and completion of the Joint Sponsorship application.

Scenario 5: The Oncological Nursing Society (ONS) is interested in developing a series of case vignettes on breast cancer prevention and detection. The course director is an RN. There is no mental health content in this program.

> Answer: ONS would not be eligible to participate in the JS program, as the course director is not an APA member and the topic does not align with APA's educational mission.

What input has the Council on Medical Education and Lifelong Learning provided?
CMELL discussed this proposal in detail during its December 2015 conference call. They have endorsed the proposal as noted above.

***

Proposed BOT Resolution for the March 2016 meeting:
Will the APA Board of Trustees approve a 12-month pilot expansion of the Joint Sponsorship Program that will allow for the addition of

- Up to 20 online programs
- Up to 10 affiliate programs
- Up to five outside programs approved by CMELL

Executive Summary
Council on Minority Mental Health and Health Disparities

Council Overview

The Council has the responsibility for the representation of and advocacy for both minority and underserved populations and psychiatrists from minority and underrepresented groups. The Council seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. The Council aims to increase awareness and understanding of cultural diversity and to foster the development of attitudes, knowledge, and skills in the areas of cultural competence through consultation, education, and advocacy within both the APA and the field of psychiatry and public policy. The Council aims to promote the recruitment into the profession and into the APA and retention/leadership development of psychiatrists from minority and underrepresented groups both within the profession and in the APA.

Action Items

None

JRC Referrals

1. **Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault** (ASMMAY 1512.H). Update. The council's Work Group on Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault held conference calls on October 20 and November 17. The work group is currently conducting a literature review and is researching nationwide protocols and requirements for mental health care to victims, roadblocks to access to care, funding issues, and legislation related to sexual assault. A draft rape resource document, prepared by work group chairperson Dr. De Faria, was completed. Because the Council on Psychiatry and Law felt that the documents needed additional work (more references and focus on psychiatry), it is now re-circulating among work group members for editing and expansion.

2. **Impact of Global Climate Change on Mental Health** (ASMMAY 1512.L). Please refer to Attachment A for the council's referral update.

Information

1. Dr. Amanda Ruiz, chairperson of the council's work group on at-risk youth, joined the November 30 conference call of the counterpart work group from the Council on Children, Adolescents, and Their Families. The two groups are working jointly to develop initiatives. At present, focus is on determining the specific subgroups of vulnerable kids work group efforts will address. In consideration are immigrant children/teens, transitional age groups, or trafficked youth. Diagnosis groups are a possibility as well.

Attachments

1. November 19 conference call minutes (Attachment B)
2. Yearly assessment report (Attachment C)

ATTACHMENT A

Work Group on The Impact of Global Climate Change on Mental Health
Nyapati Rao, MD, MS, Chairperson
Progress Report
January 2016

WORK GROUP MEMBERS:
Nyapati Rao, MD, MD (chairperson), Debbie Carter, MD, Puneet Sahota, MD (fellow), Pamela Montano, MD (fellow). In November, Dr. Felix Torres was appointed as a member of the council and has joined the work group. Dr. Torres is the co-paper of the action paper on The Impact of Global Climate Change on Mental Health. The work group was tasked to advise whether or not APA should develop a position statement on the issue.

LITERATURE REVIEW:
Dr. Rao distributed to the council his recent publication that described the destruction caused by Hurricane Sandy and its aftermath [Rao, N., & Mehra, A. (2015). Hurricane Sandy: Shared Trauma and Therapist Self-Disclosure. *Psychiatry*, *78*(1), 65-74] . In addition, the work group also examined bibliographies and references, including the American Psychological Association's position statements that address the psychological ramifications of climate change.

CONSULTATIONS:
- Dr. Ranna Parekh and Alison Bondurant helped the work group move forward by recommending that it consult with a group of psychiatrists and APA members from around the country who are also deeply interested in the psychological effects of climate change, an in particular, the impact upon underserved minority populations (Drs. Lise Van Susteren, James Recht, Elizabeth Haase, Gregory Fricchione,, and David Henderson). On December 14 these psychiatrists along with Drs . Rao and Torres participated in a conference call. Dr. Parekh and Ms. Bondurant also attended. Discussion included various perspectives, essential elements of a position statement, and the need for member and public education. The group will continue discussion at a later date.

- Dr. Rao and Ms. Bondurant had a phone conversation with Dr. Robin Cooper, an APA member and psychiatrist from San Francisco with interest in this area. Dr. Rao proposed that the APA work group consider a workshop or symposium at an appropriate meeting. Dr. Cooper subsequently distributed a literature review on psychiatric aspects of climate change and its impact on underserved minority populations, as well as a list of organizations that have developed position statements on this topic.

- Dr. Rao had a fortuitous meeting at the Group for the Advancement of Psychiatry meeting in White Plains, NY, with Dr. Elizabeth Haase, who is a film producer. She discussed her work in making films on climate disasters including the documentary "And Then the Climate Changed" (2016). She looks forward to contributing her ideas to the APA effort.

RECOMMENDATION:
The council work group recommends that APA produce a position statement on the psychiatric impact of climate change. The Committee of Psychiatric Dimensions of Disaster would be the appropriate component to write the document in view of its expertise. The council will be glad to be

a contributor with literature on the particularly inequitable impact of climate change on minority populations.

Feedback from the Council on International Psychiatry

The Council identified a need for more information on the impact of global climate change on mental health for specific populations, including minority, under-represented and under-served populations. The Council focused on populations residing near geographic areas most impacted by climate change. It was noted that these areas may include island nations and territories (including those in the Caribbean Sea and the Pacific Ocean) and countries with populations residing near Arctic territories (including the U.S. and Canada). Additionally, the Council introduced the consideration of reviewing reports of increased suicide rates in populations residing in areas impacted by climate change, specifically Alaska and the Northwest Territories of Canada.

Feedback from the Committee on Psychiatric Dimensions of Disaster

The Committee recognizes an increase in the rates of mental disorders following public health emergencies related to extreme weather events and natural disasters. The Committee also notes that such extreme weather events and natural disasters are resulting effects of climate change and disproportionately affect minority and disadvantaged populations.

In a 2015 draft report, ***The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment***, presented for public comment by the U.S. Global Change Research Program (USGCRP), a multi-agency coordinating body for federal climate change research, a chapter on "Mental Health and Well-Being" was included with contributions from APA members Robert Ursano, MD and Joshua Morganstein, MD of the Uniformed Services University of the Health Sciences. The report highlights the following four key findings:

1) **Mental Health Consequences of Exposure to Disasters:** "Many people exposed to climate-related disasters experience stress and serious mental health consequences."
2) **Specific Groups of People Are at Higher Risk:** "These groups include children, the elderly, and women (especially pregnant and post-partum women), people with pre-existing mental illness, low-income persons, first-responders, and people who are homeless."
3) **The Threat of Climate Change:** "The threat of climate change, the perceived direct experience of climate change, and changes to one's local environment can result in substantial adverse mental health outcomes and social impacts for the American public."
4) **Extreme Heat May Increase Risks for People with Mental Illness:** "People with mental illness, especially those who take certain prescription medications to treat their illnesses, are at higher risk for poor physical and mental health due to extreme heat."

The final report is expected to be released in early 2016 and presented to the President and Congress through the Office of Science and Technology Policy.

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ATTACHMENT B

Council on Minority Mental Health and Health Disparities
November 19, 2015, Conference Call
MINUTES

Present: Drs. Mangurian (chairperson), DeFaria, Lu, Vito, Akerele, Castillo. Fellows: Drs. Dominguez and Montano. **Administration:** Alison Bondurant
Excused: Drs. Williams, Benton, Hankerson, Rao, Torres, Walker, and Carter. Fellow: Dr. Pahota, Gajaria
Unexcused: Drs. Hansen, Graves; Fellows: Drs. Douglas, Taylor, Petersen, Strawn, Moore, Reid, Simpson

- The call began at noon Eastern.
- Dr. Mangurian extended gratitude to Dr. Lu for substituting for her while she was on leave.
- Dr. Mangurian announced that Dr. DeFaria's tenure as Assembly liaison to the council has ended now that she is no longer an Assembly member. Dr. DeFaria will remain on the work group on the care of victims of sexual abuse.
- **Tracking spreadsheet.** Dr. Mangurian noted that she and Ms. Bondurant created a spreadsheet to record council activities, project assignments, and members' and fellows' attendance at meetings and on conference calls. This document will serve as a good tracking tool for making status reports to the JRC and ensuring that fellows are getting involved.
- **Work groups.**
  - Ms. Bondurant offered to send conference call numbers to workgroup chairpersons to schedule calls as needed. Ms. Bondurant also recommended that they advise her in advance when calls are scheduled.
  - Ms. Bondurant pointed out that some fellows have volunteered for several work groups and may be overcommitting themselves. As such, work group chairpersons were requested to make note of fellows' participation and to give them opportunity to resign if their participation is lacking. The callers ultimately thought it best to allow fellows to participate in only one work group. Dr. Mangurian and Ms. Bondurant resolved to develop guidelines/expectations for fellows.
  - Dr. DeFaria reported that the work group on care to victims of sexual abuse met by conference call last month and will forward the minutes to Ms. Bondurant. The work group continues to collect data, and Dr. DeFaria has connected with Dr. Grayson Norquist, chairperson of the Council on Quality Care.
  - Dr. Vito mentioned that Dr. Carter, chairperson of the council's telepsychiatry subcommittee, had reached out to Dr. Shore, who leads the Board's work group on telepsychiatry. He will follow up with Dr. Carter. {NB: Dr. Carter reported later than Dr. Shore would join a work group conference call.]
  - Dr. Lu indicated that he will convene the work group on recruitment soon.
  - Dr. Dominguez highlighted his recent discussion with Drs. Williams and Parekh and Ms. Bondurant about the action paper asking APA to investigate how to provide training for psychiatrists to deliver interventions to traumatized African-American communities. He stressed

the need for a curriculum in this regard for residents and that training should be tailored not just for psychiatrists but for other providers and community organizers as well. Education material may include toolkits, webinars and other technological platforms.

- Dr. Mangurian reminded work group chairpersons to submit updates in early December.

- **Assessment of position statements**. Dr. Lu reported he is working with volunteers from the council on the diversity and affirmative action position statements. It was suggested that Dr. Rao take the lead on IMG-related statements and that Dr. Hankerson evaluate the position statement on religion. Dr. Mangurian resolved to assign individuals to review position statements if need be..
- **Annual Meeting.** Ms. Bondurant mentioned that the May council meeting might need to be rescheduled if it were to conflict with Diversity Conversations. She also reported that five council-endorsed sessions were accepted for the May scientific program.
- **Next call.** A conference call will be scheduled for January.

ATTACHMENT C

Yearly Assessment
Council on Minority Mental Health and Health Disparities
January 2016

Top 3 activities from the previous year

1. Christina Mangurian, MD, represented APA and the council at the White House/Office of Science and Technology Policy *Forum on Excellence and Innovation through Diversity in the STEM Workforce* in DC in June 2015.
2. Council organizational overhaul
   a. Regular conference calls
   b. Development and regular maintenance of an accountability spreadsheet that tracks council activities/due dates, member/fellow assignments, and member/fellow attendance (**Attachment X**)
   c. Formal delegation of Council position statements in need of review to members/fellows (**Attachment Y**)
3. Council workgroups on specific areas: 1) Telepsychiatry (related to disadvantage populations), 2) At-risk kids/juvenile justice (a collaboration with the Council on Children, Adolescents and Their Families), 3) Recruitment/retention of MUR members, 4) Improving support of mental health of traumatized communities; and 5) Removing barriers to providing compassionate care to victims of sexual assault

Tangible work products

1. Updated the position statement on *Bias-Related Incidents;* passed by the Board
2. 2015 Annual Meeting media sessions and discussions on the 2014 film *The Hundred-Foot Journey* and *Can: A Vietnamese-American's First-Person Account of Bipolar Disorder and the Path toward Recovery*
3. Submission of eights 2016 Annual Meeting sessions proposals, five were accepted:
   - The Context of Psychosis: Cultural Curiosity and Enhanced Clinical Care
   - Standing up to Violence in Police Encounters: The Players, the Victims, the Trauma and the Solutions
   - Infectious Disease/Psychiatry HIV Collaborative Care: An Innovative Model for Person-Centered Care for the Southern Underserved
   - Not Just National News: Can Multiple Isolated Incidents of Racially or Ethnically-Motivated Violence Traumatize the Larger Minority Group?
   - Integrating Sociocultural Perspectives of Postpartum Depression Among Diverse Women Improves Care
4. Development and regular maintenance of an accountability spreadsheet that tracks council activities/due dates, member/fellow assignments, and member/fellow attendance (**Attachment X**)
5. Formal delegation of the assessment of position statements in need of review to members/fellows (**Attachment Y**)

Work priorities for the coming year

1. Establish formal linkages with the seven Assembly MUR Caucuses
2. Develop tangible work products from the various work groups (noted above)
3. Integrate concepts /ideas from the White House event (described above) into the 2016 council work plan

Assess the participation of Council members (14 members/consultants; 11 fellows)

1. September meeting: 85% of members/consultants; 91% of the assigned fellows
2. 8/13 conference call: 77% of members/consultants; 64% of the assigned fellows
3. 11/19 conference call: 43% of members/consultants; 18% of the assigned fellows

Mentoring of RFM/ECP members

1. Reviewed and critiqued fellows' session proposals for the 2016 Annual Meeting session
2. Paired fellows and members for position statements review
3. At the September meeting fellows were strategically seated next to a council member with shared interests based on a demographic survey council members and fellows completed in advance

Council charge

The Council on Minority Mental Health and Health Disparities is charged with the following: The Council has the responsibility for the representation of and advocacy for both minority and underserved populations and psychiatrists from minority and underrepresented groups. The council seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. The council aims to increase awareness and understanding of cultural diversity* and to foster the development of attitudes, knowledge, and skills in the areas of cultural competence through consultation, education, and advocacy within both the APA and the field of psychiatry** and public policy. The council aims to promote the recruitment into the profession and into the APA and retention/leadership development of psychiatrists from minority and underrepresented groups both within the profession and in the APA. The council has the responsibility for selection of persons for the following awards subject to the APA approval process: Kun-Po Soo, Solomon Fuller Carter, Fryer, Simon Bolivar, Alexandra Symonds, and Tarjan. The Council will constitute workgroups of members to implement its charge.

From the 1999 APA Position Statement on Diversity:
**"Cultural diversity includes issues of race, sex, language, age, country of origin, sexual orientation, religious/spiritual beliefs, social class, and physical disability."*
***Defined as "including in undergraduate and graduate medical*

Attachment X - APA Council on Minority Mental Health and
Health Disparities Accountability Spreadsheet
January 2016

				BENTON, Brian	CARTER, Debbie
				Member	Member
Area	Details	Deadline	Status		
Meetings	Conference call 8/13 (make ups 8/25 & 8/27)	N/A	Completed	Yes	Yes
Meetings	September Components 9/15	N/A	Completed	No	Yes
Meetings	Conference call 11/19	N/A	Completed	Excused	Excused
Meetings	Conference call 1/16	N/A	Planned		
Meetings	Conference call 3/16	N/A	Planned		
Meetings	APA Annual Meeting 5/16/15, 9am - noon, Atlanta, Georgia	N/A	Planned		
Position Statement	Affirmative Action	5/16/2016	In process		
Position Statement	Diversity	5/16/2016	In process		
Position Statement	US military policy - Don't Ask, Don't Tell	5/16/2016			
Position Statement	Domestic Violence	5/16/2016			
Position Statement	Prevention of Violence	5/16/2016			
Position Statement	Domestic Violence Against Women	5/16/2016			
Position Statement	Violence in America	5/16/2016			
Position Statement	Resolution Against Racism and Racial Discrimination/Adverse Impact on MH	5/16/2016			
Position Statement	Discrimination Against IMGs	5/16/2016			
Position Statement	Religious Persecution and Genocide	5/16/2016			
Position Statement	Psychiatrists from Underrepresented Groups in Leadership Positions	5/16/2016			
Position Statement	Resolution Opposing Restriction on the Number of IMGs Entering GME Training	5/16/2016			
Position Statement	Discrimination Against Persons with Previous Psychiatric Treatment	5/16/2016			
Position Statement	Abortion	5/16/2016			
Action Paper	Removing barriers to providing compassionate care to victims of sexual assault	12/21/15*	In process		
Action Paper	Impact of Climate Change	12/21/15**	In process		Member
APA 2016 presentations	Various (topic members/chairs specified)		to be completed		
Technical Assistance	APA Annual Meeting sessions	5/1/2016	In process		
Work-group	At risk youth for judicial system	?	In process		
Work-group	Recruitment/retention of URM	?	In process		
Work-group	Telepsychiatry with MUR	?	In process		Chair
Work-group	Improving Support of Mental Health of AA Males	?	In process		
Caucus Liaison	Specific Cacus liaison identified with each member	?	Planned		
JRC Report	January JRC Report with 2015 Council Assessment Form	1/6/2016	In process		
JRC Report	June JRC Report	6/1/2016			
JRC Report	October JRC Report	10/1/2016			
Assembly Report	May Assembly Report	4/1/2016			
Assembly Report	November Assembly Report	10/1/2016			
AJP Report	Summary of 2016 council activities for Amer Journal of Psychiatry	9/1/2016			

*submit council recommendation on the feasibility of a position statement on the subject
**submit council's rationale for a position statement on the subject & any other related considerations; include comments from Disasters Committee & Council on Communications

APA Council on Minority Mental Health and Health Disparities
Accountability Spreadsheet
January 2016

CASTILLO, Enrico	EVARISTO, Akerele	GRAVES, Amanda Ruiz	HANKERSON, Sidney	HANSEN, Helena	LU, Francis	MANGURIAN, Christina (Chair)
Member	Consultant	Member	Member	Member	Member	Member
Yes	Yes	Yes	No (excused, conflict)	Yes	Yes	No (med leave)
Yes	Yes	Yes	Yes	Yes	Yes	No (med leave)
Yes	Yes	No	Excused	No	Yes	Yes
				Member	Chair	
				Member	Chair	
			Member			
			Member			
					Member	
		Chair				
Member	Member		Member		Chair	member
			Member	Member		

APA Council on Minority Mental Health and Health Disparities
Accountability Spreadsheet
January 2016

PI, Ed Corr Member	RAO, Nyapati Member	TORRES, Felix (member; appted Nov)	VITO, Jose Member	WALKER, Sandy Consultant	WILLIAMS, Donald Member	DOMINGUEZ, Matthew Fellow
No	No (excused, conflict)		Yes	Yes	Yes	
Yes	Yes		Yes	Yes	Yes	Yes
No	Excused	Excused	Yes	Excused	Excused	Yes
				Member	Member	
	Member					
	Member					
	Chair	Member				
			Member			Member
				Member	Co-chair	Co-chair

APA Council on Minority Mental Health and Health Disparities
Accountability Spreadsheet
January 2016

DOUGLAS, Lauren (fellow)	GAJARIA, Amy (fellow)	MEADOWS, Travis (fellow)	MONTANO, Pam (fellow)	MOORE, Jessica (Fellow)	REID, Racquel	PETERSON, Daena (fellow)
Fellow	Fellow	Fellow	Fellow	Fellow	Fellow	Fellow
Yes	Yes	Yes		Yes		Yes
Yes	No (wedding)	Yes	Yes	Yes	Yes	Yes
No	Excused	No	Yes	No	No	No
		Member				
		Member				
Member	Member					
	Member					
	member					
Member			Member		Member	Member
			Member			
Member				Member	Member	
			Member			
		Member	Member	Member		

APA Council on Minority Mental Health and Health Disparities
Accountability Spreadsheet
January 2016

SAHOTA, Puneet (Fellow)	SIMPSON, Annabelle (Fellow)	TAYLOR, Jared (fellow)
Fellow	Fellow	Fellow
Yes		Yes
Yes	Yes	Yes
Excused	No	No
Member		
Member		
member		
Member		
Member	Member	
	Member	Member

STATUS OF POSITION STATEMENTS
As of May 2015

Position Statements in need of review and assignments

YEAR APPROVED	YEAR TO BE REVIEWED	POSITION STATEMENT Policy Statement	CURRENT STATUS	REVIEWING/ Originating COUNCIL	APPROVALS	Requests	Christina's best guess (member)	Christina's best guess (fellow)
2009	2014	US Military policy of Don't Ask Don't Tell	ACTIVE	Minority Mental Health and Health Disparities	BOT Approved Dec 2009; ASM Approved Nov 2009		Jose Vito	Pam Montano
2007 (Retained 2001 PS)	2012	Domestic Violence	ACTIVE	Minority Mental Health and Health Disparities	NONE - PS RETAINED 2007		Helena Hansen	Jessica Moore
2007 (Retained 2001 PS)	2012	Prevention of Violence	ACTIVE	Minority Mental Health and Health Disparities	NONE - PS RETAINED 2007	P. Sahota	Brian Benton	
2007 (Retained 1993 PS)	2012	Domestic Violence Against Women	ACTIVE	Minority Mental Health and Health Disparities	NONE - PS RETAINED 2007		Helena Hansen	Jessica Moore
2007 (Retained 2000 PS)	2012	Violence in America can and must be prevented: A call for action from medicine, nursing and public health	ACTIVE	Minority Mental Health and Health Disparities	NONE - PS RETAINED 2007	A. Gajiria, P. Sahota	Sandra Walker	
2006	2011	Resolution against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health	ACTIVE	Minority Mental Health and Health Disparities	BOT APPROVED - July 2006	S. Walker, A. Gajiria, D. Williams, S. Hankeron		
2001		Discrimination against International Medical Graduates	ACTIVE	Minority Mental Health and Health Disparities		Nyapati Rao		P. Sahota
1999		Diversity	Active	Minority Mental Health and Health Disparities		Fr. Lu, H. Hansen, T. Meadows		
1997		Religious Persecution and Genocide	ACTIVE	Minority Mental Health and Health Disparities		P. Sahota, A. Gajiria, S. Hankerson		
1994		Psychiatrists from Underrepresented Groups in Leadership Roles	ACTIVE	Minority Mental Health and Health Disparities			Christina Mangurian	Amy Gajaria
1994		Resolution Opposing Any Restriction on the Number of IMG's Entering Graduate Medical Training	ACTIVE	Minority Mental Health and Health Disparities		Nyapati Rao		P. Sahota
1977		Abortion	Active	Minority Mental Health and Health Disparities			Akerele Evaristo	Anabella Simpson
1977		Affirmative Action	Active	Minority Mental Health and Health Disparities		F. Lu, H. Hansen, T. Meadows		
1977		Discrimination Against Persons with Previous Psychiatric Treatment	Active	Minority Mental Health and Health Disparities			Amanda Ruiz	Daena Peterson

COUNCIL ON PSYCHIATRY AND LAW

EXECUTIVE SUMMARY:
The Council on Psychiatry and Law has continued its work evaluating legal developments of national significance, proposed legislation, regulations, and other government intervention that affect the practice of psychiatry, including the subspecialty of forensic psychiatry.

1. **ACTION: PROPOSED POSITION PAPER ON COLLEGE AND UNIVERSITY MENTAL HEALTH**
   The Council on Psychiatry and Law has developed a position statement on College and University Mental Health. (Attachment #1)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed position statement "College and University Mental Health"?

2. **ACTION: PROPOSED RESOURCE DOCUMENT ON COLLEGE MENTAL HEALTH AND CONFIDENTIALITY**
   The Council on Psychiatry and Law has developed a resource document on College Mental Health and Confidentiality. (Attachment #2)

   Will the Joint Reference Committee approve the request of the Council to approve the resource document on "College Mental Health and Confidentiality"?

Informational Item:

1. **JRC REFERRAL: LOCATION OF CIVIL COMMITMENT**
   The Civil Commitment Workgroup, chaired by Dr. Elizabeth Ford, has had many email discussions and a conference call. The workgroup has reached out to the author of the action paper for clarification and is now currently working on a draft position paper. A draft copy will be sent to the JRC for review in June.

2. **PHYSICIAN ASSISTANCE WITH DYING WORKGROUP**
   After their joint meeting with the Committee on Judicial Action, Council on Geriatrics, and the Ethics Committee, the Council on Psychiatry and Law created a workgroup on Physician Assistance with Dying. The workgroup has been meeting by conference call and is currently reviewing requests from District Branches and collecting information.

3. **RESTRICTIVE HOUSING STANDARDS**
   At the request of APA President Renée Binder, the Council on Psychiatry and Law reviewed and drafted comments on new American Correctional Association restrictive housing standards. For the first time the proposed standards addressed exclusion from isolation for serious mental illness. APA submitted comment during the week of January 4.

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

* This Position Statement replaces the 2005 statement by the same name

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.

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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APA Council on Psychiatry and Law

Resource Document on College Mental Health and Confidentiality

Approved by Council on Psychiatry and Law, September 12, 2015*

College homicides and suicides often precipitate reviews of regulations, statutes and case law governing treatment and confidentiality.[1] In April 2007, for example, a college senior at Virginia Polytechnic Institute and State University killed 32 students and faculty, wounded many others and then killed himself. The review panel appointed by the Governor found significant confusion among university officials about the Family Educational Rights and Privacy Act (FERPA),[2] the federal law governing confidentiality of educational records, leaving them uncertain about what information could be revealed to each other as well as to the student's parents.[3] Psychiatrists seeing students as patients in college settings, either as employees of student mental health services or as private practitioners in the community, have also been confused as to their relationship to the university and the effect of federal and state laws governing confidentiality. This resource document was prepared to give practitioners a guide to providing good clinical care within the framework of relevant law.

I. Clinical Background

College students experience a variety of mental health concerns ranging from anxiety, depression, eating disorders, alcohol and substance abuse to the emergence of psychotic

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* Prepared for the Council on Psychiatry and Law by the Council's Work Group on College Mental Health: Richard J. Bonnie, Vivek Datta, Carl Fisher, Wun Kim, Debra Pinals, Victor Schwartz and Howard Zonana. This replaces the Resource Document of the same name approved by the Council in 2009.

[1] Student Mental Health and the Law, A Resource for Institutions of Higher Education- published by the Jed Foundation 2008 http://www.jedfoundation.org/assets/Programs/Program_downloads/StudentMentalHealth_Law_2008.pdf This publication presents an overview of disability law and how schools should deliver mental health services including referrals, peer counseling supervision and peer hotlines. See also Campus Mental Health- Know Your Rights, A guide for students who want to seek help for mental or emotional distress by the Judge David Bazelon Center for Mental Health Law, 2008. See http://www.bazelon.org/l21/YourMind-YourRights.pdf

[2] 20 U.S.C. § 1232g. The pertinent provisions of FERPA and implementing regulations issued by the Department of Education are reproduced in Appendix A.

[3] Virginia Tech Review Panel, "Mass Shootings at Virginia Tech April 16, 2007: Report of the Review Panel," August 2007, http://www.vtreviewpanel.org/report/index.html (accessed 2 February 09).

disorders such as bipolar disorder and schizophrenia. Colleges and universities enrolled about 21 million students in the fall of 2014, with an estimated 85% enrolled in undergraduate programs.[4] Surveys of 94,197 students from 168 campuses participating in the Spring 2014 ACHA National College Health Assessment revealed that 12% reported a diagnosis of or treatment for depression within the past year while 14.3% reported a diagnosis of or treatment for anxiety in the past year. Of the surveyed students, 32.6% said they "felt so depressed it was difficult to function", 54% felt overwhelming anxiety and 8.1%% said they "seriously considered suicide" within the prior twelve month period. [5]

Although violence towards others was prominent in the Virginia Tech case, such violence is much less common on college campuses than suicide. Suicide is the second leading cause of death among American college students.[6] Research indicates that young adults (ages twenty to twenty-four) are more likely to commit suicide than are adolescents (ages fifteen to nineteen). Males in each of these age groups are more likely to die from suicide attempts than females.

Each year approximately 1500 college students commit suicide.[7] The majority of these students are not receiving mental health treatment at the time of their deaths. College students, however, are about half as likely to kill themselves as their age-matched peers in the community. Campus prohibitions against firearms contribute to this lower rate.[8] Instead of using firearms, "students who commit suicide [in college] are

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[4] National Center for Education Statistics "Back to school statistics - Fast Facts," nces.ed.gov/fastfacts/display.asp?id

[5] American College Health Association-National College Health Assessment Spring 2014 Reference Group Data Report(Abridged).

[6] http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2014.pdf. Because of drop in rates of homicide among non-college attending 15-25 year olds, suicide is now 2nd leading cause of death in general (both college and non-college attenders).

[7] Suicide Prevention Resource Center: Promoting Mental Health and Preventing Suicide in College and University Settings. Newton, Mass, Education Development Center, 2004 and the Jed Foundation, http://www.jedfoundation.org/
The Jed Foundation was founded in 2000 by the family of Jed Satow, who committed suicide as a college sophomore. See also Paul Joffe, An Empirically Supported Program to Prevent Suicide Among a College Population 1 (2003), available at http://www.jedfoundation.org/articles/joffeuniversityofillinoisprogram.pdf. The estimated rates of suicide are still about 6.5-7.5/100,000/year. This estimate has increased because the number of higher ed students has increased.

[8] American Association of State Colleges and Universities, A Higher Education Policy Brief (November 2008): Concealed Weapons on State College Campuses: In Pursuit of

more likely to hang themselves, jump from unprotected buildings or ingest lethal chemicals commonly found in campus labs." Less than twenty percent of college students who commit suicide ever seek help from college counseling centers.

Since 1981, data have been compiled from directors of college counseling centers across the United States and Canada to determine trends in student counseling. According to the 2014 National Survey of Counseling Center Directors, which surveyed 275 colleges and universities across the United States and Canada, 58% of colleges offered psychiatric services on campus, often with insufficient psychiatric consultation time. Eleven percent of college students (363,000) sought counseling in 2014. Twenty-six percent of student-patients were taking psychotropic medications, which was up from 20% in 2003, 17% in 2000, and 9% in 1994. Counseling center directors reported that nearly 52% of their patients had severe psychological problems and 8% had impairment so serious that they could not remain in school or required extensive mental health treatment. In 2014, 4950 students in this survey (a rate of 1.5 hospitalizations for each 1000 students covered in survey) were hospitalized for mental health reasons.[9]

It is unclear whether the number of students seeking treatment is rising because the incidence of mental health problems among college students is rising or because more students are willing to talk about their problems and seek counseling. However, a recent study[10] in which college students and their non-college attending peers were interviewed found that almost 50% of college-aged individuals and their non-college attending peers had met DSM-IV criteria for a psychiatric disorder within the past year. The most common disorders in college students were alcohol use disorders and personality disorders. Moreover, the highest rates for treatment-seeking in the previous year were reported for mood disorders, whereas the lowest rates were for alcohol disorders.

II. Transition Needs of Young Adults

College students are young adults in transition, a discrete group with specific developmental needs distinguishable from those of adolescents and older adults. An important report by Institute of Medicine & National Research Council, *Investing in the Health and Well-Being of Young Adults* (2014), emphasized that young adulthood is a more hazardous period of the life course than is generally recognized. Moreover, even though young adults are at high risk of developing serious physical and mental health conditions (e.g., obesity/eating disorders, mood and addictive disorders) and have high

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Individual Liberty and Collective Security by Thomas L. Harnisch.

[9] See Gallagher, RP, Nat'l Survey of Counseling Center Directors 2008, http://www.iacsinc.org/2008%20National%20Survey%20of%20Counseling%20Center%20Directors.pdf.

[10] Blanco C, Okuda M, Wright C et al. Mental Health of College Students and Their Non-College-Attending Peers. Arch Gen Psychiatry 2008:65 (12): 1429-1437.

rates of suicide and violence, systems of care for this population are fragmented and ill-prepared to respond to their needs:

> "The transition from child to adult medical and behavioral health care often is associated with poor outcomes among young adults. Challenges include discontinuities in care, differences between the child/adolescent and adult health systems, a lack of available adult providers, difficulties in breaking the bond with pediatric providers, lack of payment for transition support, a lack of training in childhood-onset conditions among adult providers, the failure of pediatric providers to prepare adolescents for an adult model of care, and a lack of communication between pediatric and adult providers and systems of care" (p 219)

Transitioning from high school to college with a psychiatric diagnosis can be an especially challenging task. Psychiatrists treating youth entering college should take proactive efforts to facilitate their successful transition and to advocate for supportive professional practices, campus practices and public policies. Specifically, college and university officials should make information available to applicants concerning mental health resources at their institutions, including clinical, preventive, supportive services and any necessary educational accommodations. In addition, they should provide clear administrative information on confidentiality and academic leave or disciplinary policies in relation to mental health conditions.

Both sending and receiving educational institutions and clinicians before and after college should coordinate clinically appropriate transition (or sharing) of care, with active involvement of the student and interested adults. Training programs in both general psychiatry and child and adolescent psychiatry should devote a significant amount of their didactic and clinical training time to the unique developmental and clinical needs of transitional age youth on college campuses. [11]

III. Legal Issues

The Family Educational Rights and Privacy Act (FERPA) was enacted in 1974 to protect the privacy of parents and students regarding outside access to student educational records. FERPA states "no funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of educational records ... of students without the written consent of their parents to any individual, agency, or organization." Once a student reaches the age of eighteen, the rights accorded to the student's parents, including authority to permit access to

[11] JED currently has a website dedicated to transition issues, http://transitionyear.org. A successor website, *Set to Go*, being developed with guidance from AACAP and the American Academy of Pediatrics, is expected to be launched in 2015.

records, are transferred to the students themselves. After the student becomes eighteen, even the parents no longer have access to these records without the student's consent.[12]

FERPA allows university officials to disclose otherwise protected information to parents or others when "knowledge of the information is necessary to protect the health or safety of the student or other individuals." [13] Unless state laws are more restrictive, this means that university officials are permitted but not required to inform appropriate individuals when a student's behavior is thought to indicate a risk to health or safety. There remains some uncertainty whether a suicide attempt *per se* qualifies for disclosure. Since notice under FERPA is discretionary, universities often decide not to make disclosures without student consent. Because this was the Virginia Tech policy at the time of the 2007 shootings, Seung Hui Cho's parents were never notified of the escalating concerns among his teachers and others. Virginia enacted legislation following the Tech shootings requiring state colleges to notify a parent of a dependent student who receives mental health treatment at the school's student health or counseling center, if it is determined that there is a "substantial likelihood" that the student will, in the near future, cause serious physical harm to himself or others.[14]

FERPA does not apply to records of the treatment of students that are made or maintained by an independent physician, including psychiatrist, or a psychologist acting in his or her professional capacity that are used only in connection with treatment of the student and disclosed only to individuals providing the treatment.[15] Once information from the mental health or medical record is shared with or used by the institution for a purpose other than treatment (e.g., decisions about disability accommodations or medical withdrawal), FERPA applies to the shared records. In December 2008, the U.S. Department of Education amended its regulations implementing FERPA to provide additional guidance regarding sharing of information within the university and its disclosure to parents in emergency situations. The agency emphasized that institutions have a lot of leeway in making these determinations:

> (c) . . .[A]n educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or

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[12] There is an exception under FERPA, that schools may release any and all information to parents, without the consent of the eligible student, if the student is a dependent for tax purposes under the IRS rules.

[13] 34 CFR 99.36

[14] Va. Code Ann. § 37.2-815 (2009)

[15] 20 USCS § 1232g

institution in evaluating the circumstances and making its determination. [16]

Another federal statute with implications for the confidentiality of medical records is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations based on HIPAA apply if a health service or practitioner uses electronic billing, on-line insurance verification, or other specified electronic transactions and therefore is a covered entity.[17] However, treatment records covered under FERPA are excluded from coverage under the HIPAA regulations. In general, HIPAA requires patient authorization prior to release of information, but like FERPA, it contains an exception for emergency situations. A summary of the HIPAA regulations can be found on the APA website, www.psych.org, under the search term "HIPAA."

Confidentiality of health records is also regulated by state law, case law (e.g., duties to protect potential victims of patients' violence), and professional ethics. State health information privacy laws sometimes preclude disclosures that would otherwise be authorized under both FERPA and HIPAA. Practitioners therefore need to be familiar with how state laws apply in their own jurisdictions.

IV. Conclusions and Recommendations

Confidentiality is a core principle upon which trust in the treatment process is based. This concern is especially urgent for college students because colleges are relatively self-contained communities and college students are developmentally transitioning from adolescence to adulthood and just growing into their sense of themselves as independent individuals. Parents also have a strong interest in being involved in their children's health care-- even when their child might legally be an adult. In rare cases of potentially dangerous students, 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. 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.

A. Guidance to Clinicians Regarding Disclosures of Students' Mental Health Status

1. Excellent clinical judgment, a thorough understanding of the needs of the various parties in college mental health systems (including parents, roommates/other students,

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[16] 34 CFR Part 99 FERPA; Final Rule Dec. 9, 2008. Excerpts from the regulations are reproduced in Appendix A.
[17] 45 CFR 164.501

and university administrators), and good common sense--in the context of a good understanding of the law--should be the primary determinants of decision making in college mental health settings (as in all settings).

2. Parental notification should not be mandated, even when students' health or safety may be at risk. The nature of the student's relationship with his or her parents needs to be explored and assessed prior to a decision about disclosure. These are common clinical judgments that often are made in emergency rooms and inpatient settings, requiring careful consideration in collaboration with the patient. Automatic notification may be clinically inappropriate.

3. In most cases, students with serious mental health problems will be prepared to cooperate with their therapist and involve parents and others as clinically indicated. When students refuse to allow disclosures to parents or school authorities, the initial attempts at resolving the problem should flow from clinical exploration and the therapeutic process, e.g., if students are hospitalized, it is in their interest to inform the school that they will be absent from the dorms or classes so that their failure to appear will be explained.

4. Recent initiatives aiming to educate parents and university administrators about the proper understanding of FERPA and other relevant laws have been salutary. However, there has also been a worrisome tendency to overreact to recent campus tragedies by weakening confidentiality requirements and even mandating parental notification. These changes could have unintended deleterious impacts on the care of college students. If students believe that discussing troubling thoughts, feelings, fantasies or impulses will result in unwanted parental or administrative involvement, they will be significantly less likely to seek assistance from college counseling services.

5. In almost all circumstances, the best interest of the patient/student should be the primary concern of college mental health clinicians. Policies encouraging or even mandating evaluations for treatment should be considered with homicidal or suicidal students but with a reasonable threshold. Sometimes sending a student home may increase suicide risk; decisions regarding withdrawal from school should take into account all relevant considerations.

6. Student Health Services need to be clear with students and families when they are not in a treatment relationship but are acting as an agent of the university, e.g., when doing assessments about whether a student may reenter the University after a medical leave or risk assessments at the request of university officials when students are thought to be a danger to their own or others' health or safety.

B. Guidance Regarding University Policies Affecting Student Mental Health

1. Whenever possible, schools should require students to carry health insurance

2. Clinicians should be aware of health insurance consequences of not being a full-time student. Some students may find themselves without insurance if they take a leave from school. Some school-based health insurance plans provide ongoing health insurance for a year.

2. Policies should be developed so as not to discourage students from seeking treatment. For example, forcing students to take a medical leave solely on the basis of seeking treatment for suicidal thoughts or attempts is likely to be counterproductive in encouraging students to seek needed care.

3. Mental health staff should provide education and consultation to appropriate faculty committees dealing with students' educational and disciplinary issues.

4. When the school requests or mandates a mental health evaluation, it is important to have explicit policies about what will be disclosed to the university. Generally the school is interested in whether the student is safe to be in school, and more detailed clinical information need not be revealed.

5. Schools should encourage active student-to-student involvement, peer counseling, and student support groups. Students are frequently aware of problems before the administration becomes aware of them and before they spiral out of control, and they are in a good position to encourage their colleagues to seek appropriate treatment. Schools should also give concerned students a contact-point for discussing their concerns within proper legal and ethical boundaries.

6. There can be real conflicts of interest between schools and students; what may be in the individual student's best interest may conflict with the school's obligation to provide a comfortable and safe environment for other students. Difficult balancing decisions require case-by-case consideration rather than rigid policies.

7. Serious consideration needs to be given by university and college administrations to how mental health services are provided to their students. As many as 40% of colleges and universities have no on-site psychiatric services, often making it difficult and expensive for students to obtain treatment.

8. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the safety of the student cannot be managed in the school environment or when the student presents a danger to others on the campus. However, students cannot be removed from school involuntarily simply on the basis of suicidal ideation or attempt and the Department of Education's Office of Civil Rights issued a policy guidance on this topic in 2014. Withdrawal should be required only if the appropriate officials have determined, based on thorough evaluation, that that there is no reasonable way that the student's problems can be managed adequately with campus-based or local resources and

that remaining on campus presents an acute and unmanageable risk to this student. Students should have appropriate due process protections in these determinations.

9. The question of when to invoke a disciplinary proceeding instead of, or in addition to, a mental health referral can be a complicated administrative challenge. Consultation with mental health and legal affairs staff may be appropriate.

10. Mental health education and training with a focus on identifying pathology and knowing how to make referrals should be provided to campus police, faculty, student life, residence hall staff, and other institutional offices likely to come into contact with troubled students.

11. Since the Virginia Tech tragedy in April 2007, many colleges have established multidisciplinary committees charged with assessing threats of harm to self or others by students and formulating appropriate interventions. Some legislatures have directed colleges to create such "threat assessment teams." The composition and activities of these teams vary, with some focused solely on threat assessment and others dealing more broadly with struggling or at-risk students.[18] Notwithstanding their proliferation, use of these teams cannot yet be characterized as an evidence-based practice. Although some positive evidence has been published regarding threat assessment teams in secondary schools, the literature on threat assessment in colleges is largely descriptive and anecdotal.

[18] A review of campus behavioral intervention teams has been published by the Higher Education Mental Health Alliance.
http://www.jedfoundation.org/campus_teams_guide.pdf

Appendix A: Excerpts from FERPA and Applicable Regulations

The relevant portions of FERPA and the interpretive guidance issue by the Department of Education governing disclosures for behavioral and health-related information are set forth below:

20 USCA §1232(g):

(6) (A) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing, to an alleged victim of any crime of violence (as that term is defined in section 16 of title 18, United States Code [*18 USCS ß 16*]), or a nonforcible sex offense, the final results of any disciplinary proceeding conducted by such institution against the alleged perpetrator of such crime or offense with respect to such crime or offense.

(B) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing the final results of any disciplinary proceeding conducted by such institution against a student who is an alleged perpetrator of any crime of violence (as that term is defined in section 16 of title 18 [*18 USCS ß 16*], United States Code), or a nonforcible sex offense, if the institution determines as a result of that disciplinary proceeding that the student committed a violation of the institution's rules or policies with respect to such crime or offense.

20 USCA §1232(i): Drug and alcohol violation disclosures.

(1) In general. Nothing in this Act or the Higher Education Act of 1965 shall be construed to prohibit an institution of higher education from disclosing, to a parent or legal guardian of a student, information regarding any violation of any Federal, State, or local law, or of any rule or policy of the institution, governing the use or possession of alcohol or a controlled substance, regardless of whether that information is contained in the student's education records, if--

(A) the student is under the age of 21; and

(B) the institution determines that the student has committed a disciplinary violation with respect to such use or possession.

34 CFR § 99.31 (Effective Jan. 8, 2009)

Under what conditions is prior consent not required to disclose information?

(a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the consent required by § 99.30 if the disclosure meets one or more of the following conditions:

(1)(i)(A) The disclosure is to other school officials, including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests.

(B) A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party--

(1) Performs an institutional service or function for which the agency or institution would otherwise use employees;

(2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and

(3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.

(ii) An educational agency or institution must use reasonable methods to ensure that school officials obtain access to only those education records in which they have legitimate educational interests. An educational agency or institution that does not use physical or technological access controls must ensure that its administrative policy for controlling access to education records is effective and that it remains in compliance with the legitimate educational interest requirement in paragraph (a)(1)(i)(A) of this section.

(2) The disclosure is, subject to the requirements of § 99.34, to officials of another school, school system, or institution of postsecondary education where the student seeks or intends to enroll, or where the student is already enrolled so long as the disclosure is for purposes related to the student's enrollment or transfer.

Note: Section 4155(b) of the No Child Left Behind Act of 2001, 20 U.S.C. 7165(b), requires each State to assure the Secretary of Education that it has a procedure in place to facilitate the transfer of disciplinary records with respect to a suspension or expulsion of a student by a local educational agency to any private or public elementary or secondary school in which the student is subsequently enrolled or seeks, intends, or is instructed to enroll.

34 CFR § 99.36 (Effective Jan. 8, 2009)

What conditions apply to disclosure of information in health and safety emergencies?

(a) An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

(b) Nothing in this Act or this part shall prevent an educational agency or institution from--

(1) Including in the education records of a student appropriate information concerning disciplinary action taken against the student for conduct that posed a significant risk to the safety or well-being of that student, other students, or other members of the

school community;

(2) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials within the agency or institution who the agency or institution has determined have legitimate educational interests in the behavior of the student; or

(3) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials in other schools who have been determined to have legitimate educational interests in the behavior of the student.

(c) In making a determination under paragraph (a) of this section, an educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or institution in evaluating the circumstances and making its determination.

Executive Summary

The Council on Psychosomatic Medicine (CPM) focuses on psychiatric care of persons who are medically ill and/or pregnant and works at the interface of psychiatry with all other medical, obstetrical and surgical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being and healing of patients and that full membership in the house of medicine is essential for our profession.

The Council is mission-driven and prioritizes activities around the updated charge set forth by the APA Board of trustees in 2015. We are asking the JRC to review and approve a new position statement: Emergency Department Boarding of Individuals with Psychiatric Disorders (Item 6.13).

Action: Will the Joint Reference Committee recommend that the Assembly vote to approve the Position Statement on Emergency Department Boarding of Individuals with Psychitric Disorders (Item 6.13)?

Background: The number of individuals with acute mental illness who are seeking psychiatric care in emergency department (ED) settings is increasing. This is due in part to the inadequacy of mental health resources in the community, including both inpatient and outpatient services. Given the long wait times and inadequate care that patients receive,the APA Assembly passed an Action Paper in May 2015 in an effort to address this situation (see attached). The position statement was developed as a result of the Action Paper, with the goal to increase the visibility of the problem and identify solutions to improve patient care.

Dr. Kim Nordstrom was the lead author of the position statement. The statement was reviewed by the Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law.

Referral Updates

- The Board of Trustees approved the report, *Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model.* APA and APM journals are working on an agreement for publishing.

Attachments: (for Joint Reference Committee Report)

- Position Statement: Emergency Department Boarding of Individuals with Psychiatric Disorders
- Background Information: Emergency Department Boarding of Individuals with Psychiatric Disorders
- Action Paper: Emergency Department Boarding of Individuals with Psychiatric Disorders

American Psychiatric Association

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.

Authors: Kimberly Nordstrom, Jon Berlin, Naomi Schmelzer, Sejal Shah, David Gitlin
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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Item 2015A1 12.S
Assembly
May 15-17, 2015

ACTION PAPER
FINAL

TITLE: Emergency Department Boarding of Individuals with Psychiatric Disorders

WHEREAS:
Whereas, the “boarding” of individuals with psychiatric disorders has become a growing phenomenon in Emergency Departments (EDs) and is described as the extended retention in EDs of psychiatric patients on involuntary civil commitments due to a lack of available beds; and

Whereas, such boarding is contrary to established medical principles of respect and dignity of the individual patient, and inevitably results in compromised care; and

Whereas, the boarding of psychiatric patients negatively impacts individuals and families from across all socioeconomic levels and insured status; and

Whereas, the shortage of adequate psychiatric bed capacity is the most significant factor leading to boarding; and

Whereas, boarding is not imposed on non-psychiatric patients in EDs, and therefore is a discriminatory practice; and

Whereas, psychiatric boarding is not only a concern for Psychiatric and Emergency Medicine specialist physicians, but also the larger Medical Society in that scarce crisis resources of hospital EDs are diverted from the triage, assessment and treatment of patients in other medical emergencies; and

Whereas, this issue is widespread, as evidenced by the recent Washington State Supreme Court decision that declared the boarding of psychiatric patients overnight after identification of need for hospital level of care as unconstitutional and reports in North Carolina that patients are waiting in the ED for up to 3 weeks waiting for an inpatient bed; therefore

BE IT RESOLVED:
That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and

That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding.

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ESTIMATED COST:
Author: $2,058.46
APA: $1,139.49

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: none

ENDORSED BY: Area 5

KEY WORDS: Emergency Room Boarding

APA STRATEGIC GOAL: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT:

Item JRC #8.L
Joint Reference Committee
January 2016

Executive Summary

Action Items

The Council wishes to inform the Joint Reference Committee about the recommendations or edits of the following positions statements that were assigned to the Council Quality Care:

Will the Joint Reference Committee recommend to the Assembly that the current version of the Policy on Conflicts of Interest Principles and Guidelines: With Special Interest for Clinical Practice and Research continue to be endorsed?

- Please see Attachment #1

Will the Joint Reference Committee recommend to the Assembly that the current version of the Position Statement on Psychotherapy continue to be endorsed?

- Please see Attachment #2

Will the Joint Reference Committee recommend to the Assembly that the current version of the Position Statement on the Patient-Physician Covenant continue to be endorsed?

- Please see Attachment #3

Will the Joint Reference Committee recommend to the Assembly that the current version of the Position Statement on the Confidentiality of Medical Records and Physician Right to Privacy Concerning His/Her Own Health Record continue to be endorsed?

- Please see Attachment #4

Referral Updates

At present time, the Council on Quality Care does not have any referral updates to report.

Meeting Minutes

- See the minutes of the meeting of the Council on Quality Care, Attachment #5

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)

Position Statement on Psychotherapy as an Essential Skill of Psychiatrists

Approved by the Board of Trustees, July 2014
Approved by the Assembly, May 2014

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Issue

Psychiatrists are uniquely positioned to provide comprehensive, integrated treatment either by providing medication alone, psychotherapy alone, or combined treatment. Importantly, psychotherapy and prescribing medication flourish on the same foundation—confidentiality, trust, and active patient participation—which readily allows psychiatrists to change or add treatment modalities e.g., switch from psychotherapy to medications or add medication to psychotherapy, while keeping a clear focus on the complex interplay of patient, practitioner, pharmacotherapy, and psychotherapy. Even when a psychiatrist provides "only" medication, psychotherapeutic elements in the therapeutic alliance enhance the effectiveness of any medication. Indeed, although cost per session is higher for psychiatrists, integrated psychiatric care (as compared to split treatment by a psychiatrist and non-MD therapist) may lead to lower total costs and decreased patient suffering.

Position Statement

The APA advocates for psychotherapy to remain a central treatment option for all patients and for psychotherapy (alone or as part of combined treatment) by psychiatrists to be reimbursed by payers in a manner that integrates care and does not provide financial incentives for isolating biological treatments from psychosocial interventions, e.g., isolated use of medication management without consideration of psychosocial issues requiring essential psychotherapy. The APA supports the Accreditation Council for Graduate Medical Education (ACGME)/ Residency Review Committee (RRC) in their continued accreditation requirement that psychiatry resident training programs provide comprehensive training in evidence-based psychotherapies, as well as in collaborative treatment models. It collaborates with AADPRT and AACDP to address the increasing difficulty programs face in supporting the time and money required for teaching and supervising psychotherapy.

Authors: Mantosh Dewan, M.D., Michele T. Pato, M.D., Nicole Del Castillo, M.D. (Council on Research and Quality Care)

See also the related resource document.

Endorsement of the Patient-Physician Covenant

Approved by the Board of Trustees, September 1995
Reaffirmed, 2007
Reaffirmed by the Board, December 2014
Reaffirmed the by the Assembly, November 2014

"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*.

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, carer, helper, and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gate-closers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patients at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

Ralph Crawshaw, M.D.
David E. Rogers, M.D.
Edmund D. Pellegrino, M.D.
Roger J. Bulger, M.D.
George D. Lundberg, M.D.
Lonnie R. Bristow, M.D.
Christine K. Cassel, M.D.
Jeremiah A. Barondess, M.D.

JAMA. 1995;273(19):1553-1553.

Confidentiality of Medical Records: Does the Physician Have a Right to Privacy Concerning His or Her Own Health Records ?

POSITION STATEMENT

Approved by the Board of Trustees, December 1980
Approved by the Assembly, May 1981

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Prepared by the Task Force on the Impaired Physician[*] of the Council on Medical Education and Career Development.

It has been proposed that physicians (and students aspiring to become physicians) have a special duty to the public which can only be discharged by requiring that the physician's own health record, especially information pertaining to the physician's mental health, be exposed to the scrutiny of those who oversee the quality of medical care or the fitness of individuals to practice medicine. This supposed duty of disclosure is said to arise from the special role physicians have in society and the vulnerability of the public to potential harm from inept, malicious, or otherwise dangerous doctors. This role also places a burden on those who select physicians and scrutinize their performance so that the public interest is adequately safeguarded. This raises the general question, Does the expectation of medical confidentiality extend to the physician's own health records when the physician is a patient?

The short answer to this question is, No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine.

The traditional privacy of communications between a patient and his or her physician rests on the judgment that society benefits when sick people have unimpeded access to necessary medical treatment. This expectation of medical confidentiality is reflected in medical ethics (1), contract law (2), and the common law (3) and has been enacted into statutory law in a majority (N=36) of jurisdictions (4).[**] Recently, a federal district court found that the right to privacy of medical records has a Constitutional basis (5). We have been unable to find laws that except physicians from these protections when they become ill and seek treatment.

In attempting to balance the danger to the public from mental disorders in physicians against the rights of all patients to privacy, we believe that the reasonable protection of patients does not require the assumption that anyone who is or who has been a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without first presenting his or her otherwise private medical record for public scrutiny. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate. Moreover, there is, in our view, a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without diagnosis and treatment for what might be curable ills.

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[*]The Task Force (now a committee) included Robert E. Jones, M.D. (chairperson), Manuel M. Pearson, M.D., Stephen Scheiber, M.D., Douglas A. Sargent, M.D., and Robert Marvin, M.D. (Assembly liaison).

[**]As of February 1983, 42 states plus the District of Columbia had enacted psychotherapist-patient privilege statutes. The authority is the case of Zuniga v. Pierce (714 Federal Reporter 2d, 632-642, 1983).

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

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The competition for admission to medical school is severe and begins early. If it were to become generally known that potential physicians who had consulted psychiatrists or other mental health professionals would be required to disclose that fact in the medical school application process, many needing treatment either would not get it or would conceal the fact, viewing a “psychiatric history” as an impediment to acceptance. Further, as Silver and associates (6) have shown, there are no data correlating psychiatric diagnosis and treatment with performance in medical school or practice.

What is true for medical students is even more likely in the case of the practicing physician, who stands to lose his or her means of livelihood, cannot easily change a career already launched, and does not have the student's option of simply choosing not to enter medicine rather than have his or her secrets known. Recent experience with “snitch laws” in New York and elsewhere (7) suggests that this fear of disclosure is real and not merely theoretical, confirming Slovenko's suggestion (8) that mental disorder is today's “loathsome disease,” the analogue of those socially impairing conditions that first led to the development of the physician-patient privilege. Citing Eldridge's *The Law of Defamation*, Slovenko said,

Surveys indicate that the general public regards a person seeking a psychiatrist with fear, distrust, or dislike. The public generally acts differently toward a psychiatric patient. This is reflected in the law of defamation where it is provided that a statement that a person is mentally ill is an “imputation of want of ability to discharge the duties of that person's ... profession ...” and thus slander on its face.

It is no comfort to the disturbed medical student or physician that the public's prejudices may not be shared by medical school admissions committees or medical practice boards, especially since experience suggests that physicians share the public view of psychiatry and our patients. Far from protecting the public, it is likely that abolition of the confidentiality of the physician's or medical student's personal health record would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those who try to help them. We are naturally concerned, since we believe that such an impaired individual is far more likely to endanger patients than would be the case if medical treatment were a private matter for medical practitioners as it is for others.

Medical schools, hospitals, licensure boards, and other regulatory bodies seeking to know whether a history of medical or psychiatric disorder impairs present functioning are advised to do so on a case-by-case basis, as such a history has little predictive value. A medical psychiatric evaluation by a consultant hired for the purpose of determining present competence should be obtained for evaluating applicants whose fitness is questioned and who have given voluntary, informed consent. Such evaluations should be made only for cause and should not be routinely required of all applicants.

In short, the mandatory disclosure of the physician's confidential medical or personal history is without merit.

Both tradition and public policy, as reflected in the laws of privacy, favor access to therapy for all who need it, including physicians. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions. We urge support for the traditional view and oppose forced disclosure, which seems to promise more benefit than we think it can deliver.

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6. Silver LB, Nadelson CC, Joseph EJ, et al: Mental health of medical school applicants: the role of the admissions committee. J Med Educ 54:534-538, 1979
7. Block MA: Disabled physician: rehabilitation versus punishment. NY State J Med 79:1025-1028, 1979
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Council on Quality Care
December 4, 2PM-3:330PM
Conference Call

I. Opening/Introductions: Grayson Norquist, M.D., Chair

A. Conflict of Interest/Disclosure Statements

Council Member Attendance: Norquist, Altschuler, Behrens, Dalack, Kathol, Pincus, WIlner, Young, Zima, Yager, Kidd, Iles-Shih

Council Member Absence: Halverson, Borlik, McCarron, Vo, Vassan

APA Administration and Invited Guests Attendance: Kroeger, Kanefield, Kroeger, Vergare, Jayaram, Pierce, Daviss, Shugarman, Fochtmann

II. Minutes from last meeting

A. September 10, 2015 Fall Component Meeting

Minutes Approved

III. Remarks

A. Ms. Kroeger

Provided a more detailed update on the recent reorganization of the departments formerly referred to as Quality Improvement and Psychiatric Services and Healthcare Systems and Finance. She explained that this change allowed for more internal alignment to meet the strategic initiatives decided on by the Board of Trustees, recommendations made by the BOT Workgroup on Health Care Reform recommendations, and will provide more staff power with increased expertise while being mindful of budget restrictions for 2016. There was further detail provide around the increase in staff with increased expertise, two new director positions (based on reimbursement strategies, alternative payment models, psychiatric delivery systems, with high level contacts within federal agencies).

Ms. Kroeger further explained that currently HSF and QIPS work together often. Internally, staff will continue to work as they have and that both Council on Quality Care and Council on Healthcare Systems and Finance structure will remain the same.

IV. Reporting Component Updates

A. Steering Committee on Practice Guidelines, *Dr. Vergare provided report*

1. Guideline Status Update

a. Draft Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia

The draft Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia was approved by the APA Assembly on November 1, 2015. Pending approval by the Board of Trustees in December, staff has reached out to colleagues in the publication department to begin the process of developing a production schedule for print and online formats, as well as publication of an executive summary in AJP.

Concurrent with the anticipated production schedule, staff and the Practice Guidelines Executive Committee will continue their discussions regarding the various ancillary products it plans to develop as companions

to the newest practice guideline.

b. Future Guideline Development Topics

The Committee continues to discuss the guideline topics that will be undertaken in 2016. Although two additional positions were tentatively included in the 2016 budget as reported to the Council in September 2015, no additional staff support will be added in the coming year (although the Research Department has committed to providing assistance from one of its writers as needed). Given these limitations, the Committee is in the initial planning stages for two new topics. Topics in the development pipeline include:

- *Use of Pharmacotherapy for Adults with Alcohol –Use Disorders*

Dr. Victor Reus will chair the group tasked with writing this guideline using a systematic review that was completed by AHRQ in 2014. Current writing group members are being asked if they are interested in continuing their work with the group following completion of the dementia guideline. Those writing group members with dementia-specific expertise will rotate off the group and will be replaced by multidisciplinary members with expertise in the content area. Relevant stakeholders will be identified and asked to nominate individuals to serve on the writing group.

- *Bipolar Disorder*

A systematic review by AHRQ is currently in process, but has been delayed on several occasions. Barring any additional delays, it is expected that this review will be complete in mid-2016. At the time that the alcohol use guideline is complete, Dr. Reus' group will begin work on this topic.

- *Eating Disorders*

The Committee received a nomination from the field to develop an updated guideline on the topic of eating disorders. The Committee will begin the process of appointing a second writing group to develop this guideline. While the appointment process is underway, a systematic review of the available evidence will be performed that will inform development of this guideline.

- *Schizophrenia*

This topic, nominated by APA, was recently accepted by AHRQ for a systematic review. Given the timeframe for completing these reviews, it is anticipated that the second writing group will take on this topic upon completion of the eating disorders guideline.

2. Status of NLM grant-funded research on the application of principles of medical informatics to guideline development and publication

A paper on a portion of the results from the survey on computer use and information seeking has been accepted for publication. We are continuing to work on finishing other aspects of the grant although the funding has officially termed.

Dr. Vergare participated in Council discussion that included a recommendation to consider more a scientific process for selecting future topics. Presently the Steering Committee on Practice Guidelines works to influence the AHRQ on what to systematically review. Dr. Fochtmann, the guideline consultant, has

provided reviews of other topics including the one on eating disorders by piggy-backing on a systematic review completed by AHRQ. The APA would need more internal methodological expertise to continue with these reviews. Information has been shared that explains that the Other ApA is getting into similar practice guideline development—and we are currently exploring the opportunity to work together on these efforts (e.g. eating disorders). In addition, the members of the Council discussed other guideline activities the comm. might consider such as limited focused guidelines on a specific treatment issue rather than guidelines that cover broad topics. Using an approach such as this would allow the comm. to pursue several things at once with some products that might come out quicker than others.

The Committee plans to include input from the Council on Research on moving fwd.

B. Committee on Mental Health Information Technology, *Dr. Daviss provided report*

CMHIT 2015 Updates since September 2015 and 2016 Objectives Since last update:

- *Dr. Daviss represented CMHIT at the Work Group on Telepsychiatry meeting at IPS. The Work Group recorded many short, informational videos on telepsychiatry and also met to discuss the scope and sequence of next steps for the Group.*
- *Steven Chan presented on mobile health technology at IPS, which was related to the work he is doing on the Apps Task Force in CMHIT.*
- *Steve Chan and John Torous have written a piece on the Apps Task Force which will appear in Psych News.*
- *Steve Daviss has been representing CMHIT on the Ad Hoc Workgroup to Explore the Feasibility of Developing an Electronic Clinical Decision Making Tool*

<u>One Year Goals</u>

- *In concert with appropriate APA staff, develop a strategic plan to reach-out to other mental health organizations to collaborate on HIT.*
- *Develop EHR/App requirements for web site (and work with APA staff to develop web site*
- *Identify current EHRs that support psychiatry*
- *Develop criteria to review EHRs*
    - *Establish protocols to test these criteria*

<u>Three Year Goals</u>

- *Develop a database structure to store requirements, data elements, vendor information, and user comments*
- *Develop a query mechanism for providers to be able to identify EHRs which satisfy their own requirements*
- *Develop a mechanism for providing method to review and update requirements for EHRs*

C. Workgroup on Patient Safety, *Report provided by Dr. Jayaram*

Goals of the Patient Safety Committee:

- *To be the "go to group" for safety. Either field answers to questions or connect the APA to resources.*
- *To develop and train APA members in patient safety principles and topics, and provide them with learning opportunities on safety by conducting workshops, symposia, lectures that inform them regularly each year at the Annual Meeting*

- *Act as the voice for "safety" within the APA and elsewhere, including focus on the above topics, discuss issues with the media and correctly inform the public*
- *To network with agencies with similar interest and endeavors, such as the Zero Suicide Academy, the American Association of Suicidology, the Center for Prevention of Gun Violence, etc.*
- *To become the Council on Patient safety in order to integrate safety into daily care, support and perform research and training in academic centers, and reduce costs of care by avoiding adverse events.*

Update since last report

- *The chairperson of the group published a book on patient safety that is now used in residency programs since the ACGME defined the requirements for teaching safety.*
- *Members of the Workgroup have been asked to Edit/ Co- edit a Focus publication devoted to Patient Safety.*
- *A workgroup member chaired a symposium on Violence at the APA 2014 Annual Meeting. The work group member further developed a series of CME questions for the program.*
- *The workgroup chair was interviewed by The Toronto Star, CTV in Canada, Lithuanian TV, and by the Zero Suicide Academy for dissemination on suicide prevention on inpatient unit.*
- *Presented a conference on systems related changes, leadership, organizational motivation and resource use to promote quality and contain costs, assess outcomes and improve patient satisfaction. The focus was on using the LEAN methodology and the Toyota systems model. There was emphasis on regulatory practice and response to new demands, entitled: Focusing on Improving a Behavioral Health Care System Every Day.*
- *Members of the committee conducted numerous symposia, workshops and courses at the Annual Meeting on topics of safety including focusing on suicide prevention, assessment of risk and systems analysis. Some mentored on tools used to evaluate processes and outcomes; while there have been presentations on transitions and hand-offs of care. Presentations on unsafe practices in medical ICUs, dangers of the aftermath of delirium and distinguishing it from other iatrogenic acute syndromes have also been made.*
- *The Workgroup chair recently Chaired and directed a first-of-its-kind patient safety conference in Maryland that provoked much interest.*
- *The Workgroup chair recently visited the Universities of Kaunas and Vilnius in Lithuania at their invitation to discuss suicide prevention in Lithuania, the highest in Europe.*

During Council discussion, Dr. Jayaram addressed some concerns of the Workgroup members, which include: what should the group do next; how does the group obtain administrative staff assignment, and how do they receive recognition for the many activities they have participated in? Ms. Shugarman explained to the Council and Dr. Jayaram that the group is currently designated as a workgroup with their charge and specified activities to be assigned by the Council. Additionally, because they are currently designated a workgroup and not a formal committee or council, there are no funds in the budget to assign formal administrative staffing. Also, because they are designated a workgroup, rather than a council or committee, they will not receive formal recognition by way of listing in the components handbook.

Considering Ms. Shugarman's responses to Dr. Jayaram's questions, the Council will consider its goals for the workgroup and how to move forward. Dr. Norquist and Ms. Shugarman agreed to look further into the background for this workgroup and why they were not set up as a committee.

ACTION ITEM for the Council: determine the future activities of the Workgroup on Patient Safety.

D. Committee on Performance Measurement; *Report provided by Dr. Pierce*

Updates since last report (9/2015)
Two telephone conference calls with the following action plan

- *SharePoint will be used to drop documents and edit papers. This eliminates draft sharing via email and eliminates the concern over the most current versions of items.*
- *Create a position/policy statement on APA's role in the quality measurement field. During the last committee call, the decision was made that the **APA will not develop measures** because of the lack of funding but will partner with others. We started a list of referrals. A justification needs to be written as a policy.*
- *The group discussed further refinement of the notion of acting as subject matter experts and consultants in the outside development of measures. The group still has many unanswered questions, but believes the development of a position statement will help identify goals, opinions, and beliefs of where the Association should stand on measurement development and utilization.*

A group will identify the gap areas in care as they exist in current reporting programs and existing practice guidelines. Members will review practice guidelines to see where there may be an opportunity for measures.

McIntyre, Nininger, and Wrenn volunteered to take on this task. Consultation with Dr. Fochtmann (consultant on the Practice Guidelines effort).

- *Our goal is to be **proactive** for the referral of behavioral health measures. Discussion around procedures and how this will be done and the action needed to be taken. What does APA need to do to be proactive?*

After this brief update, the Committee discussed that the APA should be proactive and lead as content experts, rather than technical experts. Pierce recommended developing a white paper that will flesh this role out.
***Action**: Pierce will begin working on this type of white paper, utilizing PCPI material as a guide.*

One Year Goal
The Committee plans to develop two position statements on APA's role in measure development as experts, and gaps in Care.
Three Year Goal
Share evaluate education needs to potentially develop curriculum for training members and members-in training on performance measurement.

V. Council on Quality Care Fellow Updates;
Dr. Iles-Shih reported his participation on the Committee on Performance Measurement.
Due to lack of attendance, or partial phone call attendance, the remaining fellows will submit updates by email.

VI. New Business

A. *Registry Progress: Dr. Dalack explained the work of IMPAQ International consultants work with a workgroup of APA members with expertise in the area of registries or other related characteristics, as well as their work with internal APA staff. He explained the goal to present the recently shared report, and the Council's solicited comments with the BOT at their meeting in December. At present time the plan is to request the BOT vote to*

approve the recommended registry case, and to continue to explore the idea of an APA registry through a business plan based on the agreed upon business case.

Council discussion included proceeding with caution and concern for member buy-in.

COUNCIL ON RESEARCH
REPORT TO THE JOINT REFERENCE COMMITTEE

Executive Summary
Since the Council's face-to-face gathering at the 2015 September Components Meeting, the group has been primarily responding to various requests from APA leadership for feedback on important policy, practice, and funding initiatives (e.g., responding to FDA's alert on clozapine REMS). The various subcommittees of the Council also are continuing their work on the development of 5 manuscripts (see Action Item 2 below for 1 such paper, recently completed). Finally, as requested by the JRC, the Council made additional revisions to their revised Position Statement on Atypical Antipsychotic Medication (see Action Item 1 below). The Council will have their next in-person meeting at the 2016 APA Annual Meeting.

The Council brings the following Action Items:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on Atypical Antipsychotic Medications?

- See Attachment 1 for revised and reformatted position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised slightly for language and clarity.
- Edits to language also include those made in response to concerns expressed by the JRC at their October meeting that called for stronger wording against the off-label use of antipsychotic medications, such as for the inappropriate management of sleep.

Action Item 2: Will the Joint Reference Committee approve the Council on Research submitting for publication the manuscript on the clinical use of rTMS for depression management?

- This paper was developed primarily by members of the Council's Workgroup on Diagnostic Markers and Treatments in collaboration with the National Network of Depression Centers (NNDC) rTMS Task Force. The entire Council has reviewed and provided feedback. They would like to submit this manuscript to the *American Journal of Psychiatry* and await the JRC's approval.

Referral Updates
The Council wishes to provide updates on the following Joint Reference Committee referrals:

Referral Item Number: JRCOCT148.G.22
Title: Current Health Services Literature on Integrated Care Models
Action: The Joint Reference Committee thanked the Council for the update and requested a progress report in the Council's report to the JRC in January 2016.
Response: An update on this project is as follows: In light of the APA receiving a SAN grant from CMS as well as the APA having needs for an evaluative component to this grant, Division of Research staff will adapt findings from this integrated health care report activity to help support the SAN grant needs (e.g., using the report's findings to develop potential fidelity measures that could help ensure training programs truly do produce psychiatrists who are able to deliver effective collaborative care).

Attachments

Attachment 1: Revised Position Statement on Atypical Antipsychotic Medications

Attachment 2: Consensus Recommendations for Clinical rTMS in Depression

Attachment 1: Revised Position Statement on Atypical Antipsychotic Medications

TITLE:
Position Statement on Atypical / Second Generation Antipsychotic Medications
~~Approved by the Board of Trustees, September 2009~~
~~Approved by the Assembly, May 2009~~

BACKGROUND:

Atypical antipsychotic medications, also called second-generation antipsychotics, are 5-HT2A/D2 receptor antagonists. They are classified as "atypical" based on their ability to diminish psychotic symptoms while producing minimal extrapyramidal side effects (EPS), including tardive dyskinesia , as compared to "typical" antipsychotics (Meltzer 2013). This may be clinically important given that EPS can contribute to medication discontinuation. Atypical antipsychotic medications include clozapine and those discovered afterwards, such as asenapine, olanzapine, quetiapine, risperidone, lurasidone, aripiprazole, and ziprasidone.

Atypical antipsychotics are FDA approved (i.e., indicated use) for the following disorders: schizophrenia, bipolar disorders, as an adjunct to antidepressant therapy for major depressive disorder (only quetiapine XR, aripiprazole, and olanzapine/fluoxetine in combination); and irritability associated with autism spectrum disorder (only risperidone and aripiprazole) (Maher & Theodore, 2012; Maglione et al., 2011). Because different patients may respond to and tolerate particular agents differently, it is important for patients to have access to the full range of antipsychotic medications for indicated use, irrespective of medication costs.

Clozapine is sometimes termed the "gold standard" of atypical antipsychotic drugs due to its superior efficacy in reducing positive symptoms of treatment-resistant schizophrenia (Meltzer 2013). In fact, it is the only medication currently approved for treatment-resistant schizophrenia. Compared to other antipsychotics, clozapine also has demonstrated superiority in reducing aggression and violence associated with psychosis; decreasing psychotic symptoms in Parkinson's disease; reducing risk of tardive dyskinesia; and lowering risk of suicide in schizophrenia or schizoaffective disorder (Meltzer 2013). However, clozapine does carry additional side-effects, including, rarely, agranulocytosis, which can be avoided through monitoring, and metabolic side-effects (Meltzer 2013).

As noted above, atypical antipsychotics may be beneficial over typical antipsychotics in producing fewer EPS, including tardive dyskinesia, akathisia, and Parkinsonianism (Meltzer 2013). Despite their benefits, some atypical antipsychotics—particularly olanzapine, clozapine, quetiapine, and risperidone—can increase the risk of metabolic dysregulation and lead to weight gain, glucose intolerance, and hyperlipidemia (Meltzer 2013; Maglione et al., 2011). However, certain typical antipsychotics carry these same metabolic risks, and both classes of medications should be accompanied by routine monitoring of patients' weight and lipid profiles (Meltzer 2013). Other side effects associated with certain atypical antipsychotics include EPS, fatigue, and sedation.

Atypical antipsychotics have been used to treat schizophrenia and bipolar disorders in children and adolescents in the short-term, while long-term safety trials are still needed (Caccia 2013). Children appear to experience the same adverse event profiles seen in nonelderly adult populations, including agranulocytosis and neutropenia with clozapine, weight gain, hyperlipidemia, and glucose dysregulation (Caccia 2013). In older populations, atypical antipsychotic medications have been used to successfully treat schizophrenia; psychotic disorders; bipolar disorders; and unipolar depression with psychotic symptoms (Gareri et al., 2014). These medications should be used for these indications cautiously and at lowest effective dosages due to the

potential for significant adverse events in geriatric patients, including increased risk of mortality, stroke, and EPS (Maglione et al., 2011; Gareri et al).

These medications also are used frequently for conditions for which there are no data on efficacy (i.e., off-label use), such as managing sleep and reducing behavioral manifestations of dementia. In addition, concerns have been raised over the safety of such off-label uses. For these reasons, off-label use of antipsychotics should be used with caution in general and with vulnerable patients, such as children and the elderly with dementia, in particular. In order to ensure that antipsychotics are used in a time-limited period in elderly patients with dementia, careful monitoring and periodic review by a psychiatrist is recommended.

Several areas have been identified as important targets for future research (Maglione et al., 2011), including more studies on minimum effective dosages; additional off-label clinical trials on medications beyond those most commonly studied thus far (i.e., risperidone, olanzapine, and quetiapine); efficacy trials and adverse events associated with newer atypical antipsychotics (e.g., asenopine, iloperidone,lurasidone, paliperidone); and more data on gender-, racial-, and ethnic-related variations in treatment efficacy and outcomes associated with atypical antipsychotic use.

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ISSUE:
Certain atypical antipsychotics appear to be associated with metabolic and cardiovascular side effects. Baseline metabolic function should be assessed at the start of medication therapy and periodically during the duration of treatment.

Atypical antipsychotics should be used with caution and on an appropriate basis in elderly patients with dementia. In order to ensure that antipsychotics are used in a time-limited period in elderly patients with dementia, careful monitoring and periodic review by a psychiatrist is recommended.

STATEMENT:
Given the current state of knowledge, including randomized controlled trials and observational studies, it is our opinion that the ~~new~~ second generation of antipsychotic medications ~~(except clozapine) need~~ should continue to be made available as first-line treatments for appropriate individuals throughout all systems of care. Clozapine is the exception, given its side-effect profile. However, ~~Similarly,~~ clozapine ~~needs to~~ should be made available for individuals with treatment refractory psychotic disorders. Access to these medications needs to be made available in all systems of health care and by all public and private insurers, including all jails, prisons, and youth services facilities.

ADOPTION DATE AND AUTHORSHIP:
Approved by the Board of Trustees, September 2009; Revised October 2015
Approved by the Assembly, May 2009
Developed by the Council on Research and Quality Care; revised by the Council on Research

Attachment 2: Consensus Recommendations for Clinical rTMS in Depression

Cover Letter

XX XX, 2016 [DATE TO BE INSERTED]

Robert Freedman, MD
Editor
American Journal of Psychiatry

Re: Initial submission of manuscript, "Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression"
Dear Dr. Freedman:

Enclosed, please find the initial submission of our manuscript, "Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) for the Treatment of Depression" for consideration in the *American Journal of Psychiatry*.
With the growing use of rTMS as an antidepressant strategy, the National Network of Depression Centers (NNDC) rTMS Task Force in collaboration with the American Psychiatric Association (APA) Council of Research (COR) Workgroup on Diagnostic Markers and Treatments has created consensus recommendations to guide clinical practitioners in the safe and useful application of this relatively new treatment. These recommendations represent the first consensus statement from the NNDC and APA COR, which we hope will prove useful in guiding the safe and effective use of rTMS to treat major depressive disorder in adults.

All authors substantially contributed to the conception, design, writing, and editing of the manuscript. Also, all authors provided final approval of the submitted manuscript. Included in the submission, all authors provided conflict of interest information.

Per the journal guidelines, we recommend the following four reviewers:

Dr. David Sheehan	Email: dsheehan@health.usf.edu
Dr. Michael Thase	Email: thase@mail.med.upenn.edu
Dr. Colleen Loo	Email: colleen.loo@unsw.edu.au
Dr. Maurizio Fava	Email: mfava@partners.org

Sincerely,

Shawn M. McClintock, PhD, MSCS
UT Southwestern Medical Center
Duke University School of Medicine

Title

Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression

Byline for Authors

National Network of Depression Centers (NNDC) rTMS Task Group and American Psychiatric Association (APA) Council of Research (COR) Workgroup on Diagnostic Markers and Treatments Committee Members

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Previous Presentation

Parts of this manuscript have previously been presented at the National Network of Depression Centers (NNDC) Annual Meetings.

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Disclosures and Acknowledgments (listed in alphabetical order)

Linda Carpenter. Dr. Carpenter reports research support from the National Institutes of Health, income from clinical trial contracts with Butler Hospital from Neuronetics, Inc., NeoSync, and Cervel, and consulting income from Magstim Company, Ltd. She is member of the American Psychiatric Association (APA) Council on Research and Quality.

Ian A. Cook. Dr. Cook reports research support from Aspect Medical Systems/Covidien, National Institutes of Health, Neuronetics, and Shire. He has been on the speakers' bureau for Neuronetics and the Medical Education Speakers Network. He has been an advisor/consultant/reviewer for Allergan, Covidien, Pfizer, Neuronetics, NeuroSigma, NIH (ITVA), US Departments of Defense and Justice, VA (DSMB). He is a member of the editorial board of the World Journal of Biological Psychiatry and Editor of the Patient Management section of the American Psychiatric Association's *FOCUS* journal. Dr. Cook's biomedical intellectual property is assigned to the Regents of the University of California, and he owns stock options in NeuroSigma, where he serves as Chief Medical Officer.

Marc Dubin. Dr. Dubin reports grant support from TAL Medical and a materials transfer from Neuronetics, Inc.

Mark George. Dr. George reports research support from the National Institutes of Health, the Department of Defense, and the Veterans Administration. He has received clinical trial contracts through the Medical University of South Carolina with Brainsway, Cervel, Neuronetics, and Neosync. His research division has received material transfer from Brainsway, Neuronetics and MECTA. He serves on the DSMB for a clinical trial sponsored by Microtransponder, and is an unpaid consultant to Nervive. He has received consulting income from TAL medical. He receives an editor's stipend from Elsevier, who publish Brain Stimulation.

Mustafa M. Husain. Dr. Husain reports research support from the National Institute of Mental Health, National Institute of Neurological Disorders and Stroke, Stanley Medical Research Foundation, Neuronetics, Inc., MagStim (equipment only), Brainsway, Inc., NeoSync and consulting income from Cerebain Inc. Consultant to the Neurological Devices Panel of the Medical Devices Advisory Committee, Center for Devices and Radiological Health, Food and Drug Administration (FDA). Editorial Board Member of the Journal of ECT.

Andrew Krystal. Dr. Krystal reports research support from the National Institutes of Health, Teva, Sunovion, Neosync, Brainsway, Janssen, ANS St. Jude, Novartis, Azevan, Eisai. He is a consultant to Abbott, AstraZeneca, Attentiv, Teva, Eisai, Eli Lilly, Jazz, Janssen, Merck, Neurocrine, Novartis, Otsuka, Pfizer, Lundbeck, Roche, Sunovion, Paladin, Pernix, Transcept. Dr. Krystal is an inventor on a Duke University owned patent licensed to MECTA Corporation, though he derives no income from this. Editorial Board Member of SLEEP – Journal Deputy Editor, Journal of ECT, Biological Psychiatry, Depression and Anxiety, Journal of Affective Disorders, Biological Psychiatry: Cognitive Neuroscience and Neuroimaging, and Mind and Brain.

Vassilios Latoussakis. Dr. Latoussakis reports no financial relationships with commercial interests.

Sarah H. Lisanby. Dr. Lisanby reports research support from Brainsway, NexStim, Neosync, Stanley Medical Research Foundation, Brain Behavior Foundation, and the National Institutes of Mental Health and National Institute for Neurological Disorders and Stroke. Her lab has received equipment support from Soterix, MagVentures and Magstim. She has patent applications on brain stimulation technology assigned to Columbia University and Duke University, and receives no royalties. She has equipment loans from MagStim and MagVenture. Editorial Board Member of the Journal of ECT, Brain Imaging and Behavior, and International Journal of Geriatric Psychiatry.

Shawn M. McClintock. Dr. McClintock reports research support from the National Institutes of Health / National Institute of Mental Health. He serves on the DSMB for a clinical trial sponsored by the Department of Veteran Affairs Cooperative Studies Program. Editorial Board Member of the Journal of ECT.

William McDonald. Dr. McDonald reports research support from the National Institute of Mental Health, National Institute of Neurological Disease and Stroke, Health Resources and Services Administration, Stanley Foundation, Soterix, Neuronetics and Cervel Neurotherapeutics. Consultant on the Neurological Devices Panel of the Medical Devices Advisory Committee, Center for Devices and Radiological Health, Food and Drug Administration, member of the American Psychiatric Association (APA) Council on Research and Quality representing ECT and Neuromodulation Therapies and contract with Oxford University Press to co-edit a book on the Clinical Guide to Transcranial Magnetic Stimulation in the Treatment of Depression. Editorial Boards for American Journal of Geriatric Psychiatry and Journal for ECT and section editor for Current Psychiatry Reports.

Oscar Morales. Dr. Morales reports research support from the Brain and Behavior Foundation, Neuronetics, Inc. and Brainsway, Inc. He is an inventor on a McLean Hospital owned patent on intracranial seizure therapy (ICEST).

Brent G. Nelson. Dr. Nelson reports research support from the Brain and Behavior Foundation. He is Co-Owner of AgileMedicine, LLC.

John O'Reardon. Dr. O'Reardon reports research support from the Stanley Medical Research Foundation and Neosync, Inc.

Irving Reti. Dr. Reti reports current or prior research support from The National Institutes of Health, The US Department of Defense, The Hope for Depression Research Foundation, The Simons Foundation Autism Research Initiative, The Dana Foundation, The Johns Hopkins University School of Public Health, Neuronetics, Inc. and Brainsway, Inc. Dr. Reti is also under contract with John Wiley and Sons for editing the volume, *Brain Stimulation: Methodologies and Interventions*.
Shirlene Sampson. Dr. Sampson reports equipment support from Neuronetics, Inc.

Stephan Taylor. Dr. Taylor reports research support from National Institute of Mental Health, St. Jude Medical, Neuronetics, Inc., and Vanguard Research Group.

Christopher Wall. Dr. Wall reports no financial relationships with commercial interests.

Acknowledgements

We appreciate the helpful review and input from Dr. John Greden, and the administrative support of the National Network of Depression Centers (NNDC), particularly Ms. Casey Stone.

Abstract

Objective: To provide expert recommendations for the safe and effective application of repetitive transcranial magnetic stimulation (rTMS) in the treatment of major depressive disorder (MDD).

Method: The National Network of Depression Centers (NNDC) convened a Task Group of seventeen expert clinicians and researchers with expertise in the clinical application of rTMS including members of the American Psychiatric Association Council of Research (APA COR) Workgroup on Diagnostic Markers and Treatments. The NNDC Task Group collected evidence that included an extensive literature review supplemented with expert opinion.

Results: The NNDC Task Group and APA COR developed treatment recommendations for the administration of rTMS.

Conclusions: Multiple randomized controlled trials have supported the safety and efficacy of rTMS antidepressant therapy. These consensus recommendations provide comprehensive information for the safe and effective clinical application or rTMS in the treatment of MDD.

Introduction

There is a clinical need for additional antidepressant treatments (Greden 2001, Rush, Trivedi et al. 2006). Repetitive transcranial magnetic stimulation (rTMS) is a safe, noninvasive neuromodulation therapy for major depressive disorder (MDD) (Janicak, O'Reardon et al. 2008). rTMS is applied over the prefrontal cortex and induces a magnetic field which results in the depolarization of underlying neurons (Wasserman and Zimmermann 2012) and the modulation of the neural circuitry involved in emotional regulation and depressive symptoms (Liston, Chen et al. 2014, Salomons, Dunlop et al. 2014) (Barker, Jalinous et al. 1985, Barker, Jalinous et al. 1986, George, Wassermann et al. 1995).

The development of rTMS as an antidepressant therapy is supported by extensive clinical research (George, Lisanby et al. 2010, Levinson, Fitzgerald et al. 2010, Holtzheimer III and McDonald 2014). In 2008, the FDA approved the "NeuroStar® TMS Therapy System," (Neuronetics, Inc., Malvern, PA; 510k number: K083538) as the first device for rTMS treatment of MDD. Since then, three additional TMS devices have been approved: the "Brainsway Deep TMS System"® (Brainsway, Ltd., Har Hotzvim, Jerusalem, 510k number: K122288), the "Rapid Therapy System"® (Magstim Company Limited, Philadelphia, PA, 510k number: K143531), and the "MagVita Therapy System"® (MagVenture, Atnlanta, GA, 510K number 150641).

With FDA approval of four devices in the United States, rTMS has been adopted into clinical practice (Hutton 2014). In a number of US states, federal and commercial healthcare insurers cover rTMS therapy for MDD patients (Cook, Espinoza et al. 2014). Given the current and growing use of rTMS, it is timely that clinical recommendations be developed to inform rTMS use in clinical settings.

The goal of these recommendations is to promote consistency in the clinical application of rTMS according to the available data. Investigational rTMS application methods (e.g., brief bursts of gamma (50hz) "theta-burst" stimulation) (Bakker, Shahab et al. 2015, Chistyakov, Kreinin et al. 2015) fall outside of the current scope of this review and are not included in these consensus recommendations.

METHODS

Participants for the Consensus Recommendations

The National Network of Depression Centers (NNDC) convened a Task Group of expert clinicians and researchers on rTMS. The experts met at the NNDC Annual Conferences and via teleconferences and created a set of consensus rTMS clinical application recommendations. Beginning in 2014, the NNDC task group aligned with the American Psychiatric Association (APA) Council of Research (COR) Workgroup on Diagnostic Markers and Treatment members to revise and establish the consensus recommendations. The consensus recommendations here are informed by the available research that included three large randomized controlled trials, systematic reviews and meta-analyses of smaller sham controlled trials. As there were only three large randomized controlled trials available, we thought it prudent to not conduct a meta-analysis. In cases where the research evidence was equivocal or unclear, a consensus decision on how rTMS should be administered was reached by the authors of this paper and is denoted in the paper as “expert opinion”.

Evidence to Support the Consensus Recommendations

The NNDC Task Group collected evidence via literature reviews and expert opinions. Task Group members conducted the literature review in Ovid SP Medline (dates: 1990 - 2015), PsychInfo (dates: 1990 - 2015), and PubMed (dates: 1990 - 2015), using the following terms: major depressive disorder, MDD, depression, transcranial magnetic stimulation, repetitive transcranial magnetic stimulation, TMS, and rTMS. The search was limited to articles that were written in English. Members of the NNDC Task Group and APA COR members also provided expert opinion and comments.

RESULTS

Efficacy of rTMS in Depression

<u>Evidence basis for antidepressant efficacy</u>

The acute antidepressant properties of rTMS delivered to the dorsolateral prefrontal cortex (DLPFC) have been extensively examined. A systematic review and meta-analysis of 29 randomized, controlled clinical trials of high frequency rTMS in 1,371 participants found that the statistically and clinically significant pooled odds ratio (OR) for response was 3.3 (95% confidence interval (CI): 2.35 –

4.64) with a corresponding number needed to treat (NNT) of 6 (95% CI: 4.4 – 6.8), and the OR for remission was 3.3 (95% CI: 2.04 – 5.32) with a number needed to treat (NNT) of 8 (95% CI: 5.8 – 10.5) (Berlim, Van den Eynde et al. 2014). Similarly, another systematic review and meta-analysis of 16 double-masked, parallel-design, randomized controlled clinical trials (RCT's) of high frequency rTMS relative to inactive sham rTMS found a statistically significant effect size (Cohen's d) for antidepressant effect of -0.55 (95% CI: -0.75 - -0.35) (Kedzior, Reitz et al. 2015).

To date, there have been three multicenter RCT's of rTMS for the treatment of MDD in antidepressant medication free patients (O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010, Levkovitz, Isserles et al. 2015). The first, an industry sponsored study (O'Reardon, Solvason et al. 2007), found rTMS delivered with a figure-of-eight coil was safe and effective with a response rate of 24% and remission rate of 17% with active rTMS, compared with 15% response and 8% remission with sham rTMS. The second (George, Lisanby et al. 2010), a National Institute of Mental Health (NIMH) sponsored study with rTMS delivered with a figure-of-eight coil, found a 15% response rate and 14% remission rate with active rTMS, compared with 5% response and remission rates with sham rTMS. The third, an industry sponsored study with rTMS delivered with the H1-coil (Levkovitz, Isserles et al. 2015), demonstrated a response rate of 37% and remission rate of 30% with active rTMS compared to a 28% response rate and 16% remission rate with sham rTMS. At present, there have been no randomized trials that compared the antidepressant effects of rTMS delivered by figure-of-eight coil versus H1-coil.

While the effect size for the FDA cleared (see Footnote 1 for definition of cleared and approved) protocols with rTMS as monotherapy was in the medium range, there is potential to improve efficacy. Evidence for potential improvements has emerged in studies that optimized rTMS pulse and train parameters (McGirr, Van den Eynde et al. 2015), developed new coils (Ge, Jiang et al. 2014), and combined therapy paradigms (e.g., coupled rTMS with psychotherapy and/or pharmacotherapy (Bretlau, Lunde et al. 2008). However, these approaches are investigational at present.

Predictors of Antidepressant Response

Among the most consistently reported predictors of antidepressant response across all therapeutic modalities is the degree of treatment resistance (Prudic, Sackeim et al. 1994, Rush, Trivedi et

al. 2006). An analysis of the predictors of response in the first large rTMS RCT found that patients who failed only one medication trial, relative to two or more trials, were more likely to respond to rTMS (Lisanby, Husain et al. 2009). However, there was no relationship between degree of treatment resistance and response to rTMS in a large multisite naturalistic study (Carpenter, Janicak et al. 2012) or open case series (Connolly, Helmer et al. 2012). The present FDA guidelines also do not restrict the use of rTMS to patients with only one medication failure.

Patient clinical factors that have been correlated with a decrease in the response to rTMS include mood disorders with significant anxiety (Lisanby, Husain et al. 2009) and longer duration of the current episode (Holtzheimer, Russo et al. 2004, Brakemeier, Luborzewski et al. 2007) although neither of these have emerged as a consistent predictor of outcome in large-scale rTMS trials (Carpenter, Janicak et al. 2012). Comordid psychotic symptoms are also associated with poor response to rTMS (Slotema, Blom et al. 2010).

Expert opinion is that rTMS is appropriate as a treatment in patients with MDD even if the patient is medication resistant or has significant comorbid anxiety. However patients who have comorbid psychotic symptoms or acute suicidal ideation should be considered for more invasive treatments such as electroconvulsive therapy (ECT) (Kellner, Knapp et al. 2006).

Efficacy and Safety in Special Populations and Comorbid Psychiatric Conditions

The FDA approval of rTMS is limited to adults with MDD. However, there is evidence of the safe therapeutic use of rTMS in adolescents with mood disorders (Wall, Croarkin et al. 2011, Donaldson, Gordon et al. 2014), women with perinatal depression (Kim, Epperson et al. 2011), and a broad range of neuropsychiatric disorders such as bipolar disorder (Harel, Zangen et al. 2011), panic disorder (Mantovani, Aly et al. 2013), obsessive compulsive disorder (Mantovani, Simpson et al. 2010), depersonalization disorder (Mantovani, Simeon et al. 2011), post traumatic stress disorder (Karsen, Watts et al. 2014), and schizophrenia (Barr, Farzan et al. 2012). While these studies have suggested clinical benefit, there is insufficient evidence to support the routine clinical use of rTMS in these populations and other neuropsychiatric conditions at the present time. Children, adolescents, and pregnant women represent special populations in need of safe and effective alternative antidepressant treatments, and

ongoing rTMS studies in these areas will be important contributions to neuropsychiatric practice. Moreover, the routine clinical use of rTMS in conditions other than primary MDD is not approved by the FDA, and awaits more evidence to substantiate safety and efficacy.

Evaluation of Patients for Transcranial Magnetic Stimulation

Pre-rTMS Treatment Evaluation

A comprehensive review of the patient's health status (including historical and current medical, surgical, neurological, and psychiatric conditions and medications) and physical examination are components of an evaluation to determine medical safety and necessity of rTMS (see Table 1).

[INSERT TABLE 1 ABOUT HERE]

The pre-rTMS evaluation should identify risk factors associated with seizure induction during high frequency rTMS (Wassermann 1998, Rossi, Hallett et al. 2009) such as (1) personal or family history of epilepsy or seizure, (2) past stroke or head injury with neurological sequelae, (3) concurrent use of medications or substances that lower seizure threshold (e.g., stimulants) or dose reduction of a medication with anticonvulsant properties (e.g., benzodiazepine), and (4) the presence of neurological disorders or medical conditions that might be associated with lowered seizure threshold (e.g., sleep deprivation, cerebral aneurysm, increased intracranial pressure, recent head trauma, electrolyte imbalance, withdrawal from substances of abuse or recreational use). The safety evaluation to quantify risk factors can be aided with tools such as the TMS Adult Safety Screen (TASS) (Keel, Smith et al. 2001) or other clinic-specific screening tools. The presence of conditions such as these could change the risk-benefit ratio and should be discussed during the pre-rTMS treatment evaluation in order to apprise the patient of potentially increased risk for adverse effects (e.g., seizure) that could mitigate the potential benefits (e.g., decreased depression severity).

[INSERT TABLE 1 ABOUT HERE]

At the first TMS treatment session, a TMS procedure is conducted to correctly establish the optimal site for motor response and individual motor threshold (MT) in order to minimize side effects. Failure to identify the optimal site and/or minimal pulse intensity for the MT can result in a falsely elevated MT value and lead to rTMS stimulation at levels potentially above the safety guidelines (Wassermann 1998). In addition, the location of the optimal MT site is often used as a reference point for identification

of the prefrontal cortex treatment location. The appearance of twitching or shaking of the contralateral hand exclusively during rTMS stimulation trains should alert the clinician about spread of neuronal action potentials to motor cortex and heightened risk for generalized seizure. In such cases, rTMS treatment should be stopped until the MT is rechecked and safe protocol parameters are re-established.

Contraindications to Transcranial Magnetic Stimulation

rTMS should not be administered to patients who have ferromagnetic metal objects implanted in the head or neck areas in close proximity to the magnetic fields from the TMS coil. Eddy currents induced in metal objects by the TMS magnetic field cause the objects to heat and generate risk for thermal injury to adjacent tissue (Hsieh, Dhamne et al. 2012). The TMS magnetic field may also induce movement of ferromagnetic objects. The evaluation of the patient should include whether there has been the surgical placement of metal plates, clips, electrodes, chips, pumps, stimulators, cochlear implants, pacemakers, and other implanted medical devices, as well as past exposure to all metal fragments, tattoos rendered with ferromagnetic-containing ink, permanent piercings, and/or other possible sources of metal in the head and neck.

rTMS can induce current in subcutaneous leads in the scalp (e.g., deep brain stimulators (DBS)), which can result in unintended currents flowing in the DBS electrodes in the brain (Deng, Lisanby et al. 2010). Therefore, DBS would be considered a contraindication to TMS until further safety testing is conducted to understand this risk, or device modifications are put in place to prevent this safety hazard.

Metal implanted below the head and neck (e.g., hip prosthesis) is generally considered safe because the magnetic field falls off rapidly with distance from the rTMS coil (Deng, Lisanby et al. 2013). Also, non-ferromagnetic orthodontic hardware (e.g., braces, implants, fillings) is considered safe with rTMS. Radiograph studies to detect metal in the head and neck may be warranted when clinical history is unknown and exposure is suspected (e.g., occupational risk); however, radiography is unable to determine if the metal objects are ferromagnetic. Limited safety data have been published to address the question of potential impact of rTMS on implanted vagus nerve stimulation (VNS) and cardiac pacemaker devices, whose components are typically located in the left cervical region and in the left anterior chest wall (Philip, Carpenter et al. 2014). Thus, consultation with other specialists may be needed before commencing treatment with rTMS in patients with many contraindications.

Treatment Parameters of Repetitive Transcranial Magnetic Stimulation

Parameter selection

Repetitive TMS has different effects on the brain depending on the location of the coil and the treatment parameters including intensity, pulse frequency, train duration, intertrain interval, and the number of pulses per session (see Table 2). Treatment intensity of the magnetic field is based on the individual patient's level of cortical excitability or resting MT. The minimum amount of single-pulse energy to the motor cortex required to induce motor neuron firing and muscle contraction of the contralateral thumb represents the MT for a given patient. The location of the optimal MT site is often used as a reference point for identification of the prefrontal cortex treatment location (see section on coil location below). Therefore, imprecision in finding the optimal MT site location could result in selecting the wrong treatment site (e.g., one that is further away from the desired prefrontal cortex target and closer to the motor cortex, introducing risk of diminished antidepressant efficacy and a higher risk of seizure induction). In addition, failure to identify the optimal site and/or minimal pulse intensity for the MT can result in rTMS stimulation at levels above the safety guidelines for the safe administration of rTMS (Wassermann 1998).

[INSERT TABLE 2 ABOUT HERE]

The combination of brief periods of repetitive TMS pulses with relatively long intertrain intervals maximizes safety. The number of pulses per session is typically 3,000 per session for the figure-of-eight coil (O'Reardon, Solvason et al. 2007) and 1,980 for the H1-coil (Levkovitz, Isserles et al. 2015). Other research has found safety with up to 6,800 pulses per session with the figure-of-eight coil (Hadley, Anderson et al. 2011); however, safety with such a large number of pulses requires replication in larger clinical samples before being implemented in routine clinical practice. Moreover, to date, no data have confirmed that more than 3000 pulses per session are associated with greater efficacy (Berlim, Van den Eynde et al. 2014).

Coil selection

The FDA-cleared coils for treating depressed patients with rTMS coils include a figure-of-eight shaped coil (with or without an iron core) (Epstein and Davey 2002) or an H-shaped coil (Roth, Zangen et al. 2002). Other coil geometries are the focus of research investigations (Deng, Lisanby et al. 2013, Deng, Lisanby et al. 2014). Coils used in many clinical trials of rTMS for depression have been figure-of-

eight shapes that produce relatively focal stimulation (with a “hot spot” below the intersection of the two round “wings”) in the prefrontal cortex at a depth of 1 – 2 cm (Thielscher and Kammer 2004). The H1-coil produces bilateral stimulation in broad regions of the frontal cortex (left greater than right side) and allows a slower drop-off in magnetic field intensity (Deng, Lisanby et al. 2013). At present, no data have directly compared the relative safety or efficacy of different coils.

Coil placement

In the large-scale clinical trials, figure-of-eight coils and the H1-coil were positioned over the left dorsolateral prefrontal cortex with stimulation provided at high frequency. Also, in the NIMH sponsored study (George, Lisanby et al. 2010), some patients were treated in a later open label phase with the figure-of-eight coil positioned over the right dorsolateral prefrontal cortex, with stimulation provided at low (1 Hz) frequency (McDonald, Durkalski et al. 2011). Both high frequency stimulation over the left DLPFC and low frequency stimulation over the right DLPFC have shown antidepressant effects (Chen, Zhou et al. 2013). Low frequency stimulation decreases cortical excitability compared to the increase in cortical excitability associated with high frequency rTMS.

The FDA label specifies that the rTMS figure-of-eight coil be placed over the left dorsolateral prefrontal cortex with high frequency stimulation and the H1-coil be placed over the prefrontal cortex with high frequency stimulation. Although formally considered off label, low frequency stimulation may be advantageous in cases where there is a high risk of seizure, poor tolerability (e.g., pain), or inefficacy obtained with delivery of standard high frequency stimulation. Some evidence suggests that certain patients may respond preferentially to either low or high frequency stimulation (George and Post 2011, Berlim, Van den Eynde et al. 2013, Speer, Wasserman et al. 2014), and that there may be beneficial effects from magnetic energy delivered at a pulse frequency synchronized to the patient’s individual alpha frequency (Jin and Phillips 2014, Leuchter, Cook et al. 2015).

Acute Treatment Course Planning

Treatment sessions using the parameters found in the large-scale clinical trials (O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010, Levkovitz, Isserles et al. 2015) typically last approximately 30 - 40 minutes (see Table 3). Patients should be informed that although some studies showed depressive symptoms decrease following daily rTMS treatments (5/week) as early as 2 or 3

weeks after commencing treatment (O'Reardon, Solvason et al. 2007), a standard acute course of 20 to 30 treatment sessions over 6 weeks will likely be needed to achieve results consistent with published regulatory trials (O'Reardon, Solvason et al. 2007, Levkovitz, Isserles et al. 2015). Accordingly, patients undertaking a course of rTMS need to be able to make the time commitment for a 4 to 6 week treatment course. Several prospectively designed extension trials showed that patients who show no response to a standard acute course of 20 - 30 treatment sessions may eventually respond if their course is continued with ongoing daily (5/week) sessions beyond 6-weeks (Avery, Isenberg et al. 2008, McDonald, Durkalski et al. 2011).

[INSERT TABLE 3 ABOUT HERE]

While standard high-frequency (10 Hz) rTMS to the left prefrontal cortex region is currently the most common practice in clinical settings that use the Neuronetics NeuroStar™, Magstim Rapid2, or MagVenture Magvita™ devices with comparable figure-of-eight coils, 18 Hz stimulation over bilateral prefrontal cortex is standard with the Brainsway DeepTMS H1-coil for depression. Safety and side effect considerations may vary when stimulation is applied with different methods (e.g., other frequencies, coil types).

Recommended rTMS Procedure

Below is a summary of the key elements of an rTMS procedure including obtaining informed consent, MT determination, coil positioning, monitoring of the patient during the rTMS administration, and managing side effects (see Table 4).

[INSERT TABLE 4 ABOUT HERE]

Informed Consent

As for any medical procedure, the risks and benefits of rTMS, as well as alternate treatments (e.g., pharmacotherapy, psychotherapy) should be described in the consent form and be thoroughly discussed with the patient. As part of the consent procedure, it is important to disclose if the rTMS treatment being used is "off-label." Off-label use of a device or treatment of patients with clinical characteristics differing from those used in regulatory clinical trials may result in risks or outcomes that

are not consistent with results described in the FDA approved marketing materials for a particular device, and the patient should be aware of that risk. The FDA “label” for an rTMS device is outlined in the “User Manual” created by the device manufacturer that describes the intended use and directions for use based on clinical trials conducted with that specific device. Federal regulations require that rTMS device “Indication for Use” labels contain a description of the clinical trial population that identifies the study population according to treatment severity and disease duration, along with coil position, stimulation parameters, and directions for use consistent with procedures used in the clinical trials (O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010, Levkovitz, Isserles et al. 2015) that generated data for FDA application and regulatory approval.

While data from the large sham-controlled rTMS trials (O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010, Levkovitz, Isserles et al. 2015) is currently considered the best quality evidence for guiding clinical application of rTMS, the broader “evidence base” includes published findings from other smaller studies that addressed safety and efficacy of rTMS in a number of ways that are not included in the device labels. Examples of rTMS applications consistent with the published evidence base, but not described in product labeling include: 1) treatment of primary psychiatric conditions other than MDD without psychotic features (Slotema, Blom et al. 2010, Gorelick, Zangen et al. 2014), 2) administering more than 3000 pulses per session (Holtzheimer III, McDonald et al. 2010), 3) stimulation of the right prefrontal cortex (George, Lisanby et al. 2010, Berlim, Van den Eynde et al. 2013) and, 4) use of devices with FDA approval for delivering peripheral nerve stimulation (e.g., Neotonus, Inc. Model 1000 Muscle Stimulator System, Magventure MagPro R30 and x100) or presurgical motor and speech mapping (Nexstim) rather than brain stimulation. A tick box on the consent form could indicate whether the planned rTMS treatment is considered “on-label” or “off-label,” and/or whether the relevant scientific evidence has been reviewed with the patient. Also, a separate consent form can be used for on-label and off-label rTMS.

In general, patients should be re-consented for rTMS when there is a change in risk or benefit from what was discussed during the initial consent procedure. Each service should develop its own policy regarding how many treatments should be agreed to initially; this could be either a set number of treatments or a set time frame after which re-consent is necessary. Additional scenarios which may

warrant re-consent include a transition between in- and outpatient treatment settings, transition from acute to maintenance rTMS, or change from on- to off-label treatment (e.g., addition of right-sided pulses). A record of the re-consent process can take the form of a newly signed consent form including a note in the chart by the physician indicating the re-consent and that any changes in risks and benefits were discussed.

Motor threshold (MT) determination

The MT is defined as the minimum stimulus intensity that elicits a response in the either the abductor pollicis brevis (APB) or the first dorsal interosseus (FDI) on the contralateral side for $\geq$ 50% of applied stimuli (usually defined as $\geq$ 5 of 10 stimuli administered) (Awiszus 2012, Westin, Bassi et al. 2014). Visual observation or electro-myographic (EMG) measurement is employed to observe the muscle contraction to determine MT (Pridmore, Filho et al. 1998). Research has demonstrated that visual observation yields significantly higher MTs than EMG (Westin, Bassi et al. 2014), and it should be noted that the safety guidelines (Wassermann 1998) employed EMG-determined MT, and are specific to the figure-of-eight coil. However, in a multicenter sham controlled trial, three sites using an EMG-determined MT compared to one site using visual observation showed no significant differences in side effects or clinical outcome (George, Lisanby et al. 2010). The standard of practice in the U.S. has been that visual observation is a safe substitute for EMG-determined MT, though the FDA-approved device systems for depression do not include EMG equipment or instructions. Single pulses delivered no more frequently than every five seconds should be delivered to map out the MT region in order to minimize the effect of the single pulses on motor cortex excitability.

The standard practice for dosing rTMS with the figure-of-eight or H1-coils is to administer a stimulus at a chosen percentage (e.g., 120%) of the MT (Padberg, Zwanzger et al. 1999). As such, MT determination must be carried out before the first rTMS treatment. When daily treatments are administered, the MT should be redetermined prior to treatment whenever there has been a change in medication with potential to impact cortical excitability, in the face of other clinical events that may alter seizure threshold (e.g., sleep deprivation, change in substance use pattern, emergence of neurological symptoms) (Mufti, Holtzheimer III et al. 2010), or consideration should be given to weekly MT redetermination as there is a possibility of drift in the MT (Zarkowski, Navarro et al. 2009, George,

Lisanby et al. 2010). While data generally suggest that the MT remains relatively stable over time (Boroojerdi, Meister et al. 2002), those data were based on medication-free cohorts.

The expert recommendation is to base treatment on a measured visual or EMG-determined MT, and to check the MT either weekly or in cases where there are changes that could affect the MT.

Coil Positioning Method

A variety of techniques have been employed for positioning the TMS coil when treating patients with MDD including placing the coil 5, 5.5, or 6 cm anterior to the motor cortex (e.g., the centimeter rule), the International 10-20 System, stereotactic frames, and neuroimage guided frameless positioning technologies (see Table 5). The “5-centimeter rule” involves measurement to a location 5 centimeters anterior to the MT location in the anterior-posterior plane, which corresponds to 5.5 cm if measurement is made directly on the scalp due to convexity of the head. One large scale clinical trial (O'Reardon, Solvason et al. 2007) employed the 5 centimeter rule with the figure-of-eight coil, and another (George, Lisanby et al. 2010) followed the same rule that was modified with informed placement from magnetic resonance imaging. The latter resulted in the figure-of-eight coil being moved forward to 6 centimeters in 33.2% of the participants, although moving the coil did not improve remission rates (Johnson, Baig et al. 2013). However, the 5 cm rule would have placed the TMS coil on the premotor cortex for 9% of the patients and none of these patients remitted.

[INSERT TABLE 5 ABOUT HERE]

For the H1-coil, a large scale clinical trial employed the 6 centimeter rule (Levkovitz, Isserles et al. 2015). The centimeter rule must be considered a rough means of estimating DLPFC given the variation among individuals in skull size, motor cortex anatomy, and relationship of DLPFC to the motor cortex (Ahdab, Ayache et al. 2010). Although the clinical trial for the Neuronetics, Inc. device (O'Reardon, Solvason et al. 2007) used the 5 cm rule for coil placement, the company recommends placing the coil 5.5 cm anterior of the motor cortex.

Another approach employed in large scale clinical research (Herwig, Fallgatter et al. 2007) is the determination of coil position using individual scalp landmarks such as F3 (scalp location corresponding with left prefrontal cortex) based on the International 10-20 System for placement of EEG recording electrodes (Beam, Borckardt et al. 2009). Since individual variation in cranial size and shape are taken

into consideration with anatomical measurements for the International 10-20 System, this method may offer better precision (Mir-Moghtadaei, Caballero et al. In Press) though clinical outcomes were not directly compared using different coil positioning methods.

The stereotactic frame system for coil positioning fixes the patient's head in place with respect to a frame. This system employs a mechanical coil positioning system, which is also anchored to the frame via mechanical arms, to allow registration of the spatial coordinates of the coil position with respect to the frame and the patient's head (Herwig, Schonfeldt-Lecuona et al. 2001). The main advantage of this approach is that it allows for more precise coil positioning by holding the coil in place. However, this technique has not been used in RCTs, and may be time consuming.

Neuroimage (e.g., MRI) guided frameless positioning technologies offer the greatest precision (Herwig, Padberg et al. 2001), but this method is expensive, requires a head MRI scan that is different from a standard diagnostic brain MRI, and there is limited evidence suggesting that this approach confers higher efficacy rates (Fitzgerald, Hoy et al. 2009). Among all coil positioning methods, based on research (Herwig, Padberg et al. 2001, Herwig, Satrapi et al. 2003, Beam, Borckardt et al. 2009) and expert opinion, coil placement on the F3 position of the 10-20 system is considered the preferred coil positioning method for routine clinical use when frameless stereotaxy is unavailable or impractical.

Monitoring Patient Safety and Efficacy during rTMS Delivery

Patients should be monitored during rTMS delivery to assess for adverse effects or for any events occurring during treatment that may impact rTMS safety or efficacy (e.g., change in mental status or syncope, change in head location relative to coil). Clinicians should use checklists or other systematic assessment methods (e.g., build templates to an electronic medical record) at every rTMS session, and document variables (see Table 1 for variables to include) that may affect the treatment (e.g., changes in medication) as well as treatment-related side effects (e.g., scalp pain).

Systematic measurement of symptoms and outcomes should be used to document efficacy (e.g., changes in depressive symptoms). Depression symptom severity instruments, either clinician-rated, patient-rated, or both, should be completed weekly or bi-weekly to document changes or stability in depressive symptoms and to determine when therapeutic response and remission has been achieved (Greer and Trivedi 2014). Systematic evaluation of depressive symptoms allows for the correct

classification of treatment emergent and residual depressive symptoms that can be used to inform the treatment decision making process (Trivedi and Daly 2007, McClintock, Husain et al. 2011).

Common Side effects of rTMS

Safety data and procedure standards relevant to the use of rTMS for both research and the treatment of psychiatric disorders have been previously summarized (Wassermann 1998, Rossi, Hallett et al. 2009). Additional sources of safety data are derived from large randomized controlled clinical trials of high-frequency rTMS for depression with two types of coils (figure-of-eight, H1) (Herwig, Fallgatter et al. 2007, O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010, Levkovitz, Isserles et al. 2015).

The most common side effects of rTMS during treatment (see Table 1) are transient discomfort of the head or scalp at or around the location where TMS pulses of magnetic energy are applied. Discomfort may extend to adjacent areas of the face including locations around the ipsilateral eye, ear, nose, and jaw. The patient may experience twitching or movement of these areas during stimulation trains due to excitation of superficial nerve branches and contraction of superficial muscle groups.

Headache is sometimes reported after rTMS treatment, particularly early in the course of therapy when there has been no accommodation to the high-frequency tapping sensation created by the stimulus. The percussive sensation on the scalp may be particularly uncomfortable for individuals with high MT levels. Procedural pain and headache typically decrease with additional sessions due to habituation that occurs independent of patient outcomes (Janicak, O'Reardon et al. 2008, Borckardt, Nahas et al. 2013).

In practice, rTMS does not increase risk of migraine headaches in healthy subjects or those with a history of migraine (Lipton, Dodick et al. 2010). In fact, the FDA approved a single-pulse device (SpringTMS, eNeura, Inc.) for the treatment of acute migraine headache. Simple strategies to manage pain and headache include use of oral, over-the-counter analgesic medications (e.g., acetominophen, ibruprofen) taken before or after treatment or topical analgesic products (lidocaine/prilocaine cream or lidocaine gel, available by prescription) applied to the scalp at the location of coil placement at least 30 minutes before the treatment (Borckardt, Smith et al. 2006, Trevino, McClintock et al. 2011).

Reduction of TMS pulse amplitude is another strategy to enhance tolerability of rTMS during the initial treatments, though efficacy of rTMS delivered below 110% MT remains questionable due to limited

evidence. Comfortable positioning of the patient in the rTMS treatment chair, especially with sufficient support of head, neck, and spine, is a first step to reduce nonspecific discomfort that may contribute to post-treatment headache or other regional myalgias. Small rolls of towel or cushions tucked under the knees, buttocks, forearms, neck, or lumbar region can enhance support and facilitate muscle relaxation during rTMS.

There is no evidence of pathological change in brain tissue resulting from rTMS treatment delivered within the safety ranges (Wassermann 1998, Rossi, Hallett et al. 2009), but theoretical risks remain for protocols utilizing stimulation parameters outside evidenced-based data. Investigations into rTMS dosing modifications for optimization of treatment benefits are ongoing; published data show exposure to “accelerated “ dosing, achieved by an increased number of total daily pulses (with other parameters configured within established safety guidelines) generally appears safe in open-label studies (Holtzheimer III, McDonald et al. 2010, McGirr, Van den Eynde et al. 2015). For example, relative to sham, there were no differences in side effects with a total of 57,000 TMS stimuli delivered across three days (George, Raman et al. 2014). Long-term and controlled trials are needed to fully elucidate the safety profile of alternate rTMS dosing strategies.

Uncommon Side Effects

An uncommon side effect of rTMS is induction of mania or hypomania (Dolberg, Schreiber et al. 2001). Daily assessment of treatment-emergent activation, agitation, insomnia, irritability, or behavioral disinhibition may alert the clinician to early signs of mania, and should prompt a re-evaluation of primary diagnosis, concurrent use of stimulating medications, or possible need for a mood stabilizer.

Auditory acuity, if ear protection is worn that protects at minimum up to 30 decibels, is not affected by rTMS (Costello 2011). Thus, ear protection for the patient, TMS device operator, and others in the treatment room during active stimulation is warranted to minimize possible hearing loss (Rossi, Hallett et al. 2009).

Excessive heating of the TMS coil, a rare occurrence that is mostly associated with continuous use of the device with long trains and high intensity, may create risk for discomfort and theoretically scalp burn. FDA-approved devices have built-in thermal sensors that interrupt stimulation when coil warming is detected beyond a threshold temperature. Application of the TMS coil to wet hair or the scalp moist with

products (e.g., hair gel) may reduce ventilation around the coil surface and promote unwanted heating at the contact site. Availability of a fan or other means to cool the TMS coil or reduce ambient room temperature during or between treatments may be useful in busy clinical settings.

Vasovagal response to pain, particularly in the context of heightened anxiety, hypoglycemia, hyperventilation, or dehydration, can result in syncope during or following rTMS (Wassermann 1998). Syncope can mimic a seizure behaviorally and may include stiffening, jerking, vocalizations, oral and motor automatisms, brief head or eye deviation, incontinence, and hallucinations (Rossi, Hallett et al. 2009). Syncope is best differentiated from seizure activity by its rapid termination and return of consciousness. Features suggestive of impending syncope include pallor, dizziness, weakness, narrowing of the visual field or blurring, sweating, nausea, bradycardia, or hypotension (Rossi, Hallett et al. 2009).

Risk of Inducing Seizure

The risk of tonic-clonic seizure, a rare event during rTMS, is related to the direct stimulation of motor cortex or stimulation of adjacent brain areas with spread of neuronal excitation to motor cortex (Classen, Witte et al. 1995, Rossi, Hallett et al. 2009). Inspection of the contralateral hand for signs of twitching or movement during stimulation may ensure that stimulation does not spread from prefrontal to primary motor cortex. In one study (Johnson, Baig et al. 2013) that evaluated placement of the stimulator by MRI, the "5 cm rule" would have placed stimulation in premotor cortex for 9% of patients. The TMS administrator should be vigilant about limb movements during rTMS, as stimulation of the motor cortex can lead to generalized seizure induction with tonic-clonic movement pattern.

The risk of rTMS-induced seizures under ordinary clinical use is estimated to be 1 in 30,000 treatments (0.003%) (Carpenter, Janicak et al. 2012). There were no reports of seizure in two of the three large-scale controlled clinical trials (O'Reardon, Solvason et al. 2007, George, Lisanby et al. 2010). In the study (Levkovitz, Isserles et al. 2015) where one seizure was reported, it occurred in a participant who had heavy alcohol use the night before the rTMS treatment. A published summary of reported seizures related to rTMS (Rossi, Hallett et al. 2009) found that the majority of rTMS-related seizure events occurred in patients with pre-existing elevated risk for seizure, or when stimulation parameters exceeded the recommended safety ranges. Concurrent use of medications that lower the seizure threshold (e.g.,

imipramine, bupropion, clozapine) may increase risk of rTMS-induced seizure during or after treatment (Rossi, Hallett et al. 2009, Mufti, Holtzheimer III et al. 2010). It should be noted that seizures can also occur within safety guidelines, even in patients who present with no known risk factors. For example, Harel et al. (2011) reported one patient who had a generalized seizure in a study of 19 patients treated with rTMS with the H-coil.

For seizure risk management, the TMS device operator should visually monitor the patient during the rTMS administration for signs of motor activity, including seizures. Although EEG is the most definitive means to detect seizure activity, routine EEG monitoring is not recommended during rTMS therapy, based on the low incidence of epileptiform activity with rTMS.

All programs administering rTMS should have a documented plan for managing seizures. Those who administer rTMS should be trained as “first responders” in order to render appropriate care in the event of seizure. Most rTMS-induced seizures have been relatively brief (usually less than a minute and no longer than 5 minutes), with no association with any long term medical complications (Reti, Schwarz et al. In Press).

The acute management of an rTMS induced seizure should focus on ensuring safety and preventing complications during the event. Such management includes removing the coil from the patient’s head and placing the patient in a lateral decubitus position where they are unlikely to be harmed during clonic movements and are less likely to aspirate. The management plan should include a plan to call for emergency medical help in the unlikely event that a convulsive state is associated with injury, aspiration, cardiac arrest, other complications, or in the event the seizure does not terminate within a specified period of time (e.g., 5 minutes). Thus, the treatment room will need to have available appropriate equipment (e.g., telephone to call for emergency) for managing a seizure before the arrival of emergency response teams.

Training and Credentialing the Clinical Team Providing rTMS

The rTMS prescriber should be a clinician with prescriptive privileges who is both knowledgeable about, trained, and credentialed in rTMS. Such training should include proficiency in all aspects of the rTMS procedure. Each service should develop its own policy regarding how many times a prescriber must

obtain motor threshold or treat a patient before re-credentialing of that prescriber.

The TMS device operator should be a clinical professional who independently administers rTMS under the supervision of the rTMS prescriber. The operator should be trained in assessing the MT and administering the treatment. At all times, the TMS device operator monitors the patient during administration of the treatment, especially for adverse events, and ensures contact between the TMS coil and the patient's scalp. The operator should be trained to understand evidence of cortical excitation (i.e., movements in the hand during the procedure) and be proficient in managing a potential seizure. The operator must also be able to independently make routine adjustments (e.g., move the TMS coil) and have specific guidelines as to when to contact the rTMS prescriber. Examples of TMS device operators include certified medical assistants, medical technicians with relevant experience, physician assistants, and nurses. The TMS device operator should be approved by the hospital bylaws.

Documentation

Documentation in preparation for rTMS should include the following basic elements:

1) Comprehensive psychiatric assessment documenting the diagnosis and indication for rTMS for the patient, including risks and benefits of treatment alternatives.

2) Medical history, documentation of physical exam, and assessment of risks and benefits of rTMS for the patient, including review of rTMS contraindications.

3) Prescription for rTMS, including selection of rTMS parameters and treatment plan.

4) Written informed consent.

The procedure note documenting rTMS delivery at each treatment should include the following basic elements:

1) Time-out procedure, identifying the correct patient, correct stimulation site, and correct dosage as per Joint Commission Guidelines for implementation of the Universal Protocol for the prevention of wrong site, wrong procedure, and wrong person procedures.

2) Specific rTMS treatment parameters in sufficient detail to allow another clinician to replicate the treatment (intensity, frequency, train duration, coil type, coil placement, scalp location, number of pulses).

3) Concomitant medications.

4) Description of treatment-emergent side effects.

5) Assessment of clinical response and side effects. Using a structured clinical symptom rating scale is highly encouraged and required for reimbursement of rTMS by most federal and commercial insurers.

6) Reasons for any change in treatment plan.

7) For Medicare documentation, the procedure note must also contain the diagnosis and additional clinical information as outlined in the applicable Coverage Determination Guideline document (https://www.cms.gov/Medicare/Coverage/DeterminationProcess).

CONCLUSION

Since FDA initial clearance of the first device in 2008, rTMS is becoming increasingly incorporated into clinical practice. As such, these consensus recommendations (Table 4) will help inform clinical practitioners of safe and effective application of rTMS in treating MDD. Practitioners are encouraged to implement rTMS based on available evidence-guided recommendations, and to employ systematic measurement for documenting safety and efficacy. Additional research is warranted to determine optimal treatment parameters and algorithms for its implementation across different phases of antidepressant therapy and relapse prevention (Connolly, Helmer et al. 2012, Dunner, Aaronson et al. 2014).

Table 1. Transcranial Magnetic Stimulation Evaluation

(a) Variables to Assess before commencing rTMS

Variable	What to do if the variable is endorsed by the patient
• History of epilepsy • Family history of epilepsy • History of seizure • History of head trauma • History of loss of consciousness • History of stroke • History of brain tumor • History of traumatic brain injury • Any implanted medical devices • Any metal in the head	• Determine with the patient the risk/ benefit ratio of administering rTMS with this physical condition • Inform the patient that the presence of one of these variables could increase the risk of rTMS associated adverse effects including a TMS associated seizure • Consider consultation with other healthcare professionals (e.g., neurologist) to assess risks of possible rTMS associated adverse effects before commencing treatment with rTMS
• Current medication use	• Document the medications including name and dosage, and update the medication list at each rTMS session. • Use the information to create an individualized medication checklist to use at each rTMS session • Encourage the patient and their psychiatric provider to keep medications stable during their course of rTMS and to inform the rTMS clinical staff of any changes in medication use.
• Current alcohol/substance use	• Document the type and amount of alcohol/substance consumed • Provide education on the effects of alcohol/substance use on rTMS

rTMS = repetitive transcranial magnetic stimulation

(b) Variables to Assess at Each rTMS session

Variable	Actions or Considerations
• Sleep the night before treatment	If the patient endorsed insomnia, then • Assess the duration and severity of the insomnia • Provide education on sleep hygiene • If warranted (new onset or significant change in sleep pattern), consider rechecking motor threshold before commencing with rTMS treatment

• Any medication changes	• Document any medication changes and reconcile their medication history before each treatment • Provide education that changes in medication could affect the motor threshold • If warranted (change in medication could alter seizure threshold), consider rechecking motor threshold before commencing with rTMS treatment
• Side effects including:	
○ Headache associated with rTMS	• Document the duration and severity of the headache • Provide reassurance and educate the patient that headaches tend to occur early in treatment and decrease with successive treatments • If appropriate, recommend over-the-counter analgesic medication • Instruct the patient to monitor the headache for resolution and report back to rTMS staff
○ Neck pain associated with rTMS	• Document the duration and severity of neck pain • Adjust the patient's seating position and head position to enhance comfort • Provide neck support as needed (e.g., pillow)
○ Pain/discomfort at stimulation site (scalp)	• Document the quality, duration, and severity of pain • Provide reassurance and education to the patient that pain at stimulation site tends to be transient • If appropriate, recommend over-the-counter analgesic medication • If appropriate, recommend or prescribe topical analgesic for application to scalp (e.g., lidocaine gel) • Make subtle adjustment to coil position • Slightly reduce magnetic field intensity • Instruct the patient to monitor the pain and report information at the subsequent rTMS session
○ Scalp induration/irritation from rTMS coil	• Document the size and appearance of the erythema or edema at stimulation site on scalp • Provide education to the patient that redness is

	transient • Assess the coil temperature • Assess the coil contact on the scalp, adjust pressure if appropriate
○ Induction of manic/hypomanic symptoms	• Monitor closely for treatment-emergent insomnia, anxiety, irritability, agitation; use standard mania assessment scales in susceptible individuals • Evaluate possible role of concurrent medications • Consider the addition of a concurrent mood stabilizing medication • Consider if treatment with rTMS should be discontinued
○ Hearing loss / tinnitus	• Assess for duration and severity of hearing loss / tinnitus in relation to rTMS sessions • Check that ear plugs are intact • Provide education to the patient that hearing loss / tinnitus is a possible, though uncommon side effect • Instruct the patient to monitor the hearing loss / tinnitus and report information to the rTMS staff • Refer the patient to an audiologist as needed
○ Vasovagal Pre-syncope or Syncope	• Document the duration and severity of the symptoms • Reassure the patient that syncope is a possible, but rare side effect • Instruct the patient on adequate hydration prior to their treatment • Monitor medication use associated with orthostatic hypotension • If the patient experiences syncope, stop the current rTMS session and adjust the patient's head to a downward position in order to increase cerebral perfusion • Check the patient's blood pressure and

	pulse before and after each treatment • Refer the patient to healthcare provider (e.g. primary care physician, cardiologist) as needed
○ Seizure	• Stop the stimulation and remove the coil • Ensure the patient is safe and is breathing • Turn the patient to the side to minimize possible aspiration • Do not try to restrain the patient or put anything in the patient's mouth • Call emergency medical services (EMS) at the start of the seizure • Document the seizure activity (including start and stop time) • Discontinue treatment with rTMS pending medical evaluation

rTMS=repetitive transcranial magnetic stimulation

T**able 2. Transcranial Magnetic Stimulation Variables for Dosing**

Variables	Description
TMS Stimulation Parameters	• intensity - related to resting MT, most often 100-120% MT • pulse frequency - 1Hz or less ("low frequency") leads to reduced cortical excitability while faster ("high frequency", e.g., 5Hz, 10 Hz) increases cortical excitability • train duration and intertrain interval (ITI) - impact on safety, with shorter trains and longer ITI being less likely to induce a seizure
Coil Placement	• laterality – high frequency over left DLPFC, or low frequency over right DLPFC with the figure-of-eight coil. High frequency over the left-right DLPFCs with the H1-coil • positioning – use a positioning system (see Table 5) to place the coil over the intended cortical location
FDA Label for treating major depressive disorder in adults	• Neuronetics NeuroStar, Magstim Rapid2, and MagVenture MagVita TMS Therapy systems with figure-of-eight coils o left DLPFC at 120% MT o 3000 pulses/session, at 10Hz, in 4 second pulse trains with 26 second ITI • Brainsway DeepTMS Therapy system with H1-coil o left DLPFC at 120% MT o 1980 pulses/session, at 18Hz, in 2 second pulse trains with 20 second ITI

DLPFC=dorsolateral prefrontal cortex, ITI=Intertrain Interval, FDA=United States Food and Drug Administration, MT=motor threshold, TMS=transcranial magnetic stimulation

Table 3. Parameters for the Safe and Effective Administration of Transcranial Magnetic Stimulation in Clinical Practice*

	O'reardon et al. 2007 (O'Reardon, Solvason et al. 2007)	George et al. 2010 (George, Lisanby et al. 2010)	Levkovitz et al. 2015 (Levkovitz, Isserles et al. 2015)
Coil placement	Left DLPFC	Left DLPFC	PFC
Coil type	Figure-of-eight	Figure-of-eight	H1
Coil positioning method	5 centimeter rule	5 centimeter rule**	6 centimeter rule
Magnetic field intensity relative to resting motor threshold	120%	120%	120%
Hertz (Hz)	10 Hz	10 Hz	18 Hz
Stimulus train duration (on time)	4 seconds	4 seconds	2 seconds
Intertrain interval (off time)	26 seconds	26 seconds	20 seconds
Total number of pulses per rTMS session	3,000	3,000	1,980
Concomitant Medications	Hypnotics or anxiolytics (up to 14 daily doses) during Acute Phase; Antidepressant monotherapy initiated during rTMS taper phase and continued when rTMS was re-introduced during 24-week follow-up study (Janicak, Nahas et al. 2010)	Sedatives, hypnotics, or anxiolytics (up to 14 daily doses)	Sedatives, hypnotics, or anxiolytics

DLPFC=dorsolateral prefrontal cortex, PFC=prefrontal cortex, rTMS=repetitive transcranial magnetic stimulation
*Additional parameter safety information can be found in the respective transcranial magnetic stimulation device package insert as well as the Food and Drug Administration (FDA) 510k application material.
**In the study by George et al. (George, Lisanby et al. 2010) patients underwent head magnetic resonance imaging with fiducials (vitamin E capsules), which resulted in 33.2% of patients having the stimulating coil moved an additional 1 centimeter, for a total of 6 centimeters anterior.

Table 4. Summary of Consensus Recommendations for Transcranial Magnetic Stimulation

Variable	Recommendation
Clinical Environment for providing TMS	The clinical environment needs to include space for the TMS device, patient, and rTMS operator. The room needs to provide safety such that the rTMS operator is able to directly observe the patient. The room needs to be at an appropriate temperature such that the TMS device does not overheat. All persons in the treatment room need to wear ear protection (e.g., ear plugs) that provide at minimum 30 decibels of noise reduction. During treatment, the patient should be encouraged to remain awake, avoid activities that would make the head move (e.g., talking on cell phone), and not consume food or beverage.
Qualification of TMS operator	Qualifications for the rTMS operator may vary across TMS practices, and each practice should have a written policy. At a minimum, the TMS operator should be trained and certified to deliver rTMS including device operation, TMS coil targeting, and recognition and management of side effects. He or she should be trained as first responder to a seizure and have basic life support training certification (BLS).
TMS information to include in medical record	The medical record should include the diagnosis, device and coil types, treatment phase, cortical targeting method and cortical site for stimulation, motor threshold, stimulus intensity, frequency, stimulus duration, intertrain interval, number of stimuli, treatment related side effects, and medication usage.
Coil to use for TMS treatment	There is strong evidence that supports the use of the figure-of-eight and H1 coils, but not other TMS coils to treat depression at present.
Cortical target for starting TMS treatment	The majority of evidence with the figure-of-eight coil supports starting treatment by targeting the left DLPFC. There is some evidence that supports the figure-of-eight coil targeting the right DLPFC. There is evidence supporting bilateral targeting of the prefrontal cortex with the H1-coil.
TMS coil positioning method	There are multiple methods for positioning the rTMS coil over the targeted cortical location (see Table 5). Each method has its advantages and disadvantages, but the method that may be most practical in terms of time and accuracy is head measurements for identification of F3 using 10-20 EEG coordinates.
How often to check the motor threshold	The determination of motor threshold should occur at baseline, before commencing with the first treatment. See Table 1 regarding other considerations on how often to check the motor threshold.
Preferred length for acute TMS treatment. i.e., number of treatment sessions	Number of treatment sessions in an acute course should depend upon the risk-benefit ratio for clinical response, take side effects into consideration, and reflect measurement-based care.
Allowable psychotropic medications during TMS treatment	The safety guidelines for rTMS were determined in study participants who were free of antidepressant medications. While it is possible that psychotropic medication can affect the motor threshold, there are no known absolute contraindications to psychotropic medication usage during rTMS. All medication use and change should to be documented.

DLPFC=Dorsolateral Prefrontal Cortex, rTMS=repetitive transcranial magnetic stimulation, TMS=transcranial magnetic stimulation

Table 5. Advantages and Disadvantages of Common Coil Positioning Techniques

	Advantage	Disadvantage
5, 5.5, and 6 Centimeter Rule	• Inexpensive • Employed in large scale clinical trials • Easy to implement	• Imprecise coil position relative to anatomical target • May under or overestimate cortical target location • Is not individualized to the patient
International 10-20 System **(F3)**	• Inexpensive • Greater precision in locating cortical target • Individualizes to the patient head size/shape	• Requires tape measure and marking pen • May add additional time to rTMS procedure
Stereotactic Frame	• Greater precision in locating cortical target • Greater stability in holding coil steady	• Expensive; requires special equipment/software • May add additional time to rTMS procedure
Frameless Image Guided Navigation	• Greater precision in locating cortical target	• Expensive; requires special equipment/software • Patient will need head MRI • May add additional time to rTMS procedure

rTMS=repetitive transcranial magnetic stimulation, MRI=magnetic resonance imaging

Footnote 1

The following are definitions of “cleared” and “approved by the US Food and Drug Administration:
“cleared" the device after reviewing a premarket notification, otherwise known as a 510(k) (named for a section in the Food, Drug, and Cosmetic Act), that has been filed with FDA.
"approved" the device after reviewing a premarket approval (PMA) application that has been submitted to FDA.
Source: http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194460.htm

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AWARD REVIEW FORM

AWARD NAME: Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Education

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Med Ed on Lifelong Learning

CHAIRPERSON: ___Richard Summers, MD_____

STAFF LIAISON: ___Kay Acevedo_____

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
This certificate is awarded to APA members who have made outstanding and sustaining contributions to medical education, in both salaried and volunteer positions. Qualified nominees must have demonstrated significant contributions to the advancement of medical student education, including lectures, small group teaching, supervision, and course design.

Description of Selection Criteria for Award:
Potential nominees should have significant and sustained contributions (at least three years teaching at the nominating institution) to the advancement of resident education in one or more of the following categories:

- Teaching in different settings - psychiatry emergency services, inpatient, outpatient, community mental health, and other sub-specialty settings
- Lectures/Didactics
- Small group teaching or rounds
- Supervision
- Course design and/or administration
- Departmental committees (curriculum, evaluation, and promotions)
- Institutional committees (admissions, curriculum, student affairs, and promotions)
- Career counseling
- Research, publications, and/or presentations
- Extracurricular programs (i.e. orientation and leading support groups)

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: N/A
Cost of Cash Award: $0
Cost of Lectureship: $0
Award Account Balance: $0 (as reported by APA Online Financials)
Date Balance Determined: N/A

Award Nominees:
Salaried
Lourdes Dominguez, M.D. Columbia University
Valerie Houseknecht, M.D. Wright State University – Boonshoft School of Medicine
Abigail Kay, M.D. Thomas Jefferson University – Sidney Kimmel Medical College

Voluntary
Shirin Ali, M.D. Columbia University

Eduardo Espiridion, M.D. West Virginia School of Osteopathic Medicine
Katherine Winner, M.D.

Description of the Committee's Selection Process: Selection committee of the Council on Med Ed and Lifelong learning select the winner(s).

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NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Lourdes Dominguez, MD

APA MEMBER #: 0065632

CURRENT MEDICAL SCHOOL: Columbia University

NUMBER of YEARS NOMINEE HAS BEEN TEACHING AT CURRENT MEDICAL SCHOOL: 6 years

NOMINATED BY: Janis Cutler, MD

CHAIRPERSON ENDORSEMENT:
Maria Oquendo, MD
Vice Chair for Education, Professor of Psychiatry
Chairperson Signature over Name

Please circle category of nominee: (SALARIED*) VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

Please complete this form and return along with the following by **DECEMBER 1, 2015**:

- Letter of nomination detailing nominee's contribution to medical student education
- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
ATTN: KAY ACEVEDO
AMERICAN PSYCHIATRIC ASSOCIATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

COLUMBIA UNIVERSITY
College of Physicians and Surgeons

Department of Psychiatry
1051 Riverside Drive, Unit #5
New York, NY 10032

November 24, 2015

The Nancy C.A. Roeske, M.D. Certificate
American Psychiatric Association
Office of Graduate and Undergraduate Education
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

Dear Colleagues:

I am writing to nominate Dr. Lourdes Dominguez for the Nancy C. A. Roeske Certificate of Excellence in Medical Student Education. Dr. Dominguez is a long-standing member of our faculty who has been involved in medical student education during much of her career. In particular she has supervised students assigned to the inpatient unit serving a challenging community patient population that she runs. During the 6 years that her unit has served as a clerkship site she has interacted with over a hundred medical students.

Students have been consistently enthusiastic about their work with Dr. Dominguez. They have rated her "overall teaching effectiveness" as a mean rating of 7.6 on a 9-point scale (1-3 = below expectations, 4-6 = meets expectations, 7-9 = exceeds expectations). Students have repeatedly described her as a superb teacher, mentor, and role model. Enclosed is a summary of excerpted comments about students' work with Dr. Dominguez compiled from their written evaluations. As this documentation illustrates, Dr. Dominguez has achieved an outstanding teaching record. In addition, a number of our students have chosen a career in psychiatry as a result of their work with her. I cannot think of a more warm, encouraging, and positive role model.

In sum, Dr. Dominguez is a gifted and dedicated teacher and mentor who will be a well-deserving recipient of the Certificate of Recognition. I recommend her with great enthusiasm.

Sincerely,

Janis Cutler, M.D.
Director, Medical Student Education in Psychiatry
Professor of Clinical Psychiatry
Faculty, Columbia University
Center for Psychoanalytic Training and Research

NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Valerie Houseknecht, M.D.

APA MEMBER #: 0303718

CURRENT MEDICAL SCHOOL: Boonshoft School of Medicine, Wright State University

NUMBER of YEARS NOMINEE HAS BEEN TEACHING
AT CURRENT MEDICAL SCHOOL: 7 years

NOMINATED BY: Igor Elman, M.D. - Professor and Chair of the Department of Psychiatry

CHAIRPERSON ENDORSEMENT:

I Elman

Chairperson Signature over Name

Please circle category of nominee: (SALARIED*) VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

Please complete this form and return along with the following by **DECEMBER 1, 2015**:

- Letter of nomination detailing nominee's contribution to medical student education
- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
AMERICAN PSYCHIATRIC ASSOCIATION
DIVISION OF EDUCATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY

WSU Department of Psychiatry
First Floor, East Medical Plaza
627 S. Edwin C. Moses Blvd. Dayton, OH. 45417
Tel 937-223-8840 Fax 937-223-0758

November 22, 2015

The Nancy C.A. Roeske, M.D. Certificate Selection Committee
Attn: Kay Acevedo
American Psychiatric Association
Office of Graduate and Undergraduate Education
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

Dear Selection Committee:

I'm honored to nominate Valerie Houseknecht, M.D. for the salaried full faculty category of The Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Student Education.

Dr. Houseknecht has demonstrated a firm commitment to medical student education over the course of her many years of service with Wright State University. Dr. Houseknecht participates in the training of medical students across all four years. In the 1st and 2nd year courses, she assists in running small groups, as well as planning and coordinating the curriculum. In the 3rd year Psychiatry Clerkship, Dr. Houseknecht has been a dedicated and dependable clinical preceptor for students.

Student evaluations are uniformly positive, including a 4.67 (on a likert scale, with 5 being the best rating) in that "she challenged me to think about medical problems in new ways"; a 5.00 in "she was enthusiastic about teaching and my learning"; a 4.67 in "she provided timely and constructive feedback on my performance"; and a 5.00 in "she showed great concern for patients".

In addition to all of the above, Dr. Houseknecht is a Faculty Advisor for PsychSIGN (our student interest group in Psychiatry). She is also the Faculty Advisor for both the Boonshoft Student Wellness Group and Active Minds. She is a wonderful mentor for students interested in a career in psychiatry.

Dr. Houseknecht is an excellent clinician, educator, and role model. Student comments include: "Dr. Houseknecht was a fantastic physician to get to spend time with. Although the time I was able to spend with her was limited, she gave great insight into working the university population, as well as more knowledge about group therapies and mindfulness." "Dr. Houseknecht was a fantastic mentor. She built good rapport with her patients and was very knowledgeable about diagnosis and medications. I liked how she always asked about the patients I was seeing at the VA hospital, and some ideas of what I could look into about a patient's history, or suggestions on

how to approach patient care. I felt comfortable working with her. She always set aside time to talk about each patient, which was very educational. She also let me get involved by conducting my own interview. Overall, she was an excellent mentor."

In summary, Dr. Houseknecht's contributions to medical student education have been significant, and I highly recommend her for The Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Student Education.

Sincerely,

Ryan Mast, D.O., MBA
Director of Medical Student Education- Psychiatry
Associate Program Director of the Child and Adolescent Psychiatry Fellowship
Wright State University Boonshoft School of Medicine

NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Dr. Abigail Kay, M.D.

APA MEMBER #: 310225

CURRENT MEDICAL SCHOOL: Thomas Jefferson University Sidney Kimmel Medical College

NUMBER of YEARS NOMINEE HAS BEEN TEACHING AT CURRENT MEDICAL SCHOOL:

NOMINATED BY: Dr. Mitchell J. Cohen, M.D., Vice Chair for Education

CHAIRPERSON ENDORSEMENT:

Dr. Michael J. Vergare, M.D.

Chairperson Signature over Name

Please circle category of nominee: SALARIED* VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

Please complete this form and return along with the following by **DECEMBER 1, 2015**:

- Letter of nomination detailing nominee's contribution to medical student education
- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
ATTN: KAY ACEVEDO
AMERICAN PSYCHIATRIC ASSOCIATION
OFFICE OF GRADUATE AND UNDERGRADUATE EDUCATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Jefferson
Medical College

Department of Psychiatry
and Human Behavior

Mitchell J. M. Cohen, MD
Vice Chair, Education
Director, Pain Medicine Program

T 215.955.6592 F 215.503.2853

mitchell.cohen@jefferson.edu

November 25, 2015

American Psychiatric Association
Attn: Kay Acevedo
Office of Graduate and Undergraduate Education
100 Wilson Blvd., Suite 1825
Arlington, VA 22209

Re: 2015-2016 Roeske Certificate

Dear Award Committee:

It is with great pleasure that I write this nomination letter in strong support of Dr. Abigail Kay for the 2015-2016 Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Education.

In 2005 Dr. Kay joined our faculty in the Department of Psychiatry and Human Behavior, and has consistently demonstrated a strong commitment to the education of her students, her peers, and her patients. Since then she has taken on a progressively larger role in education, both within the department and beyond. Within the Department Dr. Kay has served as Assistant Director of the Psychiatry Clerkship and Associate Director of Undergraduate Medical Education. Outside of the Department Dr. Kay has recently been appointed Assistant Dean for Academic Affairs/ Undergraduate Medical Education at Jefferson. We are lucky that she still maintains such integral roles within our department and for our students.

Over the years Dr. Kay has expanded our educational offerings throughout the first three years of the medical college's curriculum. She began with teaching within the Sidney Kimmel Medical College's (SKMC) curriculum, and has increased her commitment over the years to include the role of course director for, not only all of our preclinical psychiatry courses, but most recently for the psychiatry portion of our newly developed training program for Physician Assistants at Thomas Jefferson University. As part of her redevelopment of our medical student psychiatry curriculum, she developed a layered approach to the lectures in which the same faculty member presents a given topic in each of the three years. Each year the faculty member introduces a more advanced layer, which also reinforces their prior knowledge base. I suspect Dr. Kay's approach is part of the reason that our students have been getting progressively higher scores on the NBME psychiatry subject examinations each year.

Dr. Kay has demonstrated her passion for working with students in their development as physicians in a myriad of ways; she has been the faculty mentor for our psychiatry interest group since 2009, has co-authored a publication with one of our students, and has co-presented multiple lectures with others. Our students clearly appreciate Dr. Kay's passion and dedication to their growth and development, and invited her to speak at many extracurricular events on topics ranging from "Taking Care of Yourself in Medical School" to "How to Quit Smoking." Dr. Kay's skills in the classroom are also superb; she is one of the top large-class teachers that we have ever had. Students in her classes and who rotate on her service tell us how much they appreciate her commitment to them and their education. Their written feedback describes her as an outstanding teacher, mentor, and physician. The students of the SKMC branch of Alpha Omega

Jefferson
Medical College

Department of Psychiatry
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Alpha recently honored her for her excellence by selecting her as one of only two faculty members chosen for honorary membership last year.

Dr. Kay is nationally recognized as a leader in medical student education and has presented her innovative educational lectures and programs at national conferences, including the Association for Directors of Medical Student Education in Psychiatry and the Association for Academic Psychiatry. She is also nationally known as an educator of physicians. She co-teaches a day-long course for clinicians, Opioid Maintenance Pharmacotherapy, at the American Association for the Treatment of Opioid Dependency. The CEO of the American Society for Addiction Medicine heard her speak on an expert panel at this same conference, then suggested that she be appointed to their CME committee as one of their reviewers of educational programs.

Dr. Kay serves as a model, to both our student-physicians and our resident-physicians, that education is a life-long process in many ways, including, most recently, her own formal education in which she completed her post-graduate training to be a Psychoanalyst. This is another area of expertise which she generously shares with our students and trainees.

It is therefore without any hesitation that our Chair Dr. Michael Vergare and I give our strongest recommendation to Dr. Abigail Kay for the Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Education. Her combination of excellence as an educator, professionalism, dedication to her patients, and her students reflect the qualities that are embodied in this award.

Sincerely,

Mitchell J. Cohen, M.D.
Professor
Vice Chair for Education
Director, Pain Medicine Program
Department of Psychiatry and Human Behavior
Sidney Kimmel Medical College at Thomas Jefferson University

Cc: Michael J. Vergare, MD, Chair
Faculty File—Dr. Abigail Kay

NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Shirin Ali, MD

APA MEMBER #: 1005658

CURRENT MEDICAL SCHOOL: Columbia University

NUMBER of YEARS NOMINEE HAS BEEN TEACHING AT CURRENT MEDICAL SCHOOL: 6 years

NOMINATED BY: Janis Cutler, MD

CHAIRPERSON ENDORSEMENT:
Maria Oquendo, MD
Vice Chair for Education, Professor of Psychiatry
Chairperson Signature over Name

Please circle category of nominee: SALARIED* (VOLUNTARY*)

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
(* Voluntary)	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

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- Letter of nomination detailing nominee's contribution to medical student education
- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
ATTN: KAY ACEVEDO
AMERICAN PSYCHIATRIC ASSOCIATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

COLUMBIA UNIVERSITY
College of Physicians and Surgeons

Department of Psychiatry
1051 Riverside Drive, Unit #5
New York, NY 10032

November 24, 2015

The Nancy C.A. Roeske, M.D. Certificate
American Psychiatric Association
Office of Graduate and Undergraduate Education
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

Dear Colleagues:

I am writing to nominate Dr. Shirin Ali for the Nancy C. A. Roeske Certificate of Excellence in Medical Student Education. Dr. Ali has been an active contributor to our medical student teaching program in several capacities since joining the faculty of the Department of Psychiatry here at Columbia University's College of Physicians and Surgeons 6 years ago.

First, she provided one-on-one supervision to our third year medical students while serving as an attending on our General Clinical Research Inpatient Unit for 3 years. During that time her students greatly enjoyed working with her, describing her as a superb teacher and psychiatrist. They rated her "overall teaching effectiveness" as a mean rating of 8.2 on a 9-point scale (1-3 = below expectations, 4-6 = meets expectations, 7-9 = exceeds expectations), which is most impressive. Detailed comments from her students are enclosed. Second, she served as a small group preceptor for our first year medical student introductory psychiatry course. Again, she received excellent feedback from her group of 12 students, who described her as "a great preceptor" and "a wonderful doctor," "one of the best teachers I've had thus far in med school." Third, she developed a seminar for the psychiatry clerkship students on the Treatment of Psychotic Disorders, which she continues to present several times per year with very positive student feedback. At this time she has presented the class to over 400 of our students and they have rated the class as a mean rating of 6.6 on a 9-point scale (1-3 = below expectations, 4-6 = meets expectations, 7-9 = exceeds expectations). In their written comments they indicate that Dr. Ali provides a "great lecture" that is "well explained," "extremely useful," and "well organized and helpful." More detailed comments are enclosed. As this extensive documentation illustrates, Dr. Ali has achieved an outstanding teaching record.

In sum, although early in her academic career, Dr. Ali is already a gifted and dedicated teacher who will be a well-deserving recipient of the Certificate of Recognition. I recommend her with great enthusiasm.

Sincerely,

Janis Cutler, M.D.
Director, Medical Student Education in Psychiatry
Professor of Clinical Psychiatry
Faculty, Columbia University
Center for Psychoanalytic Training and Research

NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: EDWARDO ESPIRIDION, M.D., DFAPA

APA MEMBER #: 84088

CURRENT MEDICAL SCHOOL: West Virginia School of Osteopathic Medicine

NUMBER of YEARS NOMINEE HAS BEEN TEACHING AT CURRENT MEDICAL SCHOOL: 6

NOMINATED BY: James Wadding, DO Regional Assistant Dean, WVSOM

CHAIRPERSON ENDORSEMENT:

RAFAEL JIMENEZ M.D.

Chairperson Signature over Name

Please circle category of nominee: SALARIED* VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g., state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g., private practice)

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- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
ATTN: KAY ACEVEDO
AMERICAN PSYCHIATRIC ASSOCIATION
OFFICE OF GRADUATE AND UNDERGRADUATE EDUCATION
1000 WILSON BLVD SUITE 1825
ARLINGTON, VA 22209

West Virginia School of Osteopathic Medicine

Statewide Campus

December 4, 2015

TO: Voting Members, Nancy C.A. Roeske, M.D. Certificate of Recognition

I am very pleased to nominate and recommend Dr Eduardo Espiridion for the 2015-16 Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Education. Dr Espiridion is a Clinical Assistant Professor of Psychiatry and an outstanding and reliable physician preceptor for the West Virginia School of Osteopathic Medicine.

Our third year students complete a one month clerkship in psychiatry at Frederick Memorial Hospital in Frederick, Maryland. Dr Espiridion excels as a preceptor, guiding student reading, challenging them to learn, and complimenting their learning experience with frequent presentations and discussions of behavioral health issues. Student evaluations have consistently been extremely positive about their experiences with Dr Espiridion, and I have had many students comment that he helped them to feel confident and well prepared for their end-of-rotation examination in psychiatry (COMAT-Psychiatry) as well as the behavioral and mental health components of their clinical national board exam (COMLEX 2-CE).

In addition to the serving as a preceptor, Dr Espiridion has willingly volunteered his time as a subject matter expert to participate in the school's syllabus revision for the Psychiatry rotation, requiring travel on a weekend to Charleston, West Virginia. His expertise and active participation was instrumental in producing a more comprehensive and functional student syllabus to benefit students in advancing their knowledge in the field.

Dr Espiridion has also reliably offered an excellent presentation on psychiatry topics relevant to third year students for the past several years during one of our monthly education days in addition to leading them through a COMLEX Board preparation session.

We feel extremely fortunate to have such a dedicated physician and educator teaching our students, and I highly recommend Dr Ed Espiridion for this prestigious recognition without reservation.

Sincerely,

James S. Wadding, DO, MPH

James S. Wadding, DO, MPH
Regional Assistant Dean, Eastern Statewide Campus
West Virginia School of Osteopathic Medicine

EASTERN REGION

2500 Foundation Way, Martinsburg WV 25401 304.596.6335 ph 304.267.0642 fax www.wvsom.edu

NOMINATION FOR

2015-2016 NANCY C.A. ROESKE, M.D. CERTIFICATE OF RECOGNITION FOR EXCELLENCE IN MEDICAL EDUCATION

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Katherine Winner, M.D.

APA MEMBER #: 1014341

CURRENT MEDICAL SCHOOL: Boonshoft School of Medicine, Wright State University

NUMBER of YEARS NOMINEE HAS BEEN TEACHING
AT CURRENT MEDICAL SCHOOL: 3+ years

NOMINATED BY: Igor Elman, M.D. - Professor and Chair of the Department of Psychiatry

CHAIRPERSON ENDORSEMENT:

I. Elman

Chairperson Signature over Name

Please circle category of nominee: SALARIED* VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

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- Nominee's curriculum vitae
- Medical student comments or copies of evaluation form/s

MAIL TO:
AMERICAN PSYCHIATRIC ASSOCIATION
DIVISION OF EDUCATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY

WSU Department of Psychiatry
First Floor, East Medical Plaza
627 S. Edwin C. Moses Blvd. Dayton, OH. 45417
Tel 937-223-8840 Fax 937-223-0758

November 14, 2015

The Nancy C.A. Roeske, M.D. Certificate Selection Committee
Attn: Kay Acevedo
American Psychiatric Association
Office of Graduate and Undergraduate Education
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

Dear Selection Committee:

It is with great pleasure that I nominate Katherine Winner, M.D. for the volunteer faculty category of The Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Student Education.

Dr. Winner's involvement in medical student education is extensive. As the Associate Director of Medical Student Education in Psychiatry at Wright State University, Dr. Winner participates in the training of medical students across all four years. In the 1st and 2nd year courses, she assists in running small groups, planning and coordinating the curriculum, grading exams, and she is a Faculty Advisor for PsychSIGN (our student interest group in Psychiatry).

In the 3rd year Psychiatry Clerkship, Dr. Winner leads small groups and didactics in addition to being a clinical preceptor for students. She has also helped to train the Education Chief Residents. For students on the Child and Adolescent Psychiatry 4th year elective, Dr. Winner also serves as a preceptor.

In addition to all of this, Dr. Winner is a mentor for students interested in a career in psychiatry. She is one of our strongest advocates for considering psychiatry as a career. Students in both the pre-clinical and clinical years have gotten a great experience from shadowing her.

Student evaluations are uniformly positive, including a 4.90 (on a likert scale, with 5 being the best rating) in that "she challenged me to think about medical problems in new ways"; a 4.90 in "she was enthusiastic about teaching and my learning"; a 4.67 in "she provided timely and constructive feedback on my performance"; and a 5.00 in "she showed great concern for patients".

In addition to being a valued educator and clinician, Dr. Winner is an excellent role model for the students. Student comments include: "I am very grateful to have gotten to learn from a wonderful teacher." "Dr. Winner was an amazing first doctor to learn from! She is incredibly patient and kind, as well as knowledgeable. She approaches and deals with very difficult family

situations with ease and tact." "Overall she was a great educator. She was willing not only to share clinical knowledge and answer my questions regarding patient care in exemplary fashion, but also willing to answer my questions related to lifestyle and real-life practice dilemmas pertaining to considering a career in psychiatry. I could not have asked for a more enthusiastic, knowledgeable, and open preceptor. She went above and beyond her duties."

In summary, I highly recommend Dr. Katherine Winner for The Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Student Education.

Sincerely,

Ryan Mast, D.O., MBA
Director of Medical Student Education- Psychiatry
Associate Program Director of the Child and Adolescent Psychiatry Fellowship
Wright State University Boonshoft School of Medicine

AWARD REVIEW FORM

AWARD NAME: Irma Bland Award for Excellence in Teaching Residents Award

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Medical Education and Lifelong Learning

CHAIRPERSON: ___Richard Summers, M.D.

STAFF LIAISON: ___Kay Acevedo, Award Liaison; Tristan Gorrindo, Council Liaison

Description of Eligibility for Award:
Established to honor APA members who have made outstanding and sustaining contributions to resident education in psychiatry, in both salaried and volunteer positions

Description of Selection Criteria for Award:
The criteria by which a nominee will be judged include the following:
Letter(s) of recommendation from the department chair and/or psychiatry residency training director documenting nominee's specific and sustained contributions to resident education, including didactics, rounds, supervision, and excellence in different settings (e.g., psychiatry emergency services, inpatient, outpatient, community mental health, and specialized settings) and Nominee's CV

Award Funding Information: NA
Winners are listed in the Annual Meeting Convocation Program and Receive an Award Certificate from the Division of Education

Award Nominees: Salaried
James E. Luebbert, M.D.
Sander Markx, M.D.

Voluntary
William C. Jangro, D.O.

Description of the Committee's Selection Process: Council Review

NOMINATION FOR
2015-2016 IRMA BLAND AWARD FOR EXCELLENCE IN TEACHING RESIDENTS

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: James F. Luebbert, M.D.

APA MEMBER #: 52977

NOMINATING RESIDENCY PROGRAM: Thomas Jefferson University
Department of Psychiatry & Human Behavior

NUMBER of YEARS NOMINEE HAS BEEN TEACHING
AT NOMINATING RESIDENCY PROGRAM: 8

NOMINATED BY: Dr. Mitchell I. Cohen, M.D., Vice Chair for Education

CHAIRPERSON ENDORSEMENT:

Dr. Michael J. Vergare, M.D.
Chairperson Signature over Name

Please circle category of nominee: • SALARIED* VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

Please complete this form and return along with a letter of nomination and nominee's curriculum vitae by **DECEMBER 1, 2015** to:

IRMA BLAND AWARD
AMERICAN PSYCHIATRIC ASSOCIATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Jefferson
Medical College

Department of Psychiatry
and Human Behavior

Mitchell J. M. Cohen, MD
Vice Chair, Education
Director, Pain Medicine Program

T 215.955.6592 P 215.503.2853

mitchell.cohen@jefferson.edu

November 30, 2015

Dear Committee:

I am pleased to recommend James F. Luebbert, M.D., for the Bland Award for excellence in education of graduate trainees in Psychiatry. Dr. Luebbert has been a pillar of the GME program in our department for the past 8 years; and, prior to joining us Dr. Luebbert was a highly valued educator of residents and fellows at the Medical College of Pennsylvania and Hahnemann Medical College.

For the past 8 years Dr. Luebbert has been a core full-time faculty educator here, serving during that time as both Director of our Division of Child and Adolescent Psychiatry and Director of our Fellowship in Child and Adolescent Psychiatry. In these key roles Dr. Luebbert influentially contributes to the education of our general psychiatry residents and our fellows in Child and Adolescent Psychiatry. Dr. Luebbert devotes 2 hours per week of individual supervision to our general psychiatry residents, 1 hour of administrative supervision to a resident that involves systematically reviewing all cases supervisees treat; and, 1 hour supervising a general psychiatry resident in treatment of child and adolescent patients. In addition Dr. Luebbert supervises general residents and child/adolescent fellows during Intake Clinic for evaluation of newly referred children and adolescents. Every Friday he also trains residents and fellows in the CAPS (Child and Adolescent Psychopharmacology Service) specialty clinic he designed and launched 4 years ago. CAPS has been a tremendously valuable teaching venue and format, with a rich case mix of tertiary challenging patients and families seen in initial and follow-up visits with an emphasis on psychopharmacology, but not excluding other elements of comprehensive care. General residents and 1st-year fellows in Child & Adolescent Fellowship are supervised and taught in CAPS by Dr. Luebbert, current chiefs from the 2nd-year child and adolescent Psychiatry Fellowship, and an experienced pediatrics and psychotherapy-trained Certified Registered Nurse Practitioner.

Since his recruitment to Jefferson in 2007 Dr. Luebbert has brought on new teaching and research faculty. Dr. Fayez El-Gabalawi, a highly regarded educator and expert hand, has joined Dr. Luebbert as his co-Director for the Fellowship. Dr. Jillian Cantor-Sackett was brought on to update and refine the Fellowship curriculum, making it more contemporary and interactive. Finally, Dr. Luebbert has been able to recruit Matthew Wintersteen Ph.D., a well-funded suicide prevention researcher and talented teacher, who has proven to be a powerful educator and mentor in research methodology as well as in group and family psychotherapies.

Fellowship graduates have been sought after by local institutions, practices, and public psychiatry since Dr. Luebbert has established a track record of producing broadly and expertly trained new child/adolescent psychiatrists. His committed and tireless efforts to build his Division and our Fellowship have born fruit—in terms of the success of graduates,

Jefferson
Medical College

Department of Psychiatry
and Human Behavior

Mitchell J. M. Cohen, MD
Vice Chair, Education
Director, Pain Medicine Program

T 215.955.6592 F 215.503.2853

mitchell.cohen@jefferson.edu

filling all spots in the match each year, and in numbers of fellows presenting original work at regional and national meetings.

Prior to our successful recruitment of Dr. Luebbert in 2007, he had been recognized previously for his educational talent and contributions, some major highlights noted below:

- 1995-1996 Herman Belmont Award as Outstanding Teacher of the Year, Child and Adolescent Psychiatric Fellows of Medical College of Pennsylvania/Hahnemann University
- 1997-1998 Overall Excellence in Teaching Award, Residents of the Department of Psychiatry, Allegheny University Hospitals
- 2002 Certificate of Appreciation for Outstanding Contributions to Improving the Behavioral Health and Wellness of Dependent Children, City of Philadelphia

Dr. James Luebbert is a dedicated, hard-working clinician, administrator, and educator. He has profoundly changed education in Child and Adolescent Psychiatry at our institution and was making meaningful contributions long before we were able to bring him to Jefferson.

Dr. Luebbert is fully deserving of recognition for his tremendous impact on GME with the Bland award. Michael Vergare M.D. and I recommend him to you for this award with highest enthusiasm and without reservations.

Yours sincerely,

Mitchell J. Cohen, M.D.
Professor and Vice Chair for Education

CC: Michael J. Vergare M.D., Professor and Chair, Psychiatry and Human Behavior
Faculty File—James F. Luebbert, M.D.

NOMINATION FOR
2015-2016 IRMA BLAND AWARD FOR EXCELLENCE IN TEACHING RESIDENTS

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Sander Markx, MD

APA MEMBER #: #ir 7127795

NOMINATING RESIDENCY PROGRAM: Columbia University Dept. of Psychiatry

NUMBER of YEARS NOMINEE HAS BEEN TEACHING
AT NOMINATING RESIDENCY PROGRAM: 8 years

NOMINATED BY: Maria Oquendo, MD

CHAIRPERSON ENDORSEMENT:

Jeffrey Lieberman, MD

Chairperson Signature over Name

Please circle category of nominee: X SALARIED* VOLUNTARY*

* Salaried	Any faculty members paid by the Medical School or Affiliated Hospital or any other source for time spent teaching students (e.g.: state, VA, etc.)
* Voluntary	Any faculty members who are NOT paid by the Medical School or Affiliated Hospital or any other source for Time spent teaching students (e.g.: private practice)

Please complete this form and return along with a letter of nomination and nominee's curriculum vitae by **DECEMBER 1, 2015** to:

IRMA BLAND AWARD
AMERICAN PSYCHIATRIC ASSOCIATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Maria A. Oquendo, M.D., F.A.P.A.
Professor of Psychiatry at
Columbia University Medical Center
Director of Residency Training
Vice Chair for Education in the Department of Psychiatry

COLUMBIA UNIVERSITY
College of Physicians and Surgeons

Department of Psychiatry
Graduate Medical Education
1051 Riverside Drive Box 103
New York, NY 10032
646 774 7566 Tel
646 774 6398 Fax

November 20, 2015

To the Chair and members of the Selection Committee,

It is with great enthusiasm that I nominate Dr. **Sander Markx**, who is Assistant Professor of Psychiatry here at the Columbia University Department of Psychiatry/New York State Psychiatric Institute, for the APA's Irma Bland Award for Excellence in Teaching Residents (salaried). Dr. Markx, who was also a resident and research fellow here, is not only a star researcher but also one of our best teachers and mentors. He is truly deserving of this prestigious award.

Originally from Holland, Dr. Markx has had a longstanding interest in the genetics of psychiatric disorders, and currently has his own lab here in which he is studying the genetics of mood disorders, psychotic disorders, and autism in the Amish population. What is absolutely extraordinary about Dr. Markx is that in addition to the incredible scientific work he is doing, he is an absolutely first rate teacher and mentor who spends an enormous amount of time working with our residents. Beginning as a resident, Dr. Markx worked with us to improve our psychopharmacology teaching in our PGY-I year. The fruit of his labor is an outstanding course of which he is the course director. This course runs for 11 weeks 3 times a year – and he's there for every class. Working closely with Deborah Cabaniss, Dr. Markx has transformed what was a power-point style lecture course into an active learning "flipped classroom" model with cases and role play. Our interns love it, and Dr. Markx has now brought in residents for several years to co-teach with him – so he is also teaching our future teachers.

A few years ago, Dr. Markx had the idea of introducing out senior residents to luminaries in the field – a "Talk to your heroes" course, as he puts it. For the past 5 years, he has run this amazing course for our PGY-IV's, introducing them to the likes of Oliver Sachs and Otto Kernberg. He also directs a course on the genetics of neuropsychiatric disorders, and teaches segments in our CL course.

As if this weren't enough, Dr. Markx is also a sought after psychopharmacology supervisor, conducting weekly psychopharm supervision for a lucky PGY-III. Finally, his lab has become a magnet for some of our best research track residents – he now has four working for him –a PGY-II, a PGY-III, and two recent graduates. They flock to him because he is the consummate mentor – clearly and actively interested in them and their careers.

In summary, we are so fortunate that a scientist of Dr. Markx's caliber has been so involved in the educational lives of our residents – as a direct teacher, supervisor, and research mentor. He is truly an excellent teacher of residents, and, as such, we hope that you will agree that he is deserving of the APA's Irma Bland Award. Dr. Jeffrey Lieberman joins me in giving Dr. Markx our highest recommendation for this prestigious honor. Please do not hesitate to contact me with any questions about Dr. Markx or this letter.

Best regards,

Maria A. Oquendo, M.D.
Professor of Psychiatry
Vice Chair for Education in the Department of Psychiatry
New York State Psychiatric Institute and Columbia University
President-Elect, American Psychiatric Association (2015-2016)

NOMINATION FOR
2015-2016 IRMA BLAND AWARD FOR EXCELLENCE IN TEACHING RESIDENTS

Completed Cover Form Must Be Submitted With Each Nomination
Incomplete Form Will Delay Review

NOMINEE: Dr. William C. Jangro, D.O.

APA MEMBER #: 1000490

NOMINATING RESIDENCY PROGRAM: Thomas Jefferson University
Department of Psychiatry & Human Behavior

NUMBER of YEARS NOMINEE HAS BEEN TEACHING
AT NOMINATING RESIDENCY PROGRAM: 4

NOMINATED BY: Dr. Mitchell I. Cohen, M.D., Vice Chair for Education

CHAIRPERSON ENDORSEMENT:

Dr. Michael J. Vergare, M.D.
Chairperson Signature over Name

Please circle category of nominee: SALARIED* o VOLUNTARY*

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AMERICAN PSYCHIATRIC ASSOCIATION
1000 WILSON BLVD, SUITE 1825
ARLINGTON, VA 22209

Jefferson
Medical College

Department of Psychiatry
and Human Behavior

Mitchell J. M. Cohen, MD
Vice Chair, Education
Director, Pain Medicine Program

T 215.955.6592 F 215.503.2853

mitchell.cohen@jefferson.edu

November 25, 2015

Irma Bland Award
American Psychiatric Association
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209

Dear Award Committee:

I am writing in strong nomination of Dr. William Jangro, D.O., for the 2015-2016 Irma Bland Award.

Dr. Jangro joined the Department of Psychiatry and Human Behavior at Thomas Jefferson University in 2011. From his first month at Jefferson Dr. Jangro's enthusiasm and talent for teaching were recognized by students, residents, fellows and faculty members. Residents sought out Dr. Jangro for mentoring and he became one of our most popular clinical supervisors. Faculty members recognized his organizational talents and follow-through on projects and turned to him for collaboration on curricular initiatives. In 2013 Dr. Jangro became Assistant Director of the Adult Psychiatry Residency Program. In 2015 he was advanced to the official Graduate Medical Education role of Associate Residency Training Director.

Since 2011 Dr. Jangro has provided the Adult Residency Program with leadership and stewardship of the residency curriculum. He has not just taught, but also has inspired residents through his clinical supervision, mentorship, and didactic seminars. His effectiveness as an educator is reflected by his selection by our residents for Jefferson's Robert Waelder Award for Distinguished and Outstanding Service as a Teacher in 2013 after just two years on the faculty.

Dr. Jangro is a responsible, skilled, subspecialty-trained clinician who is particularly talented in pain medicine, addiction assessment and treatment, and consultation psychiatry. He also works in the Jefferson Transplant Institute, providing pre-transplantation evaluations and ongoing care to post-transplant patients. In these specialized settings Dr. Jangro instructs fellows and PGY-II through PGY-IV residents on diagnosis and treatment of opiate addiction, delirium, secondary depression, and illness-associated anxiety. In all clinical teaching contexts, Dr. Jangro's clear-headed, unflappable clinical style has enhanced the effectiveness of supervision of our residents. He has presented on difficult treatment challenges faced by the consultation team in workshops at Annual Meetings of the American Psychiatric Association, involving trainees in the preparation and delivery of these workshops.

Dr. Jangro's talent in administration of our residency program, recruitment of residents, and mentoring of current residents are invaluable assets to the Department and our trainees. Future

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psychiatrists from sub-interns through senior fellows in pain and psychosomatic medicine have greatly benefitted from his commitment to teaching, the generosity of his spirit, and the professionalism that pervades his daily work.

In light of the above Chair Michael Vergare and I are pleased to nominate Dr. William Jangro, D.O., for the Irma Bland Award for Excellence in Teaching Residents.

Sincerely,

Mitchell J. Cohen, M.D.
Professor
Vice Chair for Education
Director, Pain Medicine Program
Department of Psychiatry and Human Behavior
Sidney Kimmel Medical College at Thomas Jefferson University

Cc: Michael J. Vergare, MD, Chair
Faculty File—Dr. William Jangro

Proposed Revision to the JRC Composition

Rationale:
The Joint Reference Committee is charged to oversee the work of the Councils and to serve as the conduit through which actions from the councils and Assembly pass prior to consideration by the Board of Trustees. As such, it is essential that there be continuity amongst the membership of the JRC.

The current membership of the Joint Reference Committee is as follows along with the tenure rules for each position.

1.	President-elect [Chairperson]	1 year
2.	Speaker-elect [Vice Chairperson]	1 year (often the Speaker-elect was the Recorder)
3.	Assembly Rep – Recorder	1 year
4.	Assembly Rep – Immed. Past Speaker	1 year
5.	BOT Rep	1 year (may be reappointed)
6.	BOT Rep – Immed. Past President	1 year
7.	CEO/Medical Director	tenure parallels tenure as CEO

Proposed membership and tenure:

1.	Secretary [Chairperson]	2 years – parallel with position as Secretary
2.	Speaker-elect [Vice Chairperson]	1 year (often the Speaker-elect was the Recorder)
3.	President-elect	1 year
4.	Recorder	1 year
5.	BOT Rep	1 year (may be reappointed) *Consider appointing for tenure parallel to tenure on the BOT*
6.	Immed. Past Speaker	1 year
7.	CEO/Medical Director	tenure parallels tenure as CEO