Section 12
Action Papers

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Item #s	Action Paper Titles	Authors' Cost Estimates	APA Administration Cost Estimates
2017A1 12.A	Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders	$9,240	$6,160
2017A1 12.B	Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing	$0	$2,926
2017A1 12.C	Simplification of Electronic Medical Records and Billing Codes	$3,080	$253,674
2017A1 12.D	Adopting Neuroscience-based Nomenclature (NbN) for Medications	$0	$4,928
2017A1 12.E	Revising the Nomenclature, Definition and Clinical Criteria for Partial Hospitalization Program	$0	$53,696
2017A1 12.F	APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care	$20,000	$23,100
2017A1 12.G	Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice	$4,577	$33,418
2017A1 12.H	Expanding Access to Psychiatry Subspecialty Fellowships	$1,540	$2,310
2017A1 12.I	Educational Strategies to Improve Mental Illness Perceptions of Medical Students	$0	$3,080
2017A1 12.J	Educational Strategies to Improve Mental Illness Perceptions of Non-psychiatric Physicians	$0	$3,234
2017A1 12.K	Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships	$0	$3,080
2017A1 12.L	Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)	$616	$2,310
2017A1 12.M	Juvenile Solitary Confinement	$0	$2,156
2017A1 12.N	Addressing Physician Burnout, Depression, and Suicide — Within Psychiatry and Beyond	$2,310	$4,235

2017A1 12.O	Health Care Is a Human Right	$3,542	$7,700
2017A1 12.P	Making Access to the Voting Page a Default Action During Elections	$924	$2,310
2017A1 12.Q	Dues Relief for District Branch Members from the Commonwealth of Puerto Rico	$30,375	$31,950
2017A1 12.R	Streamlining the Application Process for Former APA Members	$616	$616
2017A1 12.S	~~Connecting Psychiatrists to Volunteer Opportunities~~ **WITHDRAWN BY THE AUTHOR**		
2017A1 12.T	APA Referendum Voting Procedure	$35,000	$41,160
2017A1 12.U	November Assembly Dates	$0	$0

Item 2017A1 12.A
Reference Committee #1
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders

WHEREAS:
The current opioid use disorder epidemic has reached a point where the public and legislators are clamoring for strong action to be taken; and whereas

Many individuals believe that people in the throes of addiction lack decision-making capacity to undertake treatment voluntarily; and whereas

There is some evidence from the forensic literature that the use of coerced treatment has some effect, that mandating participation in drug treatment programs and sobriety in lieu of incarceration can lead to a reduction in drug use; and whereas

There are some who believe that the use of involuntary psychiatric commitment for substance using individuals may similarly lead to reduction in substance use; and whereas

Many states are considering altering their statutes or practice of civil commitment, in the hope of achieving involuntary psychiatric hospitalization for patients with substance use disorders; and whereas

There is much debate about whether there is any evidence to suggest that involuntary hospitalization on psychiatric units provides any benefit for individuals with substance use disorder; and whereas

Many of those proposing involuntary treatment may believe that locked substance abuse treatment centers are available, outside of the current locked psychiatric hospital system; and whereas

Psychiatric hospital units capable of caring for civilly committed individuals are not prepared to manage an influx of individuals with substance use disorders, lacking excess capacity or programming ability to provide appropriate treatment; and whereas

Mandates to increase the number of individuals subject to involuntary psychiatric hospitalization by expanding criteria by diagnosis and behavior will need significantly greater resources, which states are unlikely to be able to allocate; and whereas

There are jurisdictions which allow for coerced treatment by civil commitment, which is used to varying degrees, but which may permit some assessment of the efficacy of such treatment; and whereas

The pressure to “do something” about the opioid epidemic may lead to hasty policy decisions in the absence of evidence; and whereas

APA district branches need assistance with position statements based on science;

BE IT RESOLVED:
That the American Psychiatric Association develop a comprehensive position statement on the use of involuntary psychiatric commitment for the treatment of substance use disorders.

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ESTIMATED COST:
Author: $9,240
APA: $6,160

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: substance use disorder; involuntary treatment

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:
Council on Psychiatry and the Law

- I wasn't aware of the intensity of the political pressures described in this document, but I certainly agree with the concerns that are expressed. If such a task is undertaken, it probably should be a joint effort with the Council on Addiction, with CPL taking the lead role.

- This won't be a simple task, but it would certainly be appropriate for APA to try to stake out a position on this issue. For those with a historical bent, the debate goes back two centuries now (Attachment 1)

- Underneath all the "Whereas" the document may be pointing to a significant change in public and professional attitudes. But for what it's worth, I don't think I have seen increased professional pressure for more involuntary treatment in CT. Politicians here have made noises, however, presumably in response to the epidemic of deaths among opiate users

- I've managed a system of forensic evaluators that were inundated with these involuntary commitment evaluations for substance use and participated in program development and legislative reform on the topic (it is a long and interesting story).. and thinking lots about this, I have experience. Attached is a paper we wrote on this subject as well (in part inspired by Paul''s paper). Interestingly, after this got accepted for publication we had to write the caveat that the map was based on 2014. Michigan for example passed a statute in response to the pressure that is currently rarely used (another story related to financing the care and the petitions), but other states repealed their statutes...Also we reviewed a case for Legal Digest regarding a PA statute and commitment of minors. We had issues with that as well. I have lots more to say on the

subject. These readings may be of use. Curious what others will say about this based on their state by state experience (Attachments 2 and 3)

- I agree this is important to consider and that the many "whereas" statements in the action paper, some of which are more compelling than others, indicate that some formal guidance from the APA would be useful. I'm not sure what shape the position statement would take (e.g., advocate for substance use disorders to be recognized as qualifying diagnoses for civil commitment? re-iterate that substance use disorders are mental illnesses? advocate for treatment over criminal justice solutions?). Also adding another article for additional information. From the NYC perspective, very hard in get clinical buy in from practitioners to civilly commit for substance use disorders, however the law does not explicitly prohibit (except for alcoholism in one of the districts). p.s. heard on news last week about a sheriff in Ohio arresting people who need naloxone s/p opioid overdose on "public nuisance" charges so that they can get treatment mandated through the criminal justice system (Attachment 4)

Council on Addiction Psychiatry from Beatrice Eld
Your draft action paper was circulated to the members of the Council on Addiction Psychiatry for input and it was very well received. In fact, members believe that this is such an important issue that they would like to start work on the position statement now. I will set up a conference call with a workgroup ASAP. Staff of the Councils on Advocacy and Government Relations and Psychiatry and Law will be informed of our effort and representatives of those councils are welcome to join the workgroup.

REGULAR ARTICLE

The Origins of Commitment for Substance Abuse in the United States

Kathleen Thomsen Hall, MD, and Paul S. Appelbaum, MD

Policymakers in the United States have long been perplexed by how to deal with substance abuse. As attitudes shifted in the 19th century toward viewing substance abuse as a medical problem akin to insanity rather than as a moral failing, greater emphasis was given to the potential for treatment. Thus, by the middle of the 19th century, states began developing substance abuse commitment codes and institutions to which substance abusers could be committed. Public ambivalence over whether substance abusers should be seen as having an illness or a weakness of will, however, was reflected in the lack of sustained support for these efforts, in contrast to support accorded systems for commitment of the mentally ill. Contemporary policymakers are faced with the same ambivalence, as they struggle with the extent to which substance abusers ought to be subjected to involuntary treatment. The legacy of the early years of substance abuse commitment lives on.

J Am Acad Psychiatry Law 30:33–45, 2002

Substance abuse has captured the concern of physicians, social reformers, the legal community, and policymakers in the United States for two centuries. In the face of perennial debates over when society should intervene, how best to do so, and how to fund these interventions, legal mechanisms for substance abuse intervention took several forms in the United States in the 19th century. Habitual drunkards, dipsomaniacs, opium addicts, and cocaine inebriates were incarcerated, placed in workhouses, committed to almshouses, subjected to inquisitions leading to guardianship, and committed for treatment to inebriety asylums and related facilities. This article records one aspect of substance abuse intervention history: the evolution of the first identifiable substance abuse commitment codes.

Social Underpinnings

The post-Revolution United States was a hard-drinking place. Alcohol, the "good creature of God,"[1] was the universal remedy. Americans drank at almost three times the present rate, with per capita consumption of ethanol reaching 7.1 gallons annually by 1830. In the face of this prodigious intake, problems related to the use of alcohol became a serious concern for civic leaders, law enforcement officers, and physicians.[1–3] *Status ebrietas* accounted for the majority of arrests and incarcerations, overwhelming courts, jails, and houses of industry.[3,4–8] In a perpetual circuit between the streets, jail, and other public facilities, recidivist habitual drunkards became known as "police court rounders."[9] Common drunkards were moral offenders whom the police could arrest without warrant in public places; even private drunkenness was criminalized in Massachusetts.[7,10]

Efforts to counter substance abuse originated with the temperance movement in the late 18th century. Temperance advocates collectively opposed the abuse, and eventually use, of alcohol. With ardent speeches and religious fervor, they sought to educate the public, reform the drunkard, and sway legislatures. Even with vigorous medical leadership, both punitive and reformative threads were found within the temperance movement, and temperance writers characterized intemperance sufferers as victims.[7,11–14] It is also in the temperance literature that

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the suggestion that alcohol is irresistable first occurs, ushering in the controversy surrounding the role of volition that shapes discourse on interventions to this day.[15–17]

Despite medical involvement in the formative years of the temperance movement, reformation as envisioned by temperance advocates typically involved mutual-aid fellowships of individuals devoted to abstinence, such as the Washingtonians and subsequent fraternal temperance societies.[3] Later in the century, the increasingly moralistic focus had shifted to prohibition, for "only evil-disposed persons and fools fall victims to the alcoholic excesses."[18] Temperance advocates succeeded in enacting a wave of prohibition statutes, starting with Maine in 1851. Fifteen states soon followed suit. Prohibition statutes were short-lived, however; some were ruled unconstitutional[19] and the remainder, declared the U.S. Brewer's Association, were "not sustained by the will of the people."[20]

Despite prohibition's failures and the decline of the short-lived Washingtonian movement, mounting intolerance of public drunkenness fomented social and religious pressures to aid, treat, and contain the dependent and deviant. Embraced by the great social welfare and public health movements of the 19th century, efforts to correct or reform drunkards preoccupied authorities and reformers. Public health officials warned that intemperance was an enormous evil, and the cause of a vast amount of suffering, endangering the public and the offspring of intemperate parents.[15,21–23]

The Medical Community Responds

For centuries, physicians had warned of dangers to health and mind from excessive consumption of alcohol. Although such influential physicians as Thomas Trotter, Samuel Woodward, and Benjamin Rush characterized habitual drunkenness as a disease of the mind, they represented a minority viewpoint at the dawn of the 19th century. Temperance-movement physicians were responsible not only for developing and advancing the disease concept of alcoholism among physicians, temperance advocates, and the general public, but were among the earliest advocates for medical treatment of drunkards.[2,24–28] They were not entirely successful: Early temperance literature referred to intemperance, variously, as a disease, or productive of a disease, or an evil.[5,29] Perhaps Boorstin got it right, arguing that when evil was encountered, Jeffersonian ideas led to naturalization into a disease.[15] This was a time of conspicuous intemperance among physicians, who faced declining public confidence, censure, and admonishment for prescribing alcohol as a remedy.[2,27,30,31] In any case, the abundant dangers, or evils, were often lethal. They included suicide, delirium tremens, lunacy, congenital idiocy, and incurable maladies stemming from the habit of drunkenness.[20,23,26,33–39] Dipsomania, declared inebriety pioneer J. Edward Turner, was America's "national disease."[40]

No nomenclature for substance abuse existed before the 19th century.[41] The newly proposed disease, however, was accompanied by an enthusiastic nomenclature, and diagnostic, descriptive, and etiologic categories abounded. Among the many diagnoses used were methyskomania, mania à potú, oinomania, mania ebriosa, narcomania, absinthe imbecility, and dipsomania. Dipsomania, a morbidly uncontrollable propensity for paroxysmal bouts of drunkenness, was one of the most commonly used diagnoses, and physicians engaged in ill-fated efforts to distinguish it from habitual drunkenness. Medical causation theories included J. E. D. Esquirol's partial insanity or monomania, Thomas Crothers' physical disease, George Beard's theories of social evolution leading to nervous exhaustion and neuroasthenia, James Prichard's concepts of moral insanity, Charles Palmer's moral typology of inebriates, phrenologic explanations, and Benedict Morel's theory of cumulative hereditary degeneration.[34,42–47]

Despite these medical theories of a generally biological basis for inebriety, the disease theory remained controversial in the medical community.[48,49] Even insane asylum superintendents were unable to agree on whether inebriety was a disease or a vice. Physicians agreed, however, that for those "deprived of volition," involuntary institutional care was a necessary intervention, declaring that inebriates should be restrained on grounds of moral depravity, detained as diseased requiring treatment, or committed as *non compos mentis*.[50]

Throughout the 19th century, physicians urged medical alternatives to incarceration of inebriates.[40,51] Blaming incarceration practices for increased crime, the Connecticut Medical Society in 1830 characterized penal discipline as degrading and injurious, impolitic and cruel.[52] Thomas Crothers declared that prosecution of the inebriate as wicked was analogous to prosecution of the insane as devil-

possessed.[51] Mason warned of medical dangers when a seriously intoxicated person was taken to jail, stating, "The average policeman is not a good diagnostician."[8]

While temperance advocates became preoccupied with moral arguments, punitive measures, and restrictive approaches such as prohibition, physicians devoted to the medical treatment of inebriety were increasingly occupied with "rational" and "scientific" methods and discounted the role of volition.[44] Enfield declared, "The science of medicine has commenced a new war against an old but recently discovered disease."[53] In 1870, the American Association for the Cure of Inebriety (AACI) was founded. Composed primarily of physicians affiliated with institutions for the treatment of inebriety, the AACI ranks included such highly regarded medical leaders as the founder of the American Medical Association. The AACI held annual scientific meetings, founded a journal, encouraged legislative advocacy, and endeavored to reach a consensus regarding the etiology and treatment of inebriety. Albeit with some dissension, the AACI promoted the concept that inebriety was a true medical disorder and thus most appropriately treated in special hospitals. Promoting involuntary treatment and strict public regulation of treatment institutions, AACI physicians strove to avoid moralistic approaches. They also advocated for the absence of volitional control in substance abuse insanity defenses,[54–56] arguing that mentally diseased inebriates were "moral paralytics."[44] Even Isaac Ray, the father of American forensic psychiatry, characterized alcoholic craving as an "unutterable agony of spirit, the resistless impulse by which he is driven."[42] Why, wondered physicians such as Louise Thomas, did the temperance movement no longer call on medical science?[57]

Remedies Proposed

Decades before the emergence of identifiable substance abuse commitment codes, many states developed civil mechanisms to intervene with habitual drunkards. These mechanisms included guardianship and commitments to almshouses and workhouses. Thus emerged civil mechanisms to confine or reform the habitual drunkard, who could be sent for treatment by order of his or her committee.[58,59] Case law clarified that guardianship proceedings could be instituted against a habitual drunkard who had no estate, and a therapeutic agenda was added to the guardian's custodial responsibilities. The court affirmed that power over the person was complete and should be used to effect a reformation by kind and humane treatment.[60] The court reasoned, "The protection of property is of but little consequence in comparison with the salvation of its deluded owners, who may properly be considered as morally deranged. . . ."[61]

Physicians, who were more familiar with involuntary treatment of the mentally ill, actively sought legislation that would permit commitment of substance abusers for institutional treatment. The models to which they looked were developed in the second quarter of the 19th century, as states began to construct public facilities for the care of persons with mental illness. Before that time, most hospitalization of the mentally ill occurred on an informal basis, with family members and physicians deciding when admission and discharge were indicated. With the development of the state asylums (only two existed before 1830), enabling legislation generally preserved this approach. Thus, patients could be hospitalized at the initiative of their families or, if they were paupers, by the overseers of the poor, when they required care and treatment. The hospital superintendent's concurrence was necessary, but there was no judicial review of the admission decision. Patients retained the right to trigger a court hearing by invoking a writ of *habeas corpus*, although this was an infrequent event.[62,63]

Physicians' recommendations for commitment laws for substance abusers reflected a similar paternalistic ethos. As early as 1812, Benjamin Rush had proposed that intemperate persons be examined by a physician and magistrate for court commitment to a sober house hospital.[25] Other measures to date had been inadequate, physicians argued, and involuntary treatment was needful and merciful.[13,17,23,25,26,28,34–36,64,65] Commitment would permit the environment change, medical supervision, and vigilance required for treatment, for inebriates in the throes of uncontrollable craving were thought to use extreme deception and cunning. Furthermore, treatment was the salvation of the morally dead inebriate, who became a morally responsible being.[40] Protection of the inebriate demanded involuntary treatment due to the risks of self-ruin, squandering property, medical complications, and suicide. Inebriates were also considered a contaminating influence, thus dangerous to others.[66,67]

Invoking "preventive justice"[37] and social preservation, physicians reasoned that prevention of crimes, cost-savings to be gained by treatment, and prevention of the hereditary transmission of the "inebriate diathesis" would be served by commitment.[66] Inebriates were also a crucial disposition issue for superintendents of asylums for the insane, who supported substance abuse commitment when paired with recommendations for inebriety asylums.[68] Because the state had created the disease by permitting legal sales of alcohol, the state was responsible to pay for treatment, opined one asylum proprietor.[40]

Amid the therapeutic and paternalistic rationales for involuntary treatment, an occasional physician acknowledged a role for the inebriate in his or her own recovery process. For example, in 1855, Wilson reminded physicians that part of the cure depends solely on the drunkard himself.[17] Most, however, viewed treatment as a medical procedure. Some medical advocates of involuntary treatment even declared that claims of self-cure were fraudulent,[69] resorting to circular arguments such as that by Enfield: "Because it is a disease, it is therefore curable. . . . Being a disease, its cure rests with the physician."[53]

Benjamin Rush's 1812 response to liberty concerns set the tone for the remainder of the century:

> Let it not be said, that confining such persons in a hospital would be an infringement upon personal liberty, incompatible with the freedom of our governments. We do not use this argument when we confine a thief in jail, and yet, taking the aggregate evil of the greater number of drunkards than thieves into consideration, and the greater evils which the influence of their immoral example and conduct introduce into society than stealing, it must be obvious, that the safety and prosperity of a community will be more promoted by confining them, than a common thief (Ref. 25, pp 267–8).

Subsequent physician advocates of involuntary treatment similarly dismissed legal concerns with individual liberties as both dangerous[11,70] and "merest nonsense."[71] A committee of the Massachusetts legislature formed to evaluate the need for commitment of inebriates held a similar view.[72] Physicians viewed such abstractions as of little significance when compared with the realities of inebriety: "There is one liberty which the humane would desire to see denied to every class of people: the liberty of making themselves slaves."[17] However the matter of detaining inebriates for treatment past their initial "paroxysm" represented a conflict of duties for some physicians.[64] Isaac Ray said, "I do not see how we can help compromising either the happiness of families or the rights of the individual."[3]

How did the physicians who advocated commitment of inebriates propose to treat them? With patience, compassion, and what corrections physician Lucy Hall described as "absolute and unremitting control and protection."[12] The principles of therapeutic intervention were first outlined by Thomas Trotter and consisted of managing withdrawal, a controlled environment, physical restoration, and education.[26] Later physicians, styling the treatment as rational and scientific, emphasized remedying the preinebriate condition, manual labor, probation, and time.[18,51,73,74] Reformation was a matter of growth and development, not a "presto-chango" affair.[75]

Physicians who urged legislative mechanisms for commitment of substance-abusing patients also advised development of institutions for the treatment of inebriates. American proposals for institutional care began with Benjamin Rush's proposal for a sober-house hospital in 1812. Soon thereafter Samuel Woodward[28] and the Connecticut Medical Society (1830) called for the founding of medical asylums to treat inebriates. Woodward frankly referred to this proposal as "an experiment in treating inebriety."[13] Jailers and state hospital superintendents joined in.[50,76] Thomas Crothers, proprietor of the Walnut Lodge in Hartford, Connecticut, went so far as to state that some individuals were sane "only when confined in an asylum."[11] Treatment with chemical restraints such as chloral, bromides, and opium at home was excessively dangerous, he warned, and prolonged the duration of the disease. The structure and discipline of the institutional setting were crucial, for recovery required alternation of restraint and freedom applied with "military exactness."[77]

The first "embryo asylum" was Boston's Washingtonian Hall, founded in 1845. By 1893, the AACI reported that more than 50 U.S. inebriety hospitals and medical facilities for treatment of inebriates were in operation, including homes, "faith cure" halls, and lodging houses; another account for the same year counted 118 proprietary cure institutes affiliated with the Keeley Foundation (see Case Study 3, to follow).[1,76,77] Inebriety hospitals or asylums often provided involuntary treatment to committed inebriates. Eventually, smaller institutions formed by temperance fellowships devoted to voluntary reformation such as the Washingtonian Home in Chicago

and the San Francisco Home shifted toward coerced treatment and enforced abstinence. Police court diversions to these otherwise voluntary facilities became commonplace.[78,79]

Debate about commitment procedures reflected the class concerns that simmered among those who treated inebriates. Inebriety physicians distanced themselves from "vicious drunks" of the "criminal classes," arguing that persons should be of "good character" to be eligible for the commitment process.[3] Generally, American physicians who worked at public facilities were prone to favor broader definitions of inebriety. Those at private institutions styled dipsomania and the neurasthenic inebriate affliction of upper-class and "refined" professions as the true diseases in need of medical treatment, whereas "vicious drunks" were characterized as ignorant, degraded, and of the criminal classes.[14,46,55,76,80] U.S. physicians collaborated with British efforts to enact substance abuse commitment; the resultant Habitual Drunkards Act was heavily class oriented. The exasperated physician John Bucknill responded, "I anticipate with some repugnance the duty of carrying out its provisions for treating the rich drunkard as if his conduct were the uncontrollable result of disease, while upon the poor and ignorant wretch I must still impose the penalty of vicious excess."[81]

Opponents of commitment statutes argued that the proposed treatments were costly, ineffective, and applied to conditions about which the medical community disagreed. More precisely, they pointed out that compulsory abstinence was not cure.[49] Moralists, noting disinterest by the temperance community, criticized the abdication of voluntary treatment approaches that fostered individual responsibility and moral heroism.[48,55,78,82] Pragmatists expressed skepticism regarding superintendents who wanted to take only those inebriates who desired treatment and concerns about facilities where only brief treatment was provided. Furthermore, it would be impossible to provide such a large group with industrial employment, an important aspect of rehabilitation recommendations.[73]

The legal community expressed doubt about a dubious certification process and concerns about wrongful detention and contended that morality could not be legislated. Doctors and family were suspected of sinister motives; examiners were suspected of pecuniary interests.[83] Although the medical community paid little heed, attorneys on both sides of the Atlantic took notice when a New York statute was ruled unconstitutional (discussed later, in Case Study 1). After all, if they were truly suffering from a mental disease, why not treat dipsomaniacs under insanity laws? And what possible rationale could justify detention during periods of sobriety? Furthermore, English common law had long held drunkards to be *voluntarius daemon*, thus affording no excuse for crimes committed when intoxicated. If inebriety was a disease requiring commitment, the English practice of holding a drunkard responsible could be eroded.[40,48,82–90]

Hard-line social reformers favored prison sentences because they were shorter, cheaper, and more severe.[73,55] The disease approach represented a "fundamental challenge to the rising organizational effectiveness of the social reform of the latter part of the 19th century."[55] Commitment, opponents implied, was an extreme response to a widespread problem.[79] Declared British opponents: "Here is the project of an Act for making us all sober with a vengeance. . . . Imprisonment may come from a picnic."[38]

Statutes Are Enacted

Despite this opposition, at least 14 U.S. states as well as many other countries succeeded in enacting substance abuse commitment codes during the last half of the 19th century. American, Canadian, British, and European advocates exchanged testimony and efficacy figures; opponents did likewise. U.S. statutes covered commitments to public facilities (e.g., Refs. 91–95) and a variety of private facilities (e.g., Refs. 96–100). Many of the earliest statutes hybridized guardianship and commitment (e.g., Refs. 92,101–107). Some incorporated criminal diversion procedures and mechanisms for voluntary commitment. Other jurisdictions enacting similar substance abuse commitment codes included Australia, Austria, Belgium, most Canadian provinces, England, Germany, Ireland, New Zealand, Norway, Russia, and Switzerland. In France, a guardianship-based procedure permitted involuntary treatment for inebriates and the mentally ill.[8,37,43,71,108–110] Closely tracking U.S. legislative activities, efforts to enact a substance abuse commitment code in England began early in the 19th century, although limitation in knowledge about the disease of inebriety and the difficulty in knowing the appropriate duration for detention were the primary difficulties with enacting legislation when Laycock wrote in

1855.[35,36] Legal commentators, shrewdly observing that temperance activists and medical entrepreneurs were the primary proponents of substance abuse commitment, declared that although involuntary treatment of substance abusers was not in conflict with the moral sense of the nation, it must involve support from more than teetotalers to enact.[111] England's Habitual Drunkards Act of 1879 consisted of a much-maligned voluntary commitment procedure, although an 1898 revision finally permitted involuntary treatment.[38,112–114]

Although the medical community urged the development of commitment procedures for decades before the first facilities were founded,[13,115] as with commitment for "lunacy," substance abuse commitment codes generally accompanied the founding charter of an institution. Their evolution tracked the course of the facilities they served, beset by social pressures, medical debates, and financial woes. The facilities involved included hospitals, asylums, reformatories, charitable institutions, and even a workhouse.[40,116] Some commitment statutes reflected the rejection of small, voluntary programs that were so reluctant to use coercion that they failed to protect patients, their families, and the public or to impose discipline when they received court-ordered inebriates.[79,97,98] In the transformation and demise of the San Francisco Home, for example, Baumohl noted "a failing faith in moral suasion and a growing conviction that those who repeatedly failed the test of the pledge needed prolonged and enforced separation from alcohol, whether in jail or in an asylum under medical management."[82]

With a petition or complaint alleging habitual intemperance, most statutes permitted any inebriate, dipsomaniac, or habitual drunkard to be committed. Some required the inebriate to have lost the power of self-control—a volitional standard that emphasized the person's need for treatment. Although the AACI's model legislation proposed dangerousness to self or others as a basis for commitment in 1872, only two New York statutes used this standard.[117,118] Legal theorists such as Christopher Tiedeman[119] argued that forcibly subjecting the inebriate to medical treatment could only be justified when individuals were insane or dangerous. British law reviewers opined:

> As a cause of forfeiture of the right to bodily freedom, drunkenness probably stands on much the same footing at common law as madness. It is probable that any person may justify at common law such restraint of a drunken man as may be necessary for preventing him from doing an injury to himself or to others if there is reasonable cause to believe that such injury will be done (Ref. 90, p 691).

Due process provisions were noticeably absent from most of the earliest statutes,[94,96–98,104] although litigation changed this picture. Some specified, vaguely, "due inquiry" by the court.[120] The court also adopted due process principles from insanity commitment litigation (e.g., *In re Wellman*) regarding the need to provide notice to the alleged inebriate of the impending proceedings. Excepting Maryland, most states avoided jury trials, despite their basis in common law.[92,121]

How long to treat an inebriate was a matter of considerable debate. Most physicians advised commitment for six months to three years or until patients were able to resist temptation and thus were cured.[8,13,77,112,122] As they gained experience committing inebriates, however, physicians revised their recommendation for discharge, first to restoration of sound mind and sober habits, and finally to "medical readiness."[14,123] Those physicians who supported shorter stays argued that delirium—the feature that most closely resembled temporary insanity—resolved within days.[82,124,125] Furthermore, abstinence due to enforced restraint was entirely different from "eradicating the morbid tendency."[18] Release, if terms were specified, was typically by court order or when the committed individual was no longer "subject to dipsomania or habitual drunkenness."[95]

The history of these statutes can be illustrated by exploring their courses in three states: New York, a colorful piecemeal; Massachusetts, a public sector story; and Minnesota, a tale of jittery taxpayers at the public-private interface.

Case Study 1: The New York Story

The nation's first identifiable substance abuse commitment code accompanied the granting of the charter of the New York State Inebriate Asylum. Billed as the world's first hospital dedicated to the treatment of substance abusers, the impressive Binghamton facility opened its doors in 1864 after decades of promotional efforts by inebriety pioneer and entrepreneur J. Edward Turner. The private facility was funded by shareholders, among whom numbered ex-presidents, former supreme court justices, and other political luminaries. Turner's grand designs refer to a "castellated gothic" structure with a

chapel seating 500, a winter garden, bowling rooms, and Russian baths. Despite concerns that commitment could become "an instrument of oppression by confining persons not drunkards in the true meaning of that word without power of redress,"[40] the legislature empowered the superintendent to accept and retain all inebriates who entered the asylum, initially both voluntary patients and those who entered by "orders of the committee" of any habitual drunkard, and later by judicial commitment. Commitment required evidence in the form of *ex parte* affidavits that the drunkard was lost to self-control or unable, because of inebriation, to attend to business or was dangerous to remain at large. Despite legal challenges and vigorous opposition by liquor proprietors, Turner succeeded in getting further legislative refinements, making it a misdemeanor to sell or give alcoholic stimulants, tobacco, or opium to asylum patients, and in adding police force protection to the facility.[117] Predictably, detainees filed writs of *habeas corpus*. The courts held that the legislature had failed to pass a law that conferred authority to detain voluntary patients.[126] Furthermore, the law depriving persons of their liberty for a considerable period of time without being heard, or having the opportunity to be heard, was repugnant to the state and U.S. constitutions, and the use of *ex parte* affidavits violated due process principles.[119,127] Although the empowering statute was voided, the facility continued to receive voluntary patients. Turner was ousted within a few years by trustees who objected to his coercive measures and questioned his financial management. In 1878, the inebriate asylum was taken over by the state and turned into an asylum for the insane.[77]

Brooklyn's Kings County Inebriates Home was founded in 1867, and a second series of facility-specific New York commitment codes ensued. Responding to pressures of law enforcement, corrections, and the medical community, New York became one of several states in the post-Civil War era to permit inebriates in police custody and prison inmates confined for substance abuse-related charges to be transferred to treatment in lieu of incarceration.[93,97–99,120,127] At a time when the prevalence of addiction had risen to an estimated two to four percent of the population,[129] the 1875 King's County statute led the nation by recognizing the increasingly troubling problem of narcotic addiction.[118]

In 1882, the third series of New York substance abuse commitment statutes originated, improbably, from criminal diversion efforts with prostitutes.[99,100,130] Women with intemperate habits could be detained in charitable institutions such as the Magdalen Female Benevolent Asylum, the Home of Fallen Women, and St. Saviour's Sanitarium. Like the overturned New York Inebriate Asylum statute, the St. Saviour's statute permitted the forcible retention of voluntary inebriates. Yet again, the court held that proceedings under the act lacked due process and were invalid, in that they depended on the discretion of those who detained the patients, and that although the object of the act appeared protective rather than penal, the deprivation of liberty produced by the act was penal in effect. Furthermore, New York's effort to evade due process shortcomings by expressly permitting application for writs of *habeas corpus* was unsuccessful because this was a right detainees already possessed in common with every other citizen of New York.[131] Although not unwilling to permit involuntary hospitalization for substance abuse treatment, the New York courts were vigilant in insisting on strict procedural safeguards.

Case Study 2: The Massachusetts Story

The Massachusetts story began when state insane asylum superintendents implored the legislature to found an inebriety hospital. They, along with their colleagues in the American Association of Medical Superintendents of Asylums for the Insane, viewed inebriety asylums as the best possible way of relieving overcrowded insane asylums of the burden of caring for inebriates. Instead, Massachusetts enacted a statute in 1885 permitting just what the superintendents had "always earnestly protested against"[132]: the commitment and treatment of dipsomaniacs and inebriates at state insane asylums. The Massachusetts experience was discouraging. The dipsomaniac was to be held until no longer subject to dipsomania or habitual drunkenness or until confinement was no longer necessary for public safety or the patient's welfare. State hospitals were already overflowing with cases of ordinary insanity.[68] With the influx of inebriates, the superintendent's position degenerated into that of a policeman trying to maintain order in a crowd of inebriates and the mentally ill.[132] Judges disregarded the requirement that satisfactory evidence be furnished that the person was not of bad repute or bad character. Although committing magistrates con-

strued the statute as also applying to private asylums for the insane, the state hospitals were quickly overrun.[95]

State officials eventually responded to these concerns by opening the Massachusetts Hospital for Dipsomaniacs and Inebriates in 1893; a special inebriety hospital did not solve the management problems, however. From the outset, trustees reported ongoing difficulties managing committed inebriates, handling escapees, and excluding incorrigible patients. And then there were the disgruntled patients, who believed they had been misled about the duration of their two-year commitments. Punitive commitments by family members who relented once the inebriate had been "punished enough" further compromised efforts to maintain a therapeutic program. Trustees also reported indiscriminate or inappropriate commitments of confirmed drunkards, medically ill individuals, inebriates who were past the age of possible cure, and "vicious inebriate" criminals of bad character.[14,123] Eventually, a procedure for early release was enacted whereby trustees were required to certify that the patients would no longer be subject to dipsomania or inebriety or would not be benefited by further treatment, thus permitting problematic patients to be culled.[133]

Massachusetts detainees were a litigious lot. As early as 1834, Samuel Woodward, superintendent of the state's insane asylum in Worcester, had anticipated that individuals detained in inebriety asylums might seek redress for false imprisonment, and he recommended a hold-harmless arrangement with family, friends, and guardians. Congruent with the disease model that underpinned these statutes and in parallel with procedures for committing the insane, Massachusetts was one of several states that required a physician's examination and certificate.[95,100,103,117,120,134,135] Theodore Fisher, superintendent of the Boston Lunatic Asylum, gained experience in defending an action for improper certification and was of the opinion that ambiguity in the 1885 statute could lead physicians to certify inebriates who were actually of sound mind. In *Niven v. Boland*, a tort case against two physicians alleged to have negligently certified a patient for commitment to the Massachusetts Hospital for Dipsomaniacs, the appeals court affirmed the importance of the examining physicians. Characterizing their role as quasi-judicial, the court indicated that the privilege that attaches to parties and witnesses in other judicial proceedings should attach to examining physicians.[136]

In Fisher's address to the Massachusetts Medical Society, "Insane Drunkards," he further characterized the difficulty of retaining a committed insane drunkard, whose prominent symptoms were transient. "In a surprisingly short time he is on his feet, under perfect control, looking around for a lawyer to help him swear that his confused recollection of the circumstances of his commitment is the true version."[137] When the statute was revised, adding procedural due process protections, the burden of proof was placed on the patient, who was required to show cause why he or she should not be committed.[123,138] Massachusetts' experience highlights the tendency for statutes originally developed for therapeutic purposes to be turned into overt mechanisms for social control, with the apparent acquiescence of the judiciary.

Case Study 3: The Minnesota Story

The Minnesota story is one of concern for financial outlays. Admission into the Minnesota Inebriate Asylum in 1875 required a judicial certificate of inability to defray expenses (thus limiting public expenditures to care for the indigent), a finding of incompetence, and guardianship on account of excessive drinking. The Inebriety Asylum was subsumed by Rochester State Hospital, and before the century was over, Minnesotans prohibited treatment of inebriates at their state hospitals. With proprietary facilities booming, Minnesota county governments were then required to take on financial responsibility for the court-enforced "voluntary" treatment of inebriates. These commitments required habitual drunkards to petition for their own commitment and demonstrate a desire to be cured.[94,103,139,140] The Minnesota statute even specified, briefly, that inebriates could be committed by the counties to Keeley Cure "reputable double chloride of gold institutes."[1] The most popular of these were the franchised facilities founded by Dr. Leslie Keeley, where his patent remedy for inebriety was administered. Keeley facilities, and the supportive "Keeley Leagues" of cured or recovering individuals, were powerful enough to enact similar voluntary commitment laws in Colorado, Louisiana, Maryland, North Dakota, and the Oklahoma Territory.[1,141–145] The counties, however, were loathe to pay for such treatment, and the court held that "so-called commitments under this statute

were unconstitutional, assigning judges powers beyond their constitutional jurisdiction."[146] A subsequent revision applied only to residents of populous counties and was also found unconstitutional, because the provisions of the act thus discriminated between urban and rural drunkenness.[147] Minnesota's courts, in contrast to New York's, had concerns about commitment for substance abuse treatment that extended beyond the procedural to encompass the substantive basis for deprivation of liberty.

Impact

Inebriety physicians generally retained a hopeful outlook for the institutional (and often involuntary) treatment of inebriates. They based their opinions of efficacy on long-term follow-up surveys of thousands of patients. The published results were positive enough to generate some skepticism: Thirty-five percent of 3,000 patients from Boston's Washingtonian Home were reported temperate and well 8 to 12 years after treatment; 42 percent of inebriates treated at the Massachusetts Hospital for Dipsomaniacs and Inebriates were doing well 2 to 14 months later; and 61 percent of 1,100 patients treated at the New York State Inebriate Asylum were deemed by relatives to be temperate and well after 5 years. Other asylum proprietors quoted similarly promising results, although in none of these reports are the outcomes classified according to whether the patient was voluntary or involuntary.[68,123,148]

The evangelical tone of physicians promoting institutional treatment of inebriates became tempered as the decades passed, for their central problem was never resolved: how to treat the accumulation of refractory inebriates, the same incorrigibles who clogged courts, jails, and workhouses. As physicians endeavored to confront this issue, their tone became increasingly strident. They recommended state guardianship. They proposed long-term and even life-long detention in industrial hospitals, or emigration to a temperance island.[54,67,75,122] Dr. Clark, a police surgeon, proposed trying the Scottish system "of sending inebriates to certain islands in the Frith of Clyde and would deport to the Pacific Islands our growing and hereditary class of inebriates."[113]

Statutes serving both public and private facilities were enacted throughout the last half of the century. Although intolerance of public drunkenness provided the constituency that permitted their enactment, skeptical legislators were loathe to fund inebriety treatment. Not until the 1890s did public funding for inebriety treatment become routine in statutory language—and this only in the wave of voluntary commitment statutes requiring county funding. Their formula took advantage of societal ambivalence by removing patient language and by reintroducing voluntarism, requiring evidence that the habitual drunkard was willing to obtain treatment. This time, advocates were not medical scientists but medical entrepreneurs of the 1890s.

Commitment statutes were rarely problem-free. Physicians succeeded in influencing the revision process not only by requiring physicians' certificates but by developing admission screening criteria such as "fit subject for treatment," a determination made by physicians. They sequestered inebriates away from insane asylums (except in Maryland), asserted physician discretion over discharge or conditional discharge procedures, developed transfer procedures between facilities, and modified duration.

Physicians who promoted commitment for institutional treatment of inebriates had a significant impact in fostering the scientific study of substance abuse and developing concepts of addiction as a form of psychological or neurologic disease. Limiting this impact, however, were the incongruities of inebriety as an inheritable yet treatable condition and a disease theory that never satisfactorily addressed the matter of volition. Furthermore, a treatment philosophy focusing solely on intervention meant a failure to develop a philosophy of prevention. Thus, inebriety physicians failed to ally with the public health movements or to develop an environmental approach or a social theory of the disease.[38] Public policy interests in social control ultimately prevailed over medical interests in scientific treatment measures, even when treatment was provided in the context of legal mandates.[149]

Nineteenth-century substance abuse commitment practices faded from use with closure of inebriety asylums in the wake of prohibition of alcohol and criminalization of narcotics. Not until the 1960s did the states again enact substance abuse commitment statutes. International and federal initiatives spurred this process, as did a series of U.S. Supreme Court decisions that decriminalized alcoholism and addiction.[150–153] The majority of states now have a mechanism for involuntary civil commitment of substance abusers, and involuntary treatment mechanisms in the criminal justice system (e.g., "drug courts") have

proliferated in the past decade.[154–156] Does the history of substance abuse commitment in the 19th century hold any lessons for contemporary policy?

With all the caution that must be taken in extrapolating across disparate historical epochs, we suggest that the early years of U.S. experience with involuntary treatment of substance abuse appears to point to three conclusions. First, unless a societal consensus can be achieved regarding the desirability and legitimacy of involuntary treatment, such programs as are established will be undercut by judicially imposed restrictions, the reluctance of the public—acting through their legislators—to provide adequate funding, and the unwillingness of family members or doctors to commit patients to these programs. Attempts to achieve broad social support before implementation of involuntary programs are crucial for their success and probably require some resolution of societal ambivalence over whether substance abuse should be viewed as willful misconduct or the consequence of an unwilled affliction. Second, in the absence of effective models of treatment, support for coercive interventions with substance abusers will wane. Substance abusers will be left on their own to bear the burdens of their behavior or will be relegated to the mercies of the criminal justice system. Thus, research that demonstrates efficacy has critical importance for public policy, as well as clinical, purposes. Finally, the temptation to use systems of involuntary treatment for purposes other than those for which they were created will always be substantial. Carefully crafted eligibility criteria and due process protections are needed to minimize the risk that involuntary treatment mechanisms will be used to serve other than therapeutic ends related to social control.

Conclusions

The story of substance abuse commitment codes is that of using law to solve complex human problems. Substance abuse commitment in the 19th century did not live up to the restorative or curative potential promised by its medical advocates, who failed to solve the problem of the chronic recidivist patients that ultimately overwhelmed treatment facilities. Nineteenth-century debates over the role of coercion, the nature of the underlying disease, and the efficacy of treatment are stunningly similar to present-day policy arguments, and the dilemmas faced by our medical forebears are decidedly familiar. Nevertheless, hope is to be found in this story of the enduring nature of the medical community's ethical and scientific motivation to intervene.

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REGULAR ARTICLE

Nature and Utilization of Civil Commitment for Substance Abuse in the United States

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Substance abuse is a leading cause of morbidity and mortality in the United States. Although civil commitment has been used to address substance abuse for more than a century, little is known today about the nature and use of substance-related commitment laws in the United States. We examined statutes between July 2010 and October 2012 from all 50 states and the District of Columbia for provisions authorizing civil commitment of adults for substance abuse and recorded the criteria and evidentiary standard for commitment and the location and the maximum duration of commitment orders. High-level state representatives evaluated these data and provided information on the use of commitment. Thirty-three states have statutory provisions for the civil commitment of persons because of substance abuse. The application of these statutes ranged from a few commitment cases to thousands annually. Although dangerousness was the most common basis for commitment, many states permitted it in other contexts. The maximum duration of treatment ranged from less than 1 month to more than 1 year for both initial and subsequent civil commitment orders. These findings show wide variability in the nature and application of civil commitment statutes for substance abuse in the United States. Such diversity reflects a lack of consensus on the role that civil commitment should play in managing substance abuse and the problems associated with it.

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Substance abuse poses extensive challenges to public health and safety[1,2] and, in the United States, has an estimated annual economic impact of $193 billion for illicit drugs and $223.5 billion for alcohol.[3] Of the more than 20 million American adults who are deemed to have a substance use disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),[4] only a fraction (2%) received any substance treatment in the preceding year. Even fewer (<1%) received care from a facility specializing in substance treatment. Although a variety of factors contribute to this gap (e.g., health coverage, availability, and stigma), the overwhelming majority of Americans who misuse substances (>95%) do not believe they need such specialized care.[5]

Thus, external influences frequently play a role in initiating substance-related treatment.[6] Such forces may be informal (e.g., family pressure) or formal (e.g., mandated before returning to work) and may involve the legal system (e.g., jail diversion and drug courts).[7] Civil commitment for substance abuse occurs when a person is court mandated to a period of treatment, separate from criminal confinement and distinguished from other forms of civil commitment, such as those for mental illness or sex offender treatment following a criminal sentence. The authority to commit individuals to treatment originates from the state's interest in protecting its vulnerable citizens, known as *parens patriae*, and its police powers justify confining individuals who may be a danger

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to themselves or others. The deprivation of liberty in a civil commitment context is, at least conceptually, distinct from incarceration, since individuals are committed for treatment purposes as opposed to punishment.[8]

In the United States, civil commitment laws for substance abuse emerged and evolved in tandem with changing social and medical views on the nature of addiction[9] and were often modeled after mental health commitment statutes. In 1991, 18 states and the federal government had civil commitment laws for substance abuse.[10] By 1997, 31 states and the District of Columbia had laws authorizing substance-related commitment.[11] More recent work concluded that 17 states appear to permit civil commitment for substance use disorders either through their existing mental health commitment statutes or those specific to substance use, although the statutes were not examined.[12] The majority (74%) of European countries also have provisions that allow for substance abuse commitment.[13] Historically, U.S. commitment statutes have varied by the type of substance for which one may be committed; the criteria needed to justify commitment; who may initiate commitment proceedings; and the duration, setting, and type of treatment offered.[6,11,14–18]

Outside of a criminal justice context, broad support for substance-related civil commitment is lacking.[18] Ideological, administrative, and economic barriers hamper successful implementation of substance commitment statutes. Reasons include a reluctance to restrict autonomy through formal mechanisms of social control, particularly in settings where access to voluntary addiction treatments is limited, as it would seem to coerce care unfairly; uncertainty over what treatment strategies to use for committed individuals; and the appropriate payer for treatment during commitment.[19,20] Despite its longstanding existence, surprisingly little is known about the extent to which substance-related commitment is used, even within jurisdictions that authorize it. Thus, in the present study, we examined the nature and utilization of modern U.S. substance-specific civil commitment laws.

Methods

From July 2010 through October 2012, statutes for the 50 states and the District of Columbia (hereafter, the states) were examined to identify provisions allowing for civil commitment of adults (18 years and older) because of substance abuse alone (i.e., independent of mental illness, unless substance disorders are included in a statute's definition of mental illness) and outside a criminal justice context (i.e., did not require a concomitant criminal justice case). Statutes were accessed from the official website of each state government.

Each statute was searched using the terms "commitment," "drug," "alcohol," and "substance." For statutes in which no substance-related commitment provision was identified, the mental health commitment section was examined to determine whether substance abuse was included under the definition of mental illness. If substance abuse was not defined under mental illness, remaining sections, chapters, and subchapter headings of the entire statute were examined for language relevant to a provision for substance-based commitment.

For each statute with a substance-related civil commitment provision, the substantive criteria and evidentiary standard to authorize commitment, location of commitment, and maximum permitted period of commitment (for initial and subsequent commitment orders) was recorded. The range of statutorily defined commitment criteria (requiring a causal link to substance abuse) were coded into the following groups:

intoxication or substance abuse (i.e., substance use alone, either chronic or acute, is sufficient grounds for commitment)

dangerous to self (e.g., posing a substantial risk of imminent physical harm to self, by serious threats or attempts of suicide or other significant self-inflicted bodily harm)

dangerous to others (e.g., posing a substantial risk of imminent physical harm to one or more persons, by violent behavior or threats)

dangerous to property (posing a substantial risk of inflicting significant property damage, by acts or threats)

grave disability or incapacitation (e.g., posing a substantial risk of imminent serious physical injury to self or death, by an inability to provide for basic physical needs such as food, clothing, shelter, or medical care)

in need of substance abuse treatment (i.e., treatment is needed to stop abusing, the patient is

expected to benefit from treatment, or treatment is expected to prevent other negative outcomes)

loss of self-control (demonstrating a repeated pattern of failing to meet social, financial, or occupational responsibilities)

lack of decisional capacity (being unable to make a rational decision with respect to need for substance abuse treatment)

pregnant and abusing substances, and past treatment failure (having failed to maintain sobriety after substance abuse treatment).

The accuracy of our statutory readings and data on commitment utilization was then evaluated by high-level state representatives. We first contacted the director or head of each state department of behavioral health or substance abuse services (or equivalent), who either responded to our inquiry directly or referred us to the head of the state-run substance abuse treatment service or a similar authority. If no response was received from the director, we contacted the head of forensic mental health. If this attempt failed, we contacted the head of the legal services division for the department of behavioral health or substance abuse (or equivalent). All states responded to our request. Each representative verified the accuracy of our data and provided a specific or estimated count of annual cases of substance-related civil commitment or, if no count was available, indicated whether the statute was active and applied, never applied, or applied only under extremely rare circumstances (e.g., may be used in exceptional cases but is generally considered inapplicable). Statutes were coded as "extent of use unknown" if no count was available and the representative could not estimate the extent of use. Each representative was also invited to comment on factors that influenced the extent of the statute's use in real-world practice.

This study did not involve human subjects and was deemed not to be subject to review or exemption by the Institutional Review Board of the University of Massachusetts Medical School and the Central Office Research Review Committee of the Massachusetts Department of Mental Health.

Results

Thirty-three of the 51 states (including the District of Columbia) have a statutory provision authorizing civil commitment of adults for substance abuse (Fig. 1). Of these, 9 states never apply and 4 more very rarely apply their statutes.

Of the remaining 20 states, 7 provided utilization data for the most recent available year(s): Colorado: 150–200 (annual average); Florida: >9,000 (annual average); Hawaii: 83 in 2009; Massachusetts: >4,500 (annual average) around 2011; Missouri: 166 in 2011; Texas: 22 in 2010; and Wisconsin: 260 in 2011. Seven other states reported that commitment occurred regularly or frequently, but could not provide a specific or estimated count, typically because data were not recorded in a central location (i.e., they were either collected by county, by individual courts, or not at all). The remaining 6 states, although familiar with the statute, were unable to report the extent of the statute's use (Fig. 1).

Statutes vary on the substantive criteria used to justify commitment (Table 1). Dangerousness to self and to others is the most frequently included ground for commitment. States commonly permit commitment under alternative circumstances, with the necessary and sufficient criteria set differing by state. The evidentiary requirement (before judicial approval for commitment can be given) for these criteria also varies by state (Table 1).

The maximum periods for both initial and subsequent commitment orders range from a month or shorter to a year or longer. Some states allow commitment only to an inpatient facility and others to inpatient and outpatient facilities and programs; others do not specify the setting (Table 2).

Discussion

This is the first comprehensive examination of the nature and utilization of civil commitment laws for substance abuse in the United States. These data show that outside of the criminal justice system, states hold markedly different views toward compulsory treatment for substance abuse. This study examined statutes from July 2010 through October 2012. Our findings suggest a small increase in the number of states with civil commitment statutes in recent decades (33 compared with 31 in 1997).[10] We note our findings of the existence of substance-related commitment statutes differs from those in a recent study that identified only 17 states with commitment statutes; we suspect these differences arose from that study's having restricted the investigation to the mental health sections of statutes,[12] whereas our search included the entire statue,

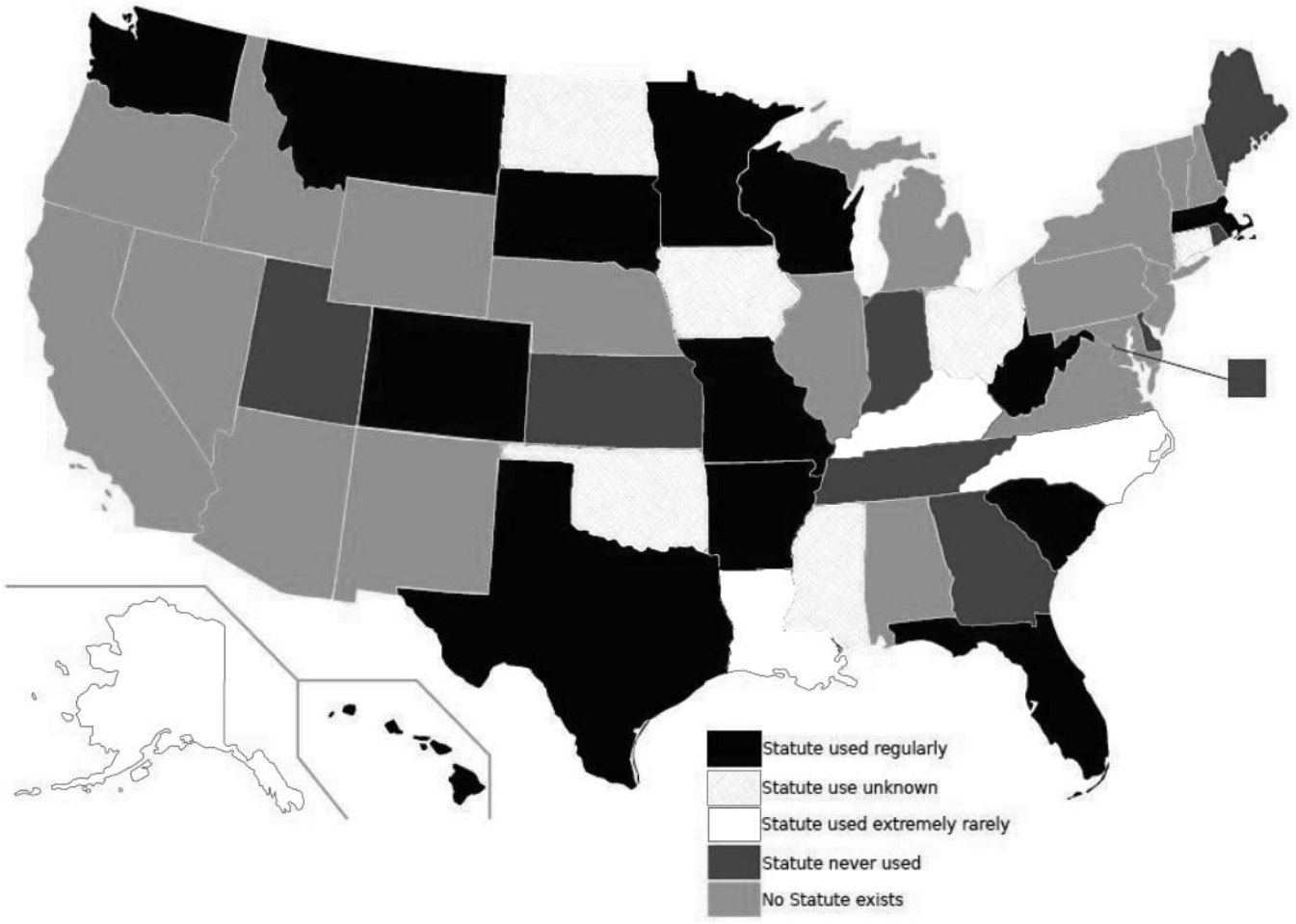

Figure 1. Existence and utilization of civil commitment statutes for substance abuse in the United States July 2010 through October 2012.

as well as contact with an authority within the state to confirm our findings. Notably, many of the statutes that we identified were found in sections of other statutes (e.g., penal code, welfare) that were separate from mental health codes. For example, Florida, which was found to have among the highest utilization of civil commitment for substance abuse, was not identified in the prior study, most likely because its provision fell under the public health section of the statute.

Although more than half of states have statutory provisions that seem to allow for civil commitment for substance abuse, it is important to note that many of these statutes have fallen into disuse. The reported reasons for nonuse varied. In Indiana, for example, the statutorily designated facility for substance commitments is no longer in operation; thus, although the statute appears to be active, its wording does not permit commitment to any other private or publicly funded entity. In other states, petitions for commitment do not have adequate support from the attorney general or judiciary. Although not specifically offered by state representatives as a reason for not using a statute, state-specific case law may further restrict commitment applications in some jurisdictions. One example from Louisiana, where substance-related commitment is extremely rare, is *In the Matter of M.M.*,[21] in which the Second Circuit Court of Appeals overturned the commitment of a man who was abusing alcohol, cannabis, alprazolam, and phenobarbital. The court held that the petition for M.M.'s commitment failed to meet the threshold of clear and convincing evidence that he posed a danger or was gravely disabled despite his self-report of heavy alcohol use, his multiple recent charges of driving under the influence, verbal altercations with his mother, suicidality, and refusal of treatment. Meanwhile, in states such as Florida and Massachusetts, commitment for substance abuse is used frequently. Three states changed their commitment

Table 1 Substantive Criteria and Evidentiary Standards in Civil Commitment Statutes for Substance Abuse

Criterion	Statute Exists, Used Regularly (n = 14)	Statute Exists, Extent of Use Unknown (n = 6)	Statute Exists, Used Rarely or Never (n = 13)	All States With Statute (n = 33)
Dangerous to others	14	6	13	33
Dangerous to self	14	6	12	32
Needs treatment*	7	6	9	22
Gravely disabled or incapacitated	10	3	6	19
Intoxicated/addicted†	8	4	7‡	19‡
Loss of self-control§	6	3	9	18
Lack of decisional capacity	5	2	6	13
Danger to property	1	1	2‡	4‡
Pregnant and abusing	1	1	–	2
Prior failed treatment	2	1	1‖	4‖
Evidentiary Standard				
Clear and convincing	11	5	6	22
Probable cause, reasonable basis	1	–	4	5
Other or unspecified standard	2	1	3	5

All values denote number of states.
* Includes requirement that treatment is deemed necessary to treat addiction, the patient is expected to benefit from treatment, or treatment is expected to prevent other negative outcomes.
† Substance abuse alone (either chronic or acute) is sufficient for commitment.
‡ Includes one state in which the criterion is listed only for alcohol or drug use.
§ Demonstrates a repeated pattern of failing to meet social, financial, or occupational responsibilities.
‖ Required by one state for outpatient commitment only.

laws during this study: in 2012, Ohio revised its statute to permit substance-related commitment, California repealed its provision, and Massachusetts extended its maximum commitment duration from 30 to 90 days. Similarly, it is conceivable that additional statutory modifications could have taken place between the time of writing and the publication of this paper.

Table 2 Maximum Length of Initial and Subsequent Commitment and Commitment Setting in States With Civil Commitment Statutes for Substance Abuse

Commitment Periods and Setting	Statute Exists, Used Regularly (n = 14)	Statute Exists, Extent of Use Unknown (n = 6)	Statute Exists, Used Rarely or Never (n = 13)	All States with Statute (n = 33)
Maximum initial commitment period*				
Up to 1 month	2	–	2	4
1–2 months	5†	1	1	7†
2–3 months	5	2	3‡	10‡
3–6 months	2	2	6‡	8‡
6–12 months	1†	–	1	2†
Longer than 1 year or indefinite	–	1	2‡	3‡
Maximum subsequent commitment period*				
1–2 months	2	–	1‡	3‡
2–3 months	7	1	3‡	11‡
3–6 months	1	1	6‡	8‡
6–12 months	3	2	2	7
>1 year	1	–	–	1
Not applicable§	–	2	3‡	5‡
Commitment setting				
Inpatient only	4	1	3‡	8‡
Inpatient or outpatient	9	5	9‡	23‡
Unspecified	1	–	2	3

* Every 30 days = 1 month. Thus, 60 days = 2 months, 90 days = 3 months, etc.
† Includes one state in which the maximum period for inpatient and outpatient commitment differ.
‡ Includes one or more states in which the maximum commitment period for alcohol and drug use differ.
§ The review process for ongoing commitment is neither judicial nor quasi-judicial in nature (e.g., falls under the authority of the state's mental health department).

Nearly all states with substance-related commitment statutes allow commitment of persons who, due to their substance abuse, pose a significant and often immediate threat of harm to themselves or others. Many also allow commitment under other circumstances including grave disability, loss of self-control or decisional capacity, and dangerousness to property or a fetus. A remarkable finding was that more than half of statutes allow commitment on the basis of substance abuse alone—that is, in the absence of additional clinical, legal, or social factors. These alternative pathways suggest that statutes were formulated to allow for a certain degree of flexibility in bringing persons with substance abuse into treatment in light of the variety of ways in which severe substance use can impair judgment and threaten personal and public safety. Although these data do not reveal the relative frequency with which any single criterion serves as the substantive basis for commitments in a given state, select criteria (for example, those relating to dangerousness) may play a more common role as grounds for commitment.[15] Nevertheless, given the concern for misuse and abuse of substance use commitment within jurisdictions where it is more widely accepted,[22] research is needed to examine further what criteria are used to justify commitments and whether specific criteria predict short- and long-term outcomes after commitment. Attention should also be paid to possible differences in how commitment laws are applied between jurisdictions within a particular state, especially given the variability in services and the individual approaches of the parties who may be involved in the commitment process (e.g., police, judges, drug court personnel, attorneys, community treatment providers, and correctional systems).

That so many states either do not have or do not use civil commitment despite the high prevalence and persistent problems associated with substance use raises the question of whether they are brought into compulsory treatment by other means. The high co-occurrence of mental health disorders with substance abuse raises the possibility that individuals are being committed under mental health statutes. In such cases, commitment criteria would be satisfied by misattributing substance-related problems to mental illness or by an array of behaviors and symptoms that arise from the confluence of substance and mental health problems. Although application of mental health commitment statutes in such cases achieves the immediate goal of bringing the patient into treatment, it risks the occurrence of two important problems. First, the practice may fail to deliver care that is most needed; if substance abuse is the primary concern, a patient may be unnecessarily forced into mental health treatment without receiving addiction-focused services. Even if the patient has co-occurring mental health and substance abuse concerns, mental health commitment does not ensure that substance abuse treatment will be integrated into their care. The second problem in using mental health commitment for substance abuse is that it pressures clinicians and judges to bend the formal commitment criteria to achieve one goal (i.e., provide protection or mitigate other adverse outcomes of continued substance abuse) at the risk of eroding trust in the medical providers and legal system that participate in the commitment process. At least in the case of mental health commitment, criteria are often interpreted in ways that allow for mandated treatment under circumstances that seem clinically indicated, even if the criteria are not formally satisfied.[23] If mental health commitment laws are being used to address problems that arise primarily from substance abuse, such procedural injustices may undermine patient engagement in treatment.[19]

Undoubtedly, the criminal justice system serves as an alternative route for bringing individuals with substance abuse problems into compulsory treatment. The rates of substance addiction are at least twice as high in criminal justice–involved populations, including probation, parole, and incarceration[24,25], as the general population. In recent decades, there has been a shift among European countries toward using commitment in a criminal justice rather than purely civil context.[26] Early research on substance commitment in the United Sates focused on populations under community-based correctional supervision,[27] both because most committed individuals had active or past criminal justice problems, and because mid-20th century commitment laws related to substance use were largely introduced as an alternative to criminal sentencing.[28] Little is known about the extent of criminal justice problems among those who are civilly committed for substance abuse in the United States today. Drug courts have achieved widespread integration into the criminal justice system and offer alternatives to incarceration for defendants with substance use problems.[29] They may operate concomitantly with civil

commitment for individuals facing criminal charges. This interface merits exploration. Future inquiry should also address whether identifiable factors predict who gets committed, including socioeconomic status, health insurance, unemployment, and membership in a particular ethnic or racial group, as has been found with mental health commitment.[30] Such factors, if they exist, would call into question whether civil commitment should be used to deal with problems that arise from social determinants of health.

Despite the longstanding existence of civil commitment for substance abuse, data on short- and long-term outcomes following commitment are surprisingly limited, outdated, and conflicting.[26,31–33] On balance, the recent evidence suggests that commitment does little to deter future substance abuse[7,18,34] for several reasons. First, the treatment offered during commitment varies by setting, jurisdiction, and length of commitment. Second, sustained abstinence from substances of abuse is consistently predicted by a patient's motivation to sustain abstinence, demonstration of self-help behavior and beliefs, and perceived self-efficacy.[35–37] Because of its compulsory nature, civil commitment may seem to oppose such positive prognostic factors. However, research is needed on the extent to which the subjective experience of coercion impedes development of internal motivation,[38] even when the treatment offered under commitment includes strategies designed to mitigate these effects. Some committed individuals paradoxically experience mandated treatment as welcome and potentially beneficial.[39,40] Thus, the interplay between coercion and satisfaction at having access to substance abuse treatment warrants further consideration. Specifically, such research should include simultaneous assessment of the range of additional pressures that may coexist with a commitment order (e.g., urging of family and employers), one's perceptions of such pressures,[21] changes in motivation during the commitment period, the severity and treatment of co-occurring disorders, and the aforementioned potential social determinants of substance outcomes (e.g., insurance status, financial resources, and social supports). These data could provide an important evidence base for evaluating the ethics-related tensions between promoting safety and patient autonomy that invariably accompany civil commitment laws.

Several limitations in our study should be noted. Although we sought to determine to what extent statutes were used in the states in which they exist, often state representatives could offer only limited information on their use; thus, the detail and quality of data on commitment varied by state. Moreover, the existence of any particular statute does not necessarily reflect how it is used in real-world settings. Some states may not make use of commitment statutes because of bed availability or other reasons. Even in states where commitment periods can be long, the order may call for a shorter period, or individuals may be released before completing the full term of the commitment.[15] Moreover, these data do not answer important questions about the type of treatment provided under commitments and the coordination of care between providers in commitment and noncommitment settings. Also, although these data suggest a slight increase in the existence of substance-related commitment laws over time, they do not offer information about year-to-year variations in utilization or statutory development within states. Given the significance and extent of substance abuse and the potential benefit of civil commitment, more attention should be given to this topic.

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LEGAL DIGEST

Procedures Governing the Involuntary Commitment of a Minor to a Drug and Alcohol Treatment Program

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Minimal Due Process Protections Required for Involuntary Commitment of Juveniles to a Drug and Alcohol Treatment Program

In *The Interest of F.C. III*, 2 A.3d 1201 (Pa. 2010), the Supreme Court of Pennsylvania held that the state statute permitting a parent or guardian to petition for civil involuntary commitment of their drug-dependent child to a drug and alcohol treatment program did not violate the due process protections provided by the Fourteenth Amendment of the United States Constitution. The court concluded that the related evaluation is civil and therapeutic, the constitutional rights of juveniles are not equivalent to those of adults, and parents' or guardians' right to make decisions for the care and custody of their children is paramount.

Facts of the Case

F.C. was a 14-year-old boy in the custody of his grandmother, C.K. She reported difficulty managing F.C. because of his regular drug use, stealing, truancy, and tendency to run away from home. He also had a history of outpatient mental health treatment. In 2007, C.K. filed a petition pursuant to Act 53 of the Pennsylvania Drug and Alcohol Abuse Control Act (1972, amended 1997) to compel F.C. to receive drug and alcohol abuse treatment on an involuntary basis. She also requested assistance in ensuring that F.C. attend the hearing on her petition. Subsequently, Allegheny County sheriffs' deputies took custody of F.C. at his home and transported him to juvenile court. There, he was interviewed by a certified addiction counselor. F.C. told the counselor that for approximately one year he had been smoking marijuana daily and sometimes had used alcohol. The counselor diagnosed cannabis dependence and recommended that F.C. have inpatient therapy. Based on this testimony, the juvenile court granted C.K.'s petition and ordered F.C. to receive treatment. He was taken to an inpatient drug treatment facility with a review scheduled within 45 days.

On appeal, F.C. argued that he had been denied due process and his right to counsel when, based solely on the Act 53 petition, he was detained and assessed in a manner in which he was "compelled to divulge private information without being given notice" and without counsel present. In addition, he argued that he was denied due process because he was restrained in shackles during the juvenile court proceeding and his right to counsel was therefore infringed on because he could not communicate with counsel. The superior court upheld the constitutionality of Act 53, explaining that the procedures underlying the Act were fundamentally fair and provided constitutionally adequate protections for minors, given the important goal of facilitating treatment. The court also denied F.C.'s contention that he was denied due process by virtue of being in visible restraints during his hearing, because the proceedings involved a judge rather than a jury, the hearing was very brief, F.C. was considered a flight risk, and the restraints did not impede his ability to communicate with counsel.

The Supreme Court of Pennsylvania granted F.C.'s further appeal on the question of whether Act 53 on its face violates the due process protections provided by the Fourteenth Amendment to the United States Constitution and whether shackling and detaining F.C. during the civil Act 53 hearing violated his due process rights.

Ruling and Reasoning

The Supreme Court of Pennsylvania affirmed and held that Act 53 provides sufficient protection to pass constitutional muster. The court relied on *Parham v. J.R.*, 442 U.S. 584 (1979), to guide its inquiry into the constitutionality of Act 53. In *Parham*, the U.S. Supreme Court held that a parent or a guardian can commit a minor to a mental institution if a physician certifies that the minor should be committed, even if the minor strenuously objects. The Supreme Court specifically rejected claims that commitment of a mi-

nor by a parent or guardian without an adversarial hearing is a deprivation of the minor's liberty without due process of law.

In *The Interest of F.C. III*, the court first pointed out that Act 53 is a civil statute, the purpose of which is not to punish the child but to aid parents and guardians in facilitating substance abuse treatment for their dependent minors. As the *Parham* Court recognized, issues of civil commitment are essentially medical.

Second, the court recognized that the Fourteenth Amendment guarantees persons procedural fairness in matters affecting life, liberty, or property and acknowledged that Act 53 implicated F.C.'s liberty interest. However, the court asserted that due process is a flexible concept with procedural protections dependent on the particular circumstances involved. Moreover, constitutional protections do not necessarily apply equally to children and adults. The court noted that, consistent with *Parham*, a minor's constitutional rights are generally limited by a state's special interests in guiding children's lives, a state's *parens patriae* power to care for its citizens, and traditional state deference to parental autonomy in child rearing. Given the presumption that (in the absence of abuse or neglect) parents act in the best interest of their children, the court held that the right of parents to make decisions for the care, custody, and control of their children is paramount. The filing of a petition to initiate the Act 53 process involves a statement of facts and good reason for treatment and is subject to penalty of unsworn falsification to authorities. The filing merely triggers an assessment process and therefore provides sufficient protection to the minor.

The *Parham* Court further held that an adversarial hearing is not required before commitment for treatment, because a confrontational proceeding would undermine the purpose of the assessment, which is essentially for medical diagnosis. Likewise, the Supreme Court of Pennsylvania held in this case that the assessment outlined in Act 53, which by statute must be conducted by specific clinicians, satisfies *Parham*'s requirement of a decision made by appropriate medical personnel. Because due process requires only an informal determination regarding the necessity of treatment, there need not be notice of the assessment and no counsel need be present. The substance abuse assessment is civil and therapeutic, and thus its administration need not be challenged by the juvenile's attorney.

In addition, the court found that the protections provided by Act 53 at the hearing to determine the necessity of treatment met the minimum protections required by the Constitution. In this formal hearing, a neutral judge considers testimony regarding the propriety of involuntary treatment, and the minor's counsel is permitted to cross-examine witnesses. If the judge finds by clear and convincing evidence that the child is drug dependent, is incapable of or unwilling to accept voluntary treatment, and will benefit from involuntary treatment, the judge orders the juvenile to treatment for a period not exceeding 45 days. Additional 45-day periods of treatment can be ordered only after a review hearing with the same safeguards noted above. The court underscored that the process is civil and therapeutic and concerns a parent or guardian seeking medical treatment for a child; treatment, if ordered, is brief.

The court concluded that the procedures set forth in Act 53, on their face, strike an appropriate balance between a minor's right to avoid unnecessary confinement for medical treatment; a parent's or guardian's right to make decisions concerning the care, custody, and control of his or her child; the state's interest in using its resources appropriately; and the need to avoid imposing unnecessary procedural obstacles that would discourage children or their families from seeking necessary help.

Finally, the court concluded that F.C.'s due process rights were not violated by virtue of his being shackled, restrained, and detained during the hearing. It noted that the right to appear free from physical restraint in court is not absolute and may be compromised when there is a danger of escape. In addition, there was no jury in the case, and there is no indication that the restraints biased the judge against F.C. Also, the restraints did not hinder him from communicating with his counsel.

Dissent

Justice Saylor dissented, arguing that Act 53 does not provide sufficient procedural protections to satisfy due process. He pointed out that the minor's initial commitment of up to 45 days is not predicated upon a risk of immediate bodily injury or death. Also, the court can order successive 45-day confinement periods indefinitely if it finds that the minor will continue to benefit from inpatient treatment.

Although Justice Saylor agreed that a juvenile's constitutional due process rights are not equivalent to those of an adult, he argued that the same standards apply equally when the Due Process Clause is concerned, with avoiding factual error as a basis for liberty deprivations. In addition, unlike the situation in *Parham* that related to a psychiatric admission, the drug-dependency assessment specified by Act 53 may be initiated by a one-sentence petition by a parent, followed by a relatively short interview by a nonphysician who is not required to conduct a thorough background evaluation based on school and social service records. Justice Saylor cautioned that Act 53 permits such "heavy handed actions" against minors in a "purely civil context," including arrest and shackling by multiple law enforcement agents followed by transport and evaluation at court, such that due process protections were inadequate.

Discussion

In this case, the court addressed the procedural requirements governing the involuntary commitment of a minor to a drug and alcohol treatment program. As the court pointed out, statutes providing for involuntary commitment for substance abuse treatment for minors in several other states offer different protections. For example, in Oklahoma and Indiana, a petition can be filed only when the minor has been evaluated by a medical professional. Unlike Act 53, several other state statutes (e.g., those of Delaware, Michigan, and Wisconsin) grant juveniles the right to an assessment by an independent examiner. Moreover, many states including Florida, Massachusetts, and Utah, require a showing that a youth is a danger to himself or others as a result of drug or alcohol dependence. Finally, many state statutes (e.g., those of Oklahoma, Utah, and Wisconsin) require the determination that inpatient treatment is the least restrictive setting that is consistent with treatment goals.

The court articulates the explicit presumption that parents and guardians (in the absence of abuse or neglect) will act in the best interest of their children and characterizes the parent or guardian's right to determine the child's care and custody as paramount. Nevertheless, Act 53 and similar statutes place the evaluator in the unique position of assessing the appropriateness of the parent or guardian's request. It is, after all, the evaluator who is tasked with assessing whether the juvenile is truly in need of inpatient commitment. Although this case describes these evaluations as therapeutic rather than punitive, best practices generally involve the review of additional sources of information to ensure that the evaluator's conclusion regarding the juvenile's need for treatment is indeed in his or her best interests and meets the local jurisdictional standard for commitment.

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Treatment Disclosures in Sex Offender Civil Commitment Evaluations

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Statements Made During Treatment-Related Activities May Not Be Privileged for Purposes of Sex Offender Civil Commitment Evaluations

In the case of *In the Interest of Maedche*, 788 N.W.2d 331 (N.D. 2010), the district court involuntarily committed Thomas Maedche as a sexually dangerous individual. On appeal, the North Dakota Supreme Court decided whether North Dakota's sexual offender civil commitment statute should be voided because of vagueness and whether treatment-related disclosures should be precluded from sex offender commitment proceedings on the basis of the self-incrimination and due process protections of the U.S. Constitution.

Facts of the Case

Thomas Maedche pled guilty and was convicted of indecent exposure for exposing himself and masturbating in front of a nine-year-old girl during a sleepover at a hotel. He submitted to a sex offender risk assessment and psychological evaluation as part of the presentence investigation report. The risk assessment, which included administration of the Static-99 and Minnesota Sex Offender Screening Tool, Revised (MnSOST-R), indicated a high risk of reof-

Statutory Definitions of Mental Illness for Involuntary Hospitalization as Related to Substance Use Disorders

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Objective: **In New York City, individuals gravely disabled by substance use disorders repeatedly present to emergency rooms yet rarely remain in treatment for more than several days and often sign out against medical advice. Although these individuals are at high risk of death and often lack the capacity to make treatment decisions, the laws in New York State are unclear about whether substance use disorders qualify as mental illnesses for the purpose of involuntary hospitalization. To better understand the national landscape of civil commitment law, with a specific focus on substance use disorders, a review was conducted of mental health statutes in all 50 states and the District of Columbia (D.C.).** ***Methods:*** **Two independent reviewers examined all state mental health statutes using Lexis Nexis and Westlaw search engines.** ***Results:*** **A total of 22 states, including D.C., do not reference substance use disorders in their statutory definitions of mental illness. Of the 29 that do, eight include substance use disorders and 21 explicitly exclude them. In addition, nine states have separate inpatient commitment laws specifically addressing substance use disorders.** ***Conclusions:*** **Civil commitment statutes vary greatly by state in terms of clarity and specificity regarding which mental illnesses are included for the purpose of involuntary hospitalization. Mental health professionals and policy makers should discuss whether individuals gravely disabled by substance use disorders, a complex and vulnerable population, should be more widely included under standard civil commitment law. (*Psychiatric Services* in Advance, January 15, 2014; doi: 10.1176/appi.ps.201300175)**

Although the great majority of individuals with substance use disorders never require civil commitment for involuntary hospitalization for treatment, there is a subpopulation of patients with complex conditions for whom addiction is so gravely disabling that they are unable to make rational treatment decisions or care for themselves independently, necessitating a higher level of care. In New York City, for example, there is a subpopulation of individuals with substance use disorders who repeatedly present to public hospital emergency rooms, never stay in treatment for more than several days, and often sign out of the hospital despite clinical recommendations otherwise, and never stay in either inpatient or outpatient treatment for more than several days. These patients have become chronically homeless and socially isolated. They have a multitude of untreated chronic medical conditions despite having hundreds of hospital admissions and accruing immense hospital costs; the minimum annual mortality rate in this subpopulation is 8.6%, or roughly 20 times the age-adjusted rate (1).

In the United States, civil commitment language typically permits involuntary hospitalization of individuals with mental illness for one of three purposes: suicidal danger to self, homicidal danger to others, or danger to self as a result of grave disability, which prevents an individual from being able to secure basic necessities such as food, clothing, or shelter. As with patients who have decompensated schizophrenia or severe and immobilizing depression who meet dangerousness criteria, individuals with severe substance use disorders may be considered eligible in some U.S. states for involuntary hospitalization when they become gravely disabled.

In New York State, the definition of mental illness for civil commitment purposes (MHL § 1.03) is very broad and allows for considerable discretion. However, the law does not reference substance use disorders. Although many clinicians may have assumed that substance use disorders did not qualify as committable mental illnesses, no case law existed until 1995 to guide interpretation. *In the Matter of Michael S.* is a case that came before a Westchester County, New York, court in 1995 (2). In this

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case, a father and doctor had petitioned a lower court to involuntarily admit an opiate-addicted patient for treatment. The lower court dismissed the complaint, writing, "There is no medical evidence to equate mental illness with drug addiction." A second court did not comment on this matter until 2010. In *Lawlor v. Lenox Hill Hospital,* a patient brought a medical malpractice claim against Lenox Hill Hospital alleging that Lenox Hill failed to psychiatrically evaluate and involuntarily treat a patient who had been medically admitted for alcohol-related injuries (3). The court again dismissed the complaint, stating, "Alcoholism is not considered a mental illness under [New York State statute] and a person cannot be involuntarily confined under that statute solely for treatment of alcoholism." A subsequent case has now relied on *Lawlor,* excluding "alcoholism" as a committable mental illness (4). These court rulings, however, have limited precedential authority and are not applicable throughout the state—or even throughout New York City. The rulings give little clarification as to what qualifies as a mental illness in New York State.

The ambiguity surrounding criteria for the commitment of addicted persons in New York may hinder clinician attempts to treat this complex population. State statutes that do not explicitly comment on substance use disorders within their definitions of mental illness for civil commitment may complicate efforts by families and providers to secure inpatient treatment for appropriate patients. Consequently, in many states it is legally difficult—or frequently believed by practitioners to be difficult (5,6)—to hospitalize patients gravely disabled by substance use disorders who do not agree to treatment.

History

In the 1845 court ruling *In the Matter of Josiah Oakes* (7), Judge Shaw of Massachusetts heralded "the great law of humanity" as the justification for temporarily restricting the liberties of persons with mental illness for the purpose of treatment. Building on English Common Law, the ruling helped develop the state interest of *parens patriae*, or caring for persons who are unable to care for themselves (8). Over the course of the mid-19th century, all states subsequently developed mental hygiene laws with civil commitment statutes that allow for the involuntary hospitalization of individuals with mental illness (9).

Until the 1960s, these statutes were relatively vague (often simply stating that anyone who was "insane" and "needed treatment" could be involuntarily committed) and left much of the decision making about hospitalization in the hands of physicians (10). Committed patients (all of whom were hospitalized because at the time outpatient commitment did not exist) were considered to be globally incompetent (that is, without any rights or ability to manage any of their affairs, including medical decisions), and mental illness alone was considered sufficient for confinement (11). In 1961, the publication of *The Mentally Disabled and the Law* (12) marked a watershed moment for the legal profession's burgeoning influence over the treatment of persons with mental illness (13). A series of sweeping societal and legal reforms followed, further inspired by civil rights movements (14). By the early 1970s, virtually all states had narrowed their criteria for involuntary hospitalization and placed more of an emphasis on dangerousness rather than need for treatment (10)—so much so that the American Psychiatric Association countered with the 1983 Model State Law in an attempt to renew emphasis on the need for treatment (15). Since the 1980s, several states have widened their criteria beyond imminent dangerousness to include risk of severe deterioration and general inability to care for self (10). Throughout this period, revisions were made to procedural rights, whereas substantive definitions of what met criteria for a mental illness remained essentially the same.

Coincident with the development of "traditional" mental hygiene laws over the past 150 years was the evolution of "drug dependence laws" that addressed the treatment of people with alcohol or drug dependence outside the traditional civil commitment process for mental illness (16). The notion of addiction as a disease or illness rather than simply criminal or immoral behavior first entered the public consciousness in the mid-1800s, originating from Temperance Movement literature questioning whether alcohol was "irresistible" for some people (17). Between the 1860s and 1890s, at least 14 states passed commitment statutes for addiction, and 50 "inebriate hospitals" were constructed across the nation (17). By the 1910s, there was interest at the federal level in committing addicted persons to inpatient treatment, as indicated by the Harrison Narcotic Act of 1914, which prompted the creation in 1935 of a national treatment center in Lexington, Kentucky, run by the U.S. Public Health Service.

It was not until the 1960s that some states and physicians once again began to treat addiction as a mental illness under the law. From the mid-1960s through the 1970s, roughly 20 states developed separate commitment procedures for persons with substance use disorders (18). Among these states, commitment was often limited to outpatient or residential treatment, such as therapeutic communities, and was frequently in lieu of a criminal trial or was implemented after conviction (18). Thus many states have had two sets of commitment laws for hospitalization: one for patients with (dangerous) mental illnesses and another for those with substance use disorders.

The debate within the medical community over the nature and treatment of substance use disorders during this period increased in intensity. In a landmark 1968 case from the U.S. Supreme Court, *Powell v. Texas*, Justice Marshall wrote, "there is no agreement among members of the medical profession about what it means to say that 'alcoholism' is a 'disease,' " which raised the concern that "therapeutic commitment" for "indigent public inebriates" entailed the risk that they would be "locked up" for an indefinite period because of the limited available evidence that alcoholism could be cured or even effectively treated (19).

The lack of consensus within the medical community has thus served as

a backdrop for the ongoing creation of inconsistent state statutes regarding addiction and civil commitment. Three editions of *The Mentally Disabled and the Law* have been published—in 1961, 1971, and 1985 (12, 20,21). A review of these editions indicates that there was little consistency among states in handling the commitment of persons with substance use disorders in the latter half of the 20th century. Although it appears that several states that permitted commitment for both alcohol and drug use disorders in 1961 continued to do so in 1985, few other trends can be identified. [Three U.S. maps in an online data supplement provide an overview of states that permitted commitment to institutionalization or hospitalization—that is, not residential or outpatient commitment—for alcohol and or drug use disorders in 1961, 1971, and 1985.]

Methods

To better understand the national landscape, civil commitment statutes for involuntary hospitalization in all 50 states and the District of Columbia (D.C.) were reviewed to assess for trends that might help guide further discussion about this important interface between mental health practice and the law. Our primary goal was to compile a comprehensive list of all statutory definitions of mental illness as related to involuntary hospitalization, with a specific focus on any mention of substance abuse or dependence. Two authors with experience in teaching and writing about mental health law (SC and EBF) reviewed all state mental health statutes as of April 11, 2013, by using Lexis Nexis and Westlaw search engines. Civil commitment and, if applicable, separate addiction-related inpatient commitment statutes were reviewed. The definition of mental illness for the purpose of involuntary hospitalization was identified and interpreted in three ways: including substance use disorders, excluding substance use disorders, or not referencing substance use disorders. Although case law was occasionally used to help interpret particularly complicated statutes, a thorough review of all case law and administrative regulations was outside the scope of this review.

Results

A total of 22 states, including D.C., do not reference substance use disorders in their statutory definitions of mental illness (Table 1). Of the 29 that do, eight explicitly include substance use disorders and 21 explicitly exclude them as qualifying mental illnesses for the purpose of commitment. Nine states have separate, additional inpatient commitment laws specifically permitting involuntary hospitalization for substance use disorders (two of which are states that otherwise exclude substance use disorders in their definitions of mental illness). In sum, 17 state statutes appear to explicitly permit involuntary hospitalization for substance use disorders either by inclusion of substance use disorders in definitions of mental illness or through separate inpatient commitment laws. An additional 15 state statutes do not reference substance use disorders such that, short of prevailing case law or administrative regulation, they appear to passively permit involuntary hospitalization. [A flow diagram and a U.S. map illustrating these findings are included in the online data supplement.]

Definitional language varies greatly from state to state in terms of clarity and specificity. For instance, Washington State (§ 71.05.020) defines a "mental disorder" vaguely as "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." In contrast, Oregon's (ORS § 426.495) mental illness definition ("Chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder") is more specific.

Some states clearly exclude or include substance use disorders in their mental illness definitions. Alabama's statute [§ 22–52–1.1 (1)] specifically excludes substance use disorders ("Mental illness, as used herein, specifically excludes the primary diagnosis of . . . substance abuse, including alcoholism"). Whereas Tennessee (§ 33–1-101) specifically includes alcoholism or drug dependence ("Mentally ill individual means an individual who suffers from a psychiatric disorder, alcoholism, or drug dependence").

Among the ten states that have separate commitment laws for substance use disorders, language regarding substance use disorders varies even more than that defining mental illness. This may in part reflect the frequent conflation (for either medical or legal purposes) of intoxication, substance abuse, and addiction and a historical carryover of distinguishing alcohol dependence from other drug dependence.

Discussion

We believe this compilation to be the first of its kind for at least the past two decades. Civil commitment statutes affect clinical practice because clinicians assess dangerousness and hospitalization criteria partly on their understanding of existing legal criteria (22). The ambiguity and inconsistency of statutory language may complicate such efforts.

State statutes regarding the hospitalization of persons with substance use disorders have largely remained stagnant since the 1970s despite progress in understanding the etiology and neurobiological pathology of substance use disorders. An abundance of evidence now associates addiction with changes in brain structure and function that persist well beyond the cessation of drug use and detoxification (23–27). Unlike views prevalent in the 1970s, expert views on substance use disorders among addiction researchers and clinicians are now consistent in describing substance use disorders as chronic brain diseases. Importantly, addiction is not simply a neurologic disease but a mental illness. It changes fundamental aspects of an individual's personality—cognition, emotions, and behaviors—that implicate decision-making capacity and self-determination (28–30). Research on treatment effectiveness has also grown considerably. By 1990 several authoritative reviews emerged spanning tens of thousands of patients enrolled in federally funded studies demonstrating that treatment leads to significant and enduring declines in drug use (31,32). Subsequently, the 1990s Drug

Table 1

Inclusion or exclusion of substance use disorders in state laws defining mental illness for the purpose of involuntary hospitalization

State	Current relevant law	Status of substance use disorders in the definition of mental illness[a]	Separate commitment law permits involuntary hospitalization[b]
Alabama	Alabama Health, Mental Health and Environmental Control Law § 22–52–1.1(1)	Excluded	
Alaska	Alaska Welfare, Social Services and Institutions Law § 47.30.915(12)	Excluded	§ 47.37.190(a)
Arizona	Arizona Revised Statutes § 36–501	Excluded	
Arkansas	Arkansas Code of 1987, Ann. § 20–47–202	Excluded	
California	California Welfare and Institutions Code § 5008 and 5585.25	Included[c]	
Colorado	Colorado Revised Statutes Ann. CRSA § 27–65–102	Not referenced	§ 27–81–112 (alcohol only)
Connecticut	Connecticut General Statutes § 17a–495	Excluded	
Delaware	16 Delaware Code § 5001	Not referenced	
Florida	Florida Statutes § 394.455	Excluded	
Georgia	Georgia Code Ann., § 37–1–1	Not referenced	OCGA § 37–7–81
Hawaii	Hawaii Revised Statutes § 334–1 and § 334–60.2	Not referenced[d]	
Idaho	Idaho Code § 66–317	Not referenced	
Illinois	405 Illinois Compiled Statutes 5/1–129	Excluded	
Indiana	Indiana Code Ann. § 12–7–2–130	Included	
Iowa	Iowa Code § 229.1	Not referenced	§ 125.75
Kansas	Kansas Statutes Ann. 59–2946	Excluded	
Kentucky	Kentucky Revised Statutes § 202A.011	Not referenced	
Louisiana	Louisiana Laws Revised Statutes 28:2	Excluded	
Maine	34-B Maine Revised Statutes § 3801	Included	
Maryland	Maryland Health-General Code Ann. § 10–101	Not referenced	
Massachusetts	Massachusetts General Laws 123 § 1	Not referenced[e]	123 § 35
Michigan	Michigan Compiled Laws § 330.1100d	Excluded	
Minnesota	Minnesota Statutes § 253B.02	Excluded	
Mississippi	Mississippi Code Ann. § 41–21–61	Excluded	§ 41–31–3
Missouri	Missouri Revised Statutes 630.005	Excluded	
Montana	Montana Code Ann. § 53–21–102	Excluded	
Nebraska	Nebraska Revised Statutes § 71–908	Included	
Nevada	Nevada Revised Statutes 433A.115	Excluded	
New Hampshire	New Hampshire Revised Statutes § 135-C:2	Excluded	
New Jersey	New Jersey Statutes Ann. 30:4–27.2	Not referenced[f]	
New Mexico	New Mexico Statutes Ann. 1978, § 24–7B–3	Not referenced	
New York	New York Mental Hygiene Law §§ 1.03 (20), 1.03(3)	Not referenced	
North Carolina	North Carolina General Statutes § 122C–3	Not referenced	§ 122C–285
North Dakota	North Dakota Century Code § 25–03.1–02	Included	
Ohio	Ohio Revised Code § 5122.01	Not referenced	
Oklahoma	43A Oklahoma Statutes Ann. § 1–102 & § 1–103	Included	
Oregon	Oregon Revised Statutes § 426.495	Excluded	
Pennsylvania	50 Pennsylvania Statutes § 4102	Not referenced	
Rhode Island	Rhode Island General Laws 1956, § 40.1–5–2	Not referenced	
South Carolina	South Carolina Code Ann. § 44–17–410	Not referenced[e]	SC Code Ann. § 44–52–10
South Dakota	South Dakota Codified Laws § 27A–1–1	Excluded	
Tennessee	Tennessee Code Ann. § 33–1–101	Included	
Texas	Texas Mental Health Code § 571.003	Excluded[g]	
Utah	Utah Code Ann. § 62A–15–602	Not referenced	
Vermont	18 Vermont Statutes Ann. § 7101	Not referenced	18 VSA § 8402 ("drug addicts" only)
Virginia	Virginia Code Ann. § 37.2–100 & 37.2–800	Included	
Washington	Revised Code of Washington § 71.05.020	Not referenced	
Washington, D.C.	Washington D.C. Code § 21–501	Not referenced	
West Virginia	West Virginia Code § 27–1–2 and § 27–5–4	Not referenced[d]	

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Table 1

Continued from previous page

State	Current relevant law	Status of substance use disorders in the definition of mental illness[a]	Separate commitment law permits involuntary hospitalization[b]
Wisconsin	Wisconsin Statutes Ann. 51.01	Excluded[g]	
Wyoming	Wyoming Statutes § 25–10–101	Excluded	

[a] Rather than "mental illness," some states use terms such as "mental disorder," "mental disability," or "mental condition."
[b] Separate law specifically permits commitment of persons with substance use disorders.
[c] California does not define mental disorder; however, its definition of grave disability for the purposes of hospitalization of persons with mental disorders explicitly includes "chronic alcoholism." There is no reference to other drug dependence.
[d] Involuntary commitment of persons with substance use disorders is allowed in addition to persons with mental illness.
[e] State does not define mental illness.
[f] New Jersey statutes state that involuntary hospitalization is not allowed for "simple" intoxication unless there are severe complications but do not explicitly reference substance use disorders.
[g] Alcoholism excluded but other substance use disorders (that is, illicit drug dependence) not referenced

Abuse Treatment Outcome Study provided evidence regarding which aspects of addiction treatment were most effective, ultimately emphasizing the importance of retention in treatment (33,34). Most recently, the literature has evolved to demonstrate that coerced treatment for substance use disorders can, in some cases, be as effective as voluntary treatment (35–39). As with other serious mental illnesses, involuntary hospitalization may be a necessary tool that allows clinicians to fully stabilize, assess, and plan (for example, arrange for mobile outreach or intensive case management) for these patients with complex conditions (1).

There is limited literature on the subject of psychiatrists' knowledge of and attitudes toward commitment criteria. However, the few available studies have repeatedly found that surveyed psychiatrists are often not familiar with the specific criteria and procedures contained in their state's statutes (5,22,40–42). In addition, some researchers have found that nonrespondents (that is, those who do not reply to surveys) are even less familiar with the criteria than respondents (43). It is also not uncommon for psychiatrists to be influenced by nonlegal criteria, such as logistical constraints involving bed availability, workload, overcrowding, and a lack of less restrictive alternatives, despite statutory guidelines to the contrary (44–46).

Conversely, in states where civil commitment is permitted for substance use disorders, it is often not used (8,47–49). A 2006 American Psychiatric Association poll of its members (N=739) concluded that 99% of psychiatrists agreed with commitment for "dangerousness," but only 22% agreed with commitment for substance use disorders (41). Although these findings do not comment on psychiatrists' attitudes about commitment for dangerous ("gravely disabled") persons with substance use disorders, they do highlight that in the broader mental health community there is disagreement about whether substance use disorders should be treated, legally, in the same manner as other severe mental illnesses.

We recognize that there are significant concerns, ideologically, logistically, and financially, with any standardization of civil commitment and, possibly, with any expansion, especially in areas of the country with relatively limited resources. First, as already mentioned, there is no clear agreement in the health care community about the best treatment practices for individuals who have gravely disabling substance use disorders. We see debate as an opportunity for addiction specialists to strive for best practices in this area.

Second, and perhaps even more important in our current era of cost containment, widening the scope of persons who qualify for inpatient hospitalization to include gravely disabled individuals with substance use disorders may further stress the already limited number of hospital beds. It is possible, however, that shifting dollars to longer-term inpatient care or stabilizing patients to transition them to less restrictive levels of care (such as residential or assertive community treatment) may actually improve overall system efficiency and cost-effectiveness. Additional resources are clearly needed for more effective early interventions that prevent the degree of deterioration that necessitates such a high level of care. It is hoped that implementation of the Affordable Care Act will expand such funding.

Third, with approximately half of states already permitting (explicitly or passively) inpatient commitment for persons with substance use disorders, one may ask why the option of involuntary hospitalization for gravely disabled substance users across all states would change the standard of care. We acknowledge that statutory language and the realities of clinical practice may not be closely aligned. However, we suggest that excluding substance use disorders from the statutory definition of mental illness for involuntary hospitalization is both scientifically outdated and may withhold a potentially life-saving treatment option from an extremely vulnerable population.

Conclusions

Laws represent the combined efforts of our elected leaders and our peers to balance the rights of individuals in society against the rights of society as a whole. Over the past 50 years, these great laws of humanity have had increasing influence on the practice of psychiatry related to conflicts

between individual autonomy, provider authority, and state power. Yet most psychiatrists have a limited understanding of relevant state statutes guiding practice related to involuntary hospitalization, particularly with regard to substance use disorders.

Civil commitment statutes related to involuntary hospitalization, especially definitions of mental illness and the inclusion or exclusion of substance use disorders, are important legal tools for psychiatrists to use in making treatment decisions. In the case of individuals who are gravely disabled by substance use disorders, involuntary hospitalization may save their lives. Since the 1980s, *DSM-III* and its progeny, in concert with findings from the past two decades of neuroscience and clinical research, identify substance use disorders in the same category as serious mental illnesses such as schizophrenia and bipolar disorder. Yet the 50 states and D.C. continue to largely address substance use disorders—at least in terms of statutory provisions—as voluntary, self-directed behavior and separate from typical models of treatment for mental illness and from the practice of involuntary hospitalization.

These concerns clearly warrant more empirical evidence regarding cost-effectiveness, duration of treatment effect, and the impact of statutory language on clinical practice. Because of recent advancements in clinical practice and research, we advocate for further exploration and discussion among psychiatrists, policy makers, and legal professionals.

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AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders
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APA Admin. Name: Beatrice Eld, Division of Education
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Addiction Psychiatry, CPL, and CAGR need to form a work group to develop position statement	3,080
2	Unclear extent to which other organizations may need to be involved (eg ASAM, AMA) for in person or phone meetings	3,080
3	District branches facing these commitment issues should submit data.	3,080
Total Staff Costs		9,240

Other Costs not included above:

0	-
Total Author Estimate	**$9,240**

APA Administration Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	workgroup works via email and conference calls. Staffing by liaisons to Councils on Addictions and Psych&Law	3,080
2	State legislative staff compile info on existing and proposed statutes re involuntary tx of SUDs	1,540
3	WG members draft statement; share with full Councils, AAAP, & ASAM for endorsement; advance statement to JRC and Assembly	1,540
Total Staff Costs		**6,160**

Other Costs not included above:

0	-
Total Administration Estimate	**$6,160**

Rvsd. Dec. 2016

Action Paper 12.A: Involuntary Psychiatric Commitment for Individuals with Substance Use Disorders

APA Administration Feedback:

Council on Psychiatry and Law
Council on Addiction Psychiatry
Council on Advocacy and Government Relations

A work group comprised of members from the above components will work via email and conference calls to strategize and draft a position statement. Staffing for the work group efforts will be by liaisons to the Council on Addiction Psychiatry and Council on Psychiatry and Law.

Assistance from state legislative staff to compile information on existing and proposed statutes in each state regarding the involuntary treatment of substance use disorders may be requested.

Once developed, the work group's draft position statement will be shared with the full Councils and then proceed through the governance process and be shared with other relevant organizations that share a similar interest.

No estimated savings or estimated revenue generation is anticipated by this action.

Item 2017A1 12.B
Reference Committee #1
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing

WHEREAS:
Nurse Practitioners (NPs) and Physician Assistants (Pas) have a valuable place in our workforce, however online schools have opened so that the NPs can receive an Advance Practice license, and for Psychologists to learn to prescribe psychotropic medications in just a short few months.

Lack of proper education and a residency has major implications on the safety of patients.

The AMA has concluded that there is a higher rate of prescribing controlled substances and a higher number of referrals and tests that are ordered for patients.

Nurses with an Advance Practice degree are commonly called APRN or APN. They have lower salary requirement and therefore are highly sought after in hospitals due to budget constraints. This is causing more difficulty for physicians to find jobs, and most especially affects the International Medical Graduate and other minorities that have consistently struggled to get hired.

Nurse Practitioners can essentially practice medicine without completing required CMEs like physicians and are held to a lower standard, jeopardizing patient safety.

Psychologists have no preparation in medical training and are poorly suited to make decisions that can affect multiple systems – not just the brain.

The AMA has already developed a position (H-35.989, H-160.947) regarding Physician Assistants as well as Nurse Practitioners and we must be on the same page so that our collaboration can be stronger in the unification of our memberships.

BE IT RESOLVED:
That the APA work with the AMA to oppose the enactment of legislation which authorizes the independent practice of Nurse Practitioners to practice medicine without a Medical Degree and upholding to the standards set out by the medical licensing board in the State in question.

That the appropriate committee create a Position Statement that reflects that the APA, in the service of patients with mental illness, are against the independent practice of Nurses and oppose prescribing rights of Psychologists.

AUTHOR:
Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
(anisarit@gmail.com)

ESTIMATED COST:
Author: $0
APA: $2,926

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: NA

ENDORSED BY:

KEY WORDS: education, nurse practitioner, safety, IMG, physician assistant, APN, NP, APRN, medical license, scope of practice, MUR

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.B: Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing
Action Paper Author(s): Sarit Hovav, M.D., Deputy Representative, International Medical Graduate Psychiatrists
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 review of relevant APA policy and development of position statement	385
2 APA collaborative lobbying with District Branches/State Associations and their respective state medical societies	770
3 develop the resolution(s), seek additional sponsors, develop talking points and coordinate advocacy efforts onsite at the AMA HOD meeting	616
Total Staff Costs	**1,771**
Other Costs not included above:	
research and creation of APA resources for policymakers (i.e., toolkit, white papers)/internal meeting to develop & coordinate grassroot strategies (15 hours)	**1,155**
Total Administration Estimate	**$2,926**

Rvsd. Dec. 2016

Action Paper 12.B: Limiting Scope of Practice for Nurse Practitioners and the Opposition of Psychologists Prescribing

APA Administration Feedback:

Department of Government Relations:
The Department of Government Affairs, working closely with APA membership, has injected a new sense of urgency in defeating inappropriate scope of practice measures sought by non-physician health care professionals. Through the Scope of Practice Partnership, APA collaborates with the American Medical Association and state medical associations to help educate legislators, regulatory agencies, and other policymakers. The Department of Government Relations reviewed the action paper taking in consideration the authors' specific request for advocacy efforts. The projected time and cost would vary widely depending on the scale and scope of the effort that is required. The Department estimates an advocacy campaign based on the premise of the action paper may entail: 5 hours, review of relevant APA policy and development of a position statement; 10 hours, APA collaborative lobbying with District Branches/State Associations and their respective state medical societies; 10 hours, research and creation of APA resources for policymakers, i.e., toolkit, white papers; and 5 hours, internal meeting with APA Communication to coordinate media and grassroot strategy.

APA AMA Delegation:
As the author points out the AMA has several relevant policies that speak to the issue of scope of practice/prescribing. There would be minimal cost for continued advocacy within the AMA House of Delegations unless, in the development of a position statement, the APA position includes some aspect that is not currently covered within existing AMA policy. A review of AMA policy and the development of a resolution would be considered at that time. Much of the heavy lifting on this issue lies with the individual AMA state medical associations. Cost would be primarily staff time to review APA policy, research existing AMA policy, and facilitate a discussion by the APA AMA delegation. If appropriate, develop the resolution(s), seek additional sponsors, develop talking points and coordinate advocacy efforts onsite at the AMA HOD meeting(s). 8 to 10 hours ($616 to $770)

Item 2017A1 12.C
Reference Committee #1
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Simplification of Electronic Medical Records and Billing Codes

WHEREAS:
The Current Procedural Terminology system is owned and operated by the AMA and first published in 1966. It was adopted in 1983 by HCFA for the review of medical claims and in 1987 for surgical procedures. Each year, the AMA receives money for selling the most current edition to many healthcare offices.

A significant component of physician's dissatisfaction with practice stems from the need to use electronic medical records.

Completion of these records slows physicians down, which in turn makes them not available to see the same number of patients they used to see.

The electronic record has become a multiple page document when printed in which it is difficult to find the important findings and conclusions. To review these records when received takes an extraordinary amount of time to obtain very little in the form of useful information. Because of the sheer amount of information sent, important information may be missed.

More time is spent completing the record than in seeing patients. Researchers followed 57 physicians from family medicine, internal medicine, cardiology and orthopedics for a combined total of 430 hours. They found physicians spend 27% of their day with patients and 49.2% of their time on EHR and desk work. Even in the exam room, only 52. 9% of time was considered direct clinical face time and 37% was considered EHR and desk work. For every hour physicians provide direct patient care, nearly 2 additional hours are spent on EHR and desk work. Many also spent an additional 1-2 hours of after-work time each night, primarily doing EHR tasks.[1]

Much of this time is mandated by the need to count bullet points in the history, ROS, physical exam (or mental status exam), etc. This counting of bullets is part of the Evaluation and Management CPT codes. Physicians approve of EHRs in concept, with better ability to remotely access patient information and improvements in quality of care. However for many physicians, the current state of EHR technology significantly worsens professional satisfaction in multiple ways including poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inability to exchange information

[1] Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialities. *Ann Intern Med.*2016;165(11):753-760.

between EHR products, and degradation of clinical documentation. Template generated notes are considered a degradation of clinical documentation. [2]

Many physicians and other service providers do not accurately fill out the current bullet point driven health record.

Patients are dissatisfied with the amount of time that physicians spend attending to their computer and not the patient.

Much of medicine is moving to a different model of reimbursement such as capitated grants, collaborative care, telemedicine, outcome-driven, etc. The Current bullet point driven system of recording visits will not be pertinent in the new value based payment systems.
Frustration with electronic records is causing some physicians to retire earlier than they had previously planned. Their dissatisfaction with their day is also a factor in dissuading young people to choose a career in medicine.

The decrease in productivity caused by having to use an EHR also decreases availability in fields of medicine that are already experiencing shortages, such as psychiatry and child psychiatry.

BE IT RESOLVED:
That the APA Delegation to the AMA lobby to change the current CPT coding requirements for the E/M codes to a simpler three tier system and that the format of electronic health records change to this simpler system.

The three levels of care will be Straightforward, Moderately Complex and Highly Complex. Physicians will record in the chart the pertinent positive and negative findings and reasoning for their conclusions but there will not be a complex system requiring a certain number of bullet points in each category. They would be held to their professional honor to designate the visit appropriately. This ultimately will result in a return of better patient care and more efficiency among physicians of all specialties.

This would by necessity require auditors of health records to have more of a medical background to determine by reading the charts if the appropriate level of care was designated, as opposed to now when they can just count bullets.

That if the CPT code requirements change, then the APA would join other medical groups in meeting with software companies about modifying the EHRs in accord with the new simpler formats.

AUTHOR:
Eileen McGee, M.D., DFAPA, Representative, Ohio Psychiatric Physicians Association

[2] Rand Corporation Executive Summary: Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy—Mark W. Friedburg, Peggy G. Chen, Kristin R. Van Busum, Frances M. Aunon, et al, 2013

SPONSORS:
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William Greenberg, M.D., Deputy Representative, Area 3
Charles Blackinton, M.D., Representative, New Jersey Psychiatric Association
Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Mary Jo Fitz-Gerald, M.D., MBA, DFAPA, FAPM RTD, Representative, Louisiana Psychiatric Medical Association

ESTIMATED COST:
Author: $3,080
APA: $253,674

ESTIMATED SAVINGS: No financial savings, but the saving of many frustrated physicians who may retire or leave clinical practice

ESTIMATED REVENUE GENERATED: none

ENDORSED BY:

KEY WORDS: CPT Codes, EHR, Physician Satisfaction

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Healthcare Systems and Financing

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.C: Simplification of Electronic Medical Records and Billing Codes
Action Paper Author(s):	Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	15	26
Number of Staff	3	6
Number of Non-Staff	-	4
Total	**18**	**36**

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Advocate with AMA staff to change billing code requirements	1,540
2 Meeting with industry to simplify electronic health records	1,540
3	-
Total Staff Costs	3,080
Other Costs not included above:	
0	-
Total Author Estimate	**$3,080**

APA Administration Estimate:

Travel Budget	No. of Attendees	Airfare	Hotel/Lodging	Ground Transportation	Per Diem/Meals	Total
Meeting 1	36	$11,050	$0	$3,000	$2,664	$16,714
Meeting 2	-	-	-	-	-	-
Total Travel Budget		**11,050**	**-**	**3,000**	**2,664**	**16,714**

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Staff time: gather, review, analyze information; coordinate committee & stakeholder meetings and calls; maintain minutes and update relevant materials as required; facilitate the process moving forward.	36,960
2 Meetings: cost of both face to face meetings and conference calls (figures above are for two face to face meetings or three smaller meetings)	-
3	-
Total Staff Costs	**36,960**
Other Costs not included above:	
Consultant time: to advise and contribute to the analysis and development of relevant documents; facilitate meetings with key stakeholders	**200,000**
Total Administration Estimate	**$253,674**

Rvsd. Dec. 2016

Action Paper 12.C: Simplification of Electronic Medical Records and Billing Codes

APA Administration Feedback:

Department of Reimbursement Policy/Committee on RBRVS, Codes and Reimbursements:

As was communicated to the author, there have been numerous discussion and ongoing efforts attempting to address concerns/frustrations with the current E/M coding structure and associated documentation requirements over the years which have yet to produce a satisfactory outcome. APA has been an active participant in these efforts at the AMA CPT Editorial Panel, the AMA RUC, CMS, and when relevant, at the AMA House of Delegates. APA has frequently raised psychiatrists' concerns directly and as part of a coalition of primary care and specialty care physicians.

The most recent discussions of the E/M codes occurred over the course of a year or more approximately two years ago as part of a CPT Editorial Panel/AMA RUC workgroup, the Joint CPT/RUC Emerging Issues Workgroup. As with previous attempts to address the structure and/or documentation requirements, this effort did not lead to any changes. There are significant concerns widely shared among the medical professions that any proposal to change the structure will likely result in a reduction in the payment due to widespread pressure to cut health care spending. Given the volume with which these codes are billed, this amount could be significant and would impact physicians across the board. The Emerging Issues Workgroup continues to convene to monitor and address changes in the way physicians are reimbursed. APA is a voting member of that workgroup and an active participant.

APA's educational materials on CPT coding and documentation are currently under review by the Committee on RBRVS, Codes and Reimbursements. The concerns raised within the action paper have been shared with them (they were primary reviewers of this action paper) and will be factored into their discussion of educational needs. APA has been engaged in ongoing work to reduce the administrative burdens for physicians through a number of venues including collaboration with the AMA and others via the AMA's Administrative Simplification Workgroup. This includes advocacy to address concerns about the limitations and burdens of EMRs. APA has been and will continue to be part of those efforts. APA is also working to improve EMR options for psychiatrists through the CMHIT and development of PsychPRO, the APA national clinical quality registry.

This would be a huge undertaking that may or may not achieve any change. We recommend continuing our existing advocacy work, which include resolution to the concerns raised in lieu of this undertaking as proposed.

Cost: $300,000 and up.
[from the action paper] That the APA Delegation to the AMA lobby to change the current CPT coding requirements for the E/M codes to a simpler three tier system and that the format of electronic health records change to this simpler system. The three levels of care will be Straightforward, Moderately Complex and Highly Complex. Physicians will record in the chart the pertinent positive and negative findings and reasoning for their conclusions but there will not be a complex system requiring a certain number of bullet points in each category.

The cost would primarily be for staff time, consultants and meeting/travel costs. This effort would require a significant amount of time of the subject matter experts with limited assistance by administrative staff. This will take a sustained multi-year effort and will include both face-to-face

meetings and conference calls. Meetings would include meetings of the Committee on RBRVS, Codes, and Reimbursements, meetings with representatives from other physician groups, and meetings with Federal/CMS officials. Key activities include:

1. Review by the relevant APA component to access the impact (financial and otherwise) of a change in the structure and associated documentation requirements.

2. Development of an actionable work plan which could include:

    - Development of a CPT coding proposal (requires both internal and external meetings to draft a coding proposal and elicit support from key physician groups)
    - Development of relevant talking points/presentations
    - Ongoing efforts to increase level of support within the physician community
    - Movement of the proposal through the CPT and RUC process or identification of alternative pathways if we are not successful within the standard process.

3. In the event a new structure as adopted, then advocacy with regard to changes in documentation requirements would need to occur. This would require the collaboration and support of a majority of the physician community as well as public and commercial payers. The work would be similar as to what is outlined above.

4. Finally, there would need to be the development and implementation of an advocacy agenda with major electronic medical record companies to ensure the resulting changes were reflected appropriately software written in a user-friendly manner. This work would be similar to what is outlined above, although the key stakeholders would be those involved in the EMR industry.

Item 2017A1 12.D
Reference Committee #2
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Adopting Neuroscience-based Nomenclature (NbN) for Medications

WHEREAS:

Categories of medications have been named for conditions they treat for a very long time (e.g., antihypertensives, antiarrhythmics, antipsychotics) despite most having multiple uses;

The past few decades have seen much greater understanding about the chemical structure and actual mechanisms of action of medications, with changes in how these categories are labeled and grouped together (e.g., angiotensin II receptor antagonists, potassium channel blockers, D2/5HT2 antagonists);

Psychotropic medication categories have not kept up with these advances in nomenclature, resulting in confusion by patients prescribed a medication in a category that does not always fit their condition (e.g., an antipsychotic for bipolar disorder);

Payers have maintained this older nomenclature, sometimes limiting the number of covered medications per category;

There now exists a well-developed and broadly-adopted neuroscience-based nomenclature (NbN) that categorizes psychiatric medications based on pharmacology and mode of action (nbnomenclature.org);

NbN was developed by an international task force of leading scientific organizations, including the American College of Neuropsychopharmacology (ACNP), European College of Neuropsychopharmacology (ECNP), Asian College of Neuropsychopharmacology (AsCNP), International College of Neuropsychopharmacology (CINP), and International Union of Basic and Clinical Pharmacology (IUPHAR);

A growing number of publications and organizations is adopting NbN's standardized terminology to replace the outdated historical categories;

Adoption of this neuroscience-based nomenclature by the APA and its publications would benefit the field and our patients by using specific terminology that uses more accurate descriptions of how psychiatric medications work in the brain; and

Advocacy by APA for policymakers and payers to adopt this nomenclature may facilitate more rational coverage policies resulting in greater access to all NbN categories of medications; therefore

BE IT RESOLVED:

That the APA adopt and promote the international Neuroscience-based Nomenclature (NbN) standard terminology developed by ACNP, ECNP, CINP, AsCNP, and IUPHAR, in its publications, policies, and communications;

That the APA seek opportunities to promote adoption of NbN terminology by payers and policymakers; and

That the APA CEO and Medical Director be responsible for carrying out these adoption and promotion activities.

AUTHORS:
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SPONSORS:
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ESTIMATED COST:
Author: $0
APA: $4,928

ESTIMATED SAVINGS: unknown

ESTIMATED REVENUE GENERATED: unknown

ENDORSED BY:

KEY WORDS: medications, standards, pharmacology, nomenclature, payment policies

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Education

REVIEWED BY RELEVANT APA COMPONENT:

Example from nbnomenclature.org/authors:

Antipsychotic (Neuroleptics, Major tranquillisers)	**Drugs for psychosis**		
Typical (1st generation)	dopamine	receptor antagonist (D2)	flupenthixol, fluphenazine, haloperidol, perphenazine, pimozide, pipotiazine, sulpiride, trifluoperazine, zuclopenthixol
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	chlorpromazine, thioridazine
Atypical (2nd generation)	dopamine	receptor antagonist (D2)	amisulpiride
	dopamine, serotonin	receptor antagonist (D2, 5-HT2)	iloperidone, loxapine, lurasidone, olanzapine, perospirone, sertindole, ziprasidone, zotepine
	dopamine, serotonin	receptor partial agonist (D2, 5-HT1A)	aripiprazole
	dopamine, serotonin, noradrenaline	receptor antagonist (D2, 5-HT2, NE alpha-2)	asenapine, clozapine, risperidone, paliperidone
		MM; receptor antagonist (D2, 5-HT2) and reuptake inhibitor (NET)(metabolite)	quetiapine
Anxiolytic	**Drugs for Anxiety**		
(benzodiazepine)	GABA	Positive Allosteric Modulator (GABA-A receptor, benzodiazepine site)	alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, lorazepam, oxazepam
	serotonin	receptor partial agonist (5-HT1A)	buspirone
	glutamate	voltage-gated calcium channel blocker	gabapentin, pregabalin

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.D: Adopting Neuroscience-based Nomenclature (NbN) for Medications
Action Paper Author(s): Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society
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APA Admin. Name: Glenn O'Neal, Office of Communications
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Additional staff hours spent per year editing APA's public facing communications channels to address the author's concerns.	4,928
2	-
3	-
Total Staff Costs	**4,928**
Other Costs not included above:	
0	-
Total Administration Estimate	**$4,928**

Rvsd. Dec. 2016

Action Paper 12.D: Adopting Neuroscience-Based Nomenclature (NbN) for Medications

APA Administration Feedback:

Office of Communications:

APA administration is mindful of the author's concerns. Our staff employs rigorous checks to maintain a high standard of clinical accuracy in all APA-branded materials. In technical materials – especially those fully under our control, such as content that is entirely generated in-house – APA is highly consistent in its use of language and has full-time editors in its employ, including psychiatrist editors-in-chief. However, we note that there are instances when APA produces content for a lay or patient/family audience. When producing content for non-specialized audiences, APA communications staff aims for accessible, plain language that also makes the content discoverable by search engines, which is how the public calls upon much of our content. While terms such as "antidepressants" may not conform to NbN standards, they are high traffic search terms through which a large part of APA's audience finds content on Psychiatry.org.

Taking this into account, APA Communications estimates a minimum of 64 hours of extra staff time per year at a total cost of $4,928 spent editing APA's public facing communications channels to address the author's concerns, and we note that a complete erasure of common search terms may cause our content to be less findable though search engines.

APA Publishing:

This action will not pose any problem, but it will take some time to implement given the nature of publishing schedules.

Item 2017A1 12.E
Reference Committee #2
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program

WHEREAS:

1. Partial Hospitalization is a term coined long time ago to distinguish it from complete or total hospitalization when state hospitals provided daily outpatient therapy on hospital grounds at the request of patients discharged after long term inpatient hospitalization to facilitate transition to outside world;
2. Partial Hospitalization Program (PHP) has, over the years, become a recognized and established outpatient treatment program entity vital in the continuum of psychiatric care along with Intensive Outpatient Program (IOP) but the Centers for Medicare/ Medicaid services and the health insurance industry have repeatedly revised the clinical criteria of these programs to suit their own financial agendas;
3. PHP is a confusing misnomer to clinicians, patients and public alike because of the terms: 'partial' frequently mistaken for 'biased' or 'incomplete', and 'hospitalization' for 'inpatient' or pejoratively for "confinement'; some PHP's have shortened the term 'hospitalization program' to 'hospital program' conveying a different meaning; the American Association for Partial Hospitalization (AAPH) also changed its name to Association for Ambulatory Behavioral Health (AABH) partly because of this confusion and to emphasize its outpatient ambulatory aspect;
4. Day Hospitalization Program is a term sometimes used interchangeably with PHP but fraught with same confusion or stigma while Day Treatment Program is another interchangeable term but does not convey the intensity level of treatment;
5. Confusion also exists as to what constitutes PHP in contrast to IOP with differing definitions, criteria and reimbursement rates among insurance providers and clinical facilities.

BE IT RESOLVED:
That:

1. The APA appoint a task force to review and revise nomenclature, definition and clinical criteria for Partial Hospitalization Program for the purpose of uniform and consistent utility among clinicians, researchers, patients, general public, clinical facilities and health insurance industry, and to reduce stigma and confusion.
2. The task force also review, and revise if appropriate, the definition and clinical criteria for Intensive Outpatient Program for similar purpose.
3. The task force, after consultation and input from appropriate APA councils, submit a report to the Assembly by May 2018.
4. The task force also recommend to Assembly on how to implement and advocate the revisions to all parties concerned.

AUTHOR:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
(smadakasira@hotmail.com)

ESTIMATED COST:
Author: $0
APA: $53,696

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Partial Hospitalization, Intensive Outpatient Program, Stigma

APA STRATEGIC PRIORITIES: Advancing psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT: Council on Advocacy and Government Relations approves this paper (The recommendations from the Council have been incorporated into the paper).

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Working with the President to appoint members to the Taskforce	231
2 Organizing phone calls and producing background material for the Task Force as necessary	2,695
3 Reviewing and proofing a report to the Assembly.	770
Total Staff Costs	**3,696**
Other Costs not included above:	
APA to advocate for the nomenclature, criteria, & definition to be accepted by states, insurance companies, and the federal government would be an intensive, multi-year effort.	**50,000**
Total Administration Estimate	**$53,696**

Rvsd. Dec. 2016

Action Paper 12.E: Revising the Nomenclature, Definition, and Clinical Criteria for Partial Hospitalization Program

APA Administration Feedback:

Division of Policy:
As noted in the paper, the term Partial Hospitalization was coined over 30 years ago and has evolved with differences in state-operated programs, insurance definitions, and geographic convention. There are also definitions in regulations issued by the Centers for Medicare and Medicaid. Having the Task Force review the nomenclature, definition, and clinical criteria with the ultimate goal to achieve uniformity and consistency would be a huge undertaking that may not achieve much change without substantial resources and priority put forth for advocacy given that literature will likely include multiplicity of terms and insurers will continue to set their own criteria. The Council on Health Care Systems and Financing is conducting an analysis of level of care that may be able to address the concern around the confusion of terminology. We don't recommend an additional Task Force at this time until the Council makes its recommendation regarding appropriate endorsement of level of care criteria.

Explanation of Costs:
The cost would be about $3,696 for the Taskforce.

For the Taskforce to be created and complete its work, we anticipate it would take approximately 50 hours of staff time, depending on how much support the Task Force needs. Staff activities include:

- Working with the President to appoint members to the Taskforce
- Organizing phone calls and producing background material for the Task Force as necessary
- Reviewing, proofing, and finalizing a report to the Assembly.

Beyond the Taskforce, it would take a substantial amount of time for staff to advocate for the nomenclature, criteria, and definition to be accepted by states, insurance companies, and the federal government. It would also likely be a multi-year effort. The staff time could cost about $50,000.

Item 2017A1 12.F
Reference Committee #2
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care

WHEREAS:

Whereas, Physician Aid in Dying is an important and highly visible national issue. Physician aid in dying, sometimes termed physician-assisted suicide or death with dignity, refers to an end-of-life option for medical care in which a physician can prescribe, and a mentally capable adult with a terminal illness and less than six months to live can self-administer, a life-ending medication provided that specific requirements are met.

Whereas, Six states currently allow physician aid in dying, and others are considering similar legislation. Physician aid in dying is authorized in Oregon, Washington, Vermont, California, Colorado and Montana. In more than 20 other states there are efforts to pass legislation.[i]

Whereas, The AMA is evaluating its opposition to "physician-assisted suicide". In 1996 the AMA developed a policy opposed to "physician-assisted suicide," which has stood for 20 years. However, in June 2016, in response to a resolution submitted by the Oregon Medical Association, the AMA House of Delegates instructed the AMA and its Council on Ethical and Judicial Affairs to study medical aid in dying as an end-of-life option with consideration of (1) data collected from the states that currently authorize aid in dying, and (2) input from some of the physicians who have provided medical aid in dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician aid in dying.

Whereas, Physician surveys about aid in dying show a trend toward majority support. A 2016 Medscape survey found support among U.S. physicians at 57%, up from 46% in 2010.[ii] Opposition has decreased from 41% to 29% since 2010.[iii] Recent surveys in Colorado and Maryland[iv] indicate support at similar levels.

Whereas, In states authorizing aid in dying, psychiatrists may be called to evaluate patients for capacity. If there is a question about a patient's capacity, one or both physicians who are required to evaluate the patient (the attending physician and/or consulting physician) must request a mental health evaluation by a psychiatrist or psychologist.

Whereas, A membership survey will inform APA policy development. According to the AMA News article, *How physician surveys impact major issues*, posted Jan 08, 2017, surveys can provide much-needed information to inform health policy and health care delivery.[v] In addition, many within state and national policy communities look towards the APA for a position on physician aid in dying. Development of such a position will require an understanding of members' positions on the issue.

BE IT RESOLVED:
The APA will conduct a membership survey on physician aid in dying. The survey instrument will first provide background information on the issues and then include specific questions on members' attitudes and positions.

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Molly Strauss, M.D., DLFAPA, APA Member

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Philip Candilis, M.D, FAPA, APA Member
David Pollack, M.D., DLFAPA, APA Member

ESTIMATED COST:
Author: $20,000
APA: $23,100

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Aid in Dying (AID), Physician Assisted Death (PAD)

APA STRATEGIC PRIORITIES:

REVIEWED BY RELEVANT APA COMPONENT:

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[i] The Council of the District of Columbia approved, and the Mayor signed, a resolution authorizing physician aid in dying. The resolution will be law unless the U.S. Congress intervenes

[ii] http://www.cms.org/articles/physician-assisted-death-polling-shows-a-divided-membership

[iii] http://www.medscape.com/viewarticle/873844

[iv] http://www.medchi.org/Portals/18/files/Law%20&%20Advocacy/Initiatives%20Page/MedChi%20Survey%20on%20Assisted%20Suicide.pdf?ver=2016-08-09-111636-707

[v] https://wire.ama-assn.org/ama-news/how-physician-surveys-impact-major-issues?&utm_source=BHClistID&utm_medium=BulletinHealthCare&utm_term=010917&utm_content=MorningRounds&utm_campaign=BHCMessageID

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.F: APA Member Survey on Medical Aid in Dying as Option for End-of-Life Care
Action Paper Author(s): Elizabeth Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society
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APA Admin. Name: Glenn O'Neal, Office of Communications
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Mr. Vanderbilt told me cost would be about $20,000, based on cost of previous surveys.	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	20,000
Total Author Estimate	**20,000**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Outside vendor cost for survey.	20,020
2 APA staff hours needed to work on survey.	3,080
3	-
Total Staff Costs	**23,100**
Other Costs not included above:	
0	-
Total Administration Estimate	**23,100**

Rvsd. Dec. 2016

Action Paper 12.F: APA Member Survey on Medical Aid in Dying as Option for End-Of-Life Care

APA Administration Feedback:

Office of Communications:
A typical scientific survey of national APA membership will cost approximately $20,000 - $25,000 depending on the length of the survey and desired margin of error. Such surveys typically combine telephone and online response options and are administered by a polling outfit working alongside the APA.

APA staff support will be required to procure up-to-date lists, bid out the project to appropriate vendors, design the survey and work with the selected vendor to create a summary of findings. An estimate of approximately 40 hours of staff time at a cost of $3,542 would be necessary to complete the survey.

Item 2017A1 12.G
Reference Committee #2
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice

WHEREAS:

1. There is an uptick in marketing on the use of pharmacogenomic testing.

2. The content of advertising for pharmacogenomic testing contains:
   A. misleading statements such as "Today there are GeneSight® tests available for depression, anxiety and other behavioral health conditions . . . " which implies the tests are for diagnosing disorders [1]
   B. an unsubstantiated statement that suicide "may possibly be avoided by doing pharmacogenomic (PGx) testing" [2]
   C. a false implication that a physician who was sentenced for 30 years for the death of three patients Is associated with not doing pharmacogenomic testing although the physician recklessly prescribed opioids without medical necessity and the patients overdosed. [3]

3. There should be a sufficient evidence base to support the use of pharmacogenomic testing in clinical practice and that demonstrates beneficial outcomes.

4. A MD, PhD internationally renowned expert on biological psychiatry opined that there isn't sufficient evidence at this time to support the claims of pharmacogenomic testing companies by saying, "Since it's a saliva test, they are spitting in the wind."

5. There have been failed attempts to use biomarkers in psychiatry such as the dexamethasone suppression test and urine testing to differentiate between a serotonergic vs. noradrenergic depression.

6. The use of these tests adds to health care cost, and thus, are they cost-effective?

   [Assurex Health states that its GeneSight® tests have been used for 215,000 patients. [4] If commercial Insurance, Medicare or Medicaid pay for the tests, the average cost of four available GeneSight® test panels is $2,848.50 and the cost for doing all four panels at once is $6,224. (Average cost X 215,000 tests (assuming one test per patient) = $612,427,500 (over ½ billion dollars) If all the tests were psychotropic tests, the health care cost is $5,500 x 215,000 =

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[1] GeneSight® Brochure

[2] Letter to Dr Joseph Napoli from John Adkins, Consultant for Pharmacogenetic Testing, MedxPrim/Admera, February 20, 2017

[3] https://www.aol.com/article/2016/02/05/california-doctor-gets-30-years-to-life-in-landmark-overdose-cas/21308642/, retrieved 2017-02-02

[4] *Op. cit.* GeneSight® Brochure

$1,182,500,000 (over one billion dollars). (See Attachment.) The cost of testing might be offset to some degree by a savings in the cost of medication.[5]]

7. DNA tests results need to be secured to protect the personal health information of those who are tested, and thus, does the benefit of the test results outweigh the risk of this information not being adequately protected?

8. There is a precedent for an action paper generating a resource document.
   ["APA Position Statement on the Clinical and Forensic Application of Brain Imaging" – J Napoli *et al,* passed by the Assembly in May 2009 resulted in "Consensus Report of the APA Work Group on Neuroimaging Markers of Biomarkers: Resource Document" – M First *et al,* July 2012]

9. Personalized medicine and pharmacogenomic testing might be beneficial, especially in addressing biological diversity to inform treatment.

10. More research is needed to further understand how pharmacogenomic biomarkers correlate with pharmacotherapy and can be predictive for selecting pharmacological agents.

11. Providing education and guidance for the use and limitations of pharmacogenomics in clinical practice would be a service to APA members.

BE IT RESOLVED:
That:

1. The APA educate its members about the use and limitations of pharmacogenomic testing in clinical psychiatric practice and advance integrated collaborative care by educating non-psychiatrist physicians about the use and limitations of pharmacogenomic testing for psychiatric care.

2. The Council on Medical Education and Lifelong Learning offer education on pharmacogenomics and pharmacogenomic testing via various educational activities (e.g., Member's Course of the Mouth, Annual Meeting and IPS) and other means, e.g., via *Psychiatric News* articles.

3. The Council on Quality Care: A. include a statement on the use and limitations of pharmaco-genomic testing in all pertinent practice guidelines covering rating the strength of research evidence and recommendations, benefits and harms, and quality measurement considerations B. consider producing a resource document on the use and limitations of pharmacogenomic testing in clinical practice

4. The Council on Research promote research on pharmacogenomic testing, especially addressing study questions about informing clinical practice and treatment outcomes using pharmaco-genomic testing.

[5] Winner, JG et al Combinatorial pharmacogenomic guidance for psychiatric medications reduces overall pharmacy costs in a 1 year prospective evaluation Curr Med Res Opin 2015;31(9): 1633-43

5. The Council on Advocacy and Government Relations explore whether the APA should advocate for truth in advertising for pharmacogenomic testing, and thus, promote accurate consumer education.

6. An article on pharmacogenomic testing and its limitations be placed on the APA Website "Patients & Families" section to provide accurate information for consumers.

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SPONSORS:
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Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Steven Daviss M.D., DFAPA, Representative, Maryland Psychiatric Society
Isabel Norian, M.D., Representative, New Hampshire Psychiatric Society
Richard A. Ratner, M.D., ACROSS Representative, The American Society for Adolescent Psychiatry
Lisa K. Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
Richard Altesman, M.D. DLFAPA, Representative, Psychiatric Society of Westchester
Eileen McGee, M.D., Representative, Ohio Psychiatric Physicians Association
Mary Anne Albaugh M.D., Representative, Pennsylvania Psychiatric Society
James C West, M.D., Representative, Society of Uniformed Psychiatrists
Patrick R. Aquino, M.D., Representative, Massachusetts Psychiatric Society

ESTIMATED COST:
Author: $4,577
APA: $33,418

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: This can generate revenue by providing education and guidance to non-member psychiatrists for a fee.

ENDORSED BY: Area 3, March 4, 2017

KEY WORDS: Advertising, Education, Clinical Practice, Consumer Education, Integrated Collaborative Care, Marketing, Member Service, Pharmacogenomics, Quality Care, Research, Testing

APA STRATEGIC PRIORITIES: Education, Advancing Psychiatry, Supporting Research, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
Sent to the Council on Advocacy and Government, the Council on Medical Education and Lifelong Learning, the Council on Quality Care and the Council on Research

Attachment

GeneSight® Rates				
Test (Based on medical necessity)	Commercial Insurance, Medicaid or Medicare Pays	Patient on Commercial Insurance or Medicare Advantage Co-Payment (1)	Patient on Medicaid, Medicare or Workers Comp Pays	Direct Pay
Psychotropic	$5,500	$330	0	$1,750 (2)
Analgesic	$4,200	$330	0	$1,750 (2)
ADHD	$1,550	$330	0	$440
MTHFR (Folic Acid)	$150	0	0	$150
Financial Assistance		(1) Patient receives financial assistance application form		
Income $0 - $50,000		$20		
$50,001 - $75,000		$150 or $12.50 per month		
> $75,000		$330 or $27.50 per month		
New York and Florida				
> $150,00		Either pay direct pay rate or difference between what commercial insurance allows and what commercial insurance pays		
(2) Rate of these two tests combined = $1,750 / Rate of all four test combined = $1,750				

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.G: Providing Education and Guidance for the Use and Limiations of Pharmacogenomics in Clincial Practice
Action Paper Author(s):	Joseph C. Napoli, M.D, DLFAPA, Representative, Area 3
Phone/email:	201-461-0212 / napoli@resiliency.us
APA Admin. Name:	Samantha Shugarman, Reimbursement Policy
Phone/email	sshugarman@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	5
Number of Staff	-	1
Number of Non-Staff	-	-
Total	**-**	**6**

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Add article to APA Website 0.5 hr $38.50	77
2	-
3	-
Total Staff Costs	77
Other Costs not included above:	
0 for including statements in practice guidelines because this would be included in the cost of producing the practice guidelines / $4,500 for staff and incidental costs for producing a consensus report. This is based on a cost estimate done by APA Admin for the May 2009 action paper, which resulted in a consensus report being produced, increasing the because of the increase of	4,500
Total Author Estimate	**4,577**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Resolve 1 &2: Online webinar which includes Continuing Medical Education, educational design, remote capture, editing, LMS posting and hosting costs approximately $4500 in in-kind staff time.	4,543
2 Resolve 3A &3B: $20-30k extra per guideline for those where we do the pharmacogenomics search. Additional detail on summary.	26,950
3 Resolve 5: costs associated applied to CAGR staff time.	385
Total Staff Costs	**31,878**
Other Costs not included above:	
Resolve 6: This could cost about 20 hours for the APA staff member, between updating the material to reflect the appropriate audience, and to guide the document through the APA governance chain, before staff post the material on the APA website.	**1,540**
Total Administration Estimate	**33,418**

Rvsd. Dec. 2016

Action Paper 12.G: Providing Education and Guidance for the Use and Limitations of Pharmacogenomics in Clinical Practice

APA Administration Feedback:

Rationale for Costs Assessment: This cost assessment includes many components that rely on the successful advancement of the individual Action Paper Resolves. To provide a reliable assessment, multiple members of the APA Administration were consulted, based on the description of activities in each resolve.

Department of Education/Council on Medical Education and Lifelong Learning

Resolve One and Two were combined, as the activities overlap:

1. "The APA educate its members about the use and limitations of pharmacogenomic testing in clinical psychiatric practice and advance integrated collaborative care by educating non-psychiatrist physicians about the use and limitations of pharmacogenomic testing for psychiatric care."
2. "The Council on Medical Education and Lifelong Learning offer education on pharmacogenomics and pharmacogenomic testing via various educational activities (e.g., Member's Course of the Mouth, Annual Meeting and IPS) and other means, e.g., via *Psychiatric News* articles."

Explanation of Cost: Per Education Department Administration, a presentation at the APA Annual Meeting comes at no cost, but a subject matter expert must submit an abstract for the Annual Meeting and it must be accepted through the peer review process of the scientific program committee. Also, it is important to note that the American Psychiatric Association Foundation (APAF) has an endowed award in pharmacogenomics which provides a lecture each year at the Annual Meeting on the topic of pharmacogenomics. In response to the language that addresses "various educational activities," an online webinar including Continuous Medical Education, educational design, remote-video conferencing capability, editing, Learning Management System posting and hosting costs approximately $4500 in in-kind staff time.

Department of Practice Management/Department of Reimbursement Policy/Council on Quality Care
Based on discussion with Practice Guideline Administration and Consultants and Quality Administration, costs associated with **Resolve Three**:

3. "The Council on Quality Care: A. include a statement on the use and limitations of pharmaco-genomic testing in all pertinent practice guidelines covering rating the strength of research evidence and recommendations, benefits and harms, and quality measurement considerations B. consider producing a resource document on the use and limitations of pharmacogenomic testing in clinical practice."

Explanation of Cost: Letter A. of this resolve is estimated to cost $20-30k extra **per practice guideline** for those where we do the pharmacogenomics systematic literature search (whether it was an external or internal review). Additional consideration would have to be made for the size of the literature per topic. Also, it is expected that all costs would rise over time due to the growth of the medical literature and inflation rate.

It should be noted that under the current practice guideline development process, the developers have included some information on pharmacogenomics when it is already part of literature review. But in the

past, pharmacogenomics papers are not always part of the scope of reviews. If they are not part of the reviews, and it is determined by this resolve, that it should be, it might need an independent search of the literature and extraction of the data by APA staff.

To consider the cost estimate of letter B., it would have to be assumed that either a systematic literature review occurred and was paid for based on the cost assessment in A. or each member of the Workgroup would be responsible for participating in this venture (though not sure how reliable an expectation that is) at and that the findings supported the content necessary to develop a resource document. It would require the development of a work group that focuses on this area. From the seating of Workgroup members by APA staff and member-volunteers, plus time related to drafting the manuscript, and pushing the manuscript through the APA governance chain, this would cost approximately 80 hours, or $6160.00.

Department of Research/Council on Research

In consultation with the Department of Research staff on **Resolve Four:**

4. "The Council on Research promote research on pharmacogenomic testing, especially addressing study questions about informing clinical practice and treatment outcomes using pharmaco-genomic testing."

Explanation of Cost: Appropriate staff explained that they could not provide an assessment, as the cost of staff hours or additional resources could not be ascertained by the information presented in the resolve. Namely, the Council on Research does not promote areas of research, or develop study questions for researchers to answer. Also, it could not be determined if the phrase "addressing study questions" would be meant for the Council on Medical Education and Lifelong Learning, if these questions are intended to assist in education around pharmacogenomics.

Department of Government Relations/Council on Advocacy and Government Relations:

Resolve Five addresses The Council on Advocacy and Government Relations and requests that this group:

5. "…explore whether the APA should advocate for truth in advertising for pharmacogenomic testing, and thus, promote accurate consumer education."

Explanation of Cost: The APA staff liaison to the Council on Advocacy and Government Relations suggested the amount of time required to carry out this resolve be limited to about 5 hours of staff time or $385.00.

Department of Reimbursement Policy/Council on Quality Care:

6. "An article on pharmacogenomic testing and its limitations be placed on the APA Website "Patients & Families" section to provide accurate information for consumers.

Explanation of Cost: Given that this information is related to the resource document detailed in Resolve 3B, it would require staff time and expert-member time to cultivate a document out of the details found within the Resource Document. This could cost about 20 hours for the APA staff member, between updating the material to reflect the appropriate audience, and to guide the document through the APA governance chain, before staff post the material on the APA website.

Item 2017A1 12.H
Consent Calendar
Back-up (if removed): Reference Committee #3
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Expanding Access to Psychiatry Subspecialty Fellowships

WHEREAS:

There have been two separate accreditation systems for residency programs in psychiatry, as in many specialties: the majority accredited by the Accreditation Council on Graduate Medical Education (ACGME) and others accredited by the American Osteopathic Association (AOA); and whereas

The ACGME and AOA have agreed to merge the accreditation process, such that those programs currently under AOA auspices are in the process of applying for ACGME accreditation; and whereas

The Residency Review Committee for psychiatry expects to grant accreditation status for many of the applying programs, but will only be accrediting the current year; and whereas

ACGME rules for psychiatry subspecialty fellowships require that applicants be trained in an ACGME accredited program, for all years of training, meaning that any resident in a current AOA program will not be eligible for fellowships for at least another two years for Child and Adolescent Psychiatry (CAP) or three years for Psychosomatic Medicine (PM), Addiction Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry; and whereas

There are other ACGME specialties which permit exceptions to this ACGME requirement; and whereas

The American Board of Psychiatry and Neurology recently changed its requirement for eligibility to sit for its certification exam, permitting any resident graduating from an ACGME accredited program to apply for certification, even if the program had previously been only AOA accredited; and whereas

The ABPN rules change would now permit AOA-trained residents to apply for both general Psychiatry certification as well as subspecialty certification, removing one of the barriers keeping AOA residents from ACGME fellowship application; and whereas

The fellowship match in psychiatry subspecialties this year left many programs with unfilled positions, with only 70% of CAP positions filled, and PM only filling 48% of its slots; and whereas

Many residents in AOA programs have expressed an interest in ACGME fellowships, but are blocked by the current policies of ACGME, and will never be eligible for fellowships unless they complete additional years of ACGME accredited residencies; and whereas

Subspecialty fellowships are an important part of overall psychiatric education, and are worth encouraging to the extent possible; and whereas

The number of subspecialized psychiatrists is not adequate to meet the needs of our population; and whereas

Efforts by the affected subspecialty organizations to increase fellowship applicants and eligibility have not been successful to this point; therefore

BE IT RESOLVED:

The American Psychiatric Association urge the ACGME to consider mechanisms to enable residents of AOA accredited programs to be eligible to enter ACGME accredited psychiatry subspecialty fellowships, such as extending ACGME accreditation to prior years of training ("grandfathering") during this period of transition.

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Joseph Napoli M.D., DFAPA, Representative, Area 3
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ESTIMATED COST:
Author: $1,540
APA: $2,310

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS:

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.H: Expanding Access to Psychiatry Subspecialty Fellowships
Action Paper Author(s):	Kenneth M. Certa M.D., Representative, Pennsylvania Psychiatric Society
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APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email	703-907-8637 kmoeller@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Council on Education will need to advocate with the Psychiatry RRC in an attempt to grant an exception to the requirements..	770
2 One would hope that a letter and followup phone contacts would suffice.	770
3	-
Total Staff Costs	1,540
Other Costs not included above:	
0	-
Total Author Estimate	**$1,540**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Advocate with the Psychiatry RRC in an attempt to grant an exception to the ACGME requirements for subspecialty	770
2 letter and follow up	770
3 administrative staff time to coordinate Council position	770
Total Staff Costs	**2,310**
Other Costs not included above:	
0	-
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.H: *Expanding Access to Psychiatry Subspecialty Fellowships*

APA Administration Feedback:

Division of Education:
ACGME says: At this point, there are no exceptions permitted and all years of training must be completed in an ACGME accredited program. The eligibility program requirements are outlined in detail on the single accreditation system page on the ACGME website at www.acgme.org.

The Council on Medical Education and Lifelong learning discussed this action paper and is generally supportive of this position if adequate steps have not already been taken by ABPN and ACGME.

Item 2017A1 12.I
Reference Committee #3
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Medical Students

WHEREAS:

1. Negative perceptions of mental illness, also referred to as stigma, are a primary barrier to treatment and recovery of the afflicted persons and not uncommon among future generations of physicians as they bring their own perceptions to medical school, then assimilate stereotypes from the medical culture;
2. The negative perceptions of medical students also play a role in reluctance in acknowledging their own mental health problems and choosing a psychiatric career;
3. Medical students' attitudes early on in training tend to be more amenable to change, thus it is possible to change their attitudes and perceptions toward mental illness and psychiatry through proper and early education and training;
4. As APA embarks on a strategic initiative on educating and producing new resources on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease negative perceptions of medical students regarding mental illness and psychiatry is critical to this initiative for the long run;
5. Contact-based educational strategies in which medical students are exposed to and interact with persons with mental illness who constitute models of successful recovery, have been effective in changing negative attitudes of medical students;
6. Other successful strategies involve evaluation and discussion of own perceptions and attitudes of medical students toward mental illness as part of early behavioral health course.

BE IT RESOLVED:

That the APA charge the Council on Medical Education and Lifelong Learning (CMELL) to

1. Ascertain with the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Association of Chairs of Departments of Psychiatry (AACDP), the need for and their interest in implementing educational training strategies for improving medical students' perceptions regarding mental illness and psychiatry, and if there is sufficient interest,
2. Partner with ADSEMP in reviewing and developing educational strategies that particularly involve exposure or contact with authentic patients who have experienced and successfully recovered from mental illness, and discussions of medical students' own perceptions and attitudes regarding mental illness, early on in medical student education,
3. APA to support the developed product and advocate for implementing the developed strategies to various medical education organizations including ADMSEP, AACDP and ACGME.

AUTHORS:
Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association (smadakasira@hotmail.com)
Valerie Arnold, M.D., Representative, Tennessee Psychiatric Association

ESTIMATED COST:
Author: $0
APA: $3,080

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Mississippi Psychiatric Association, Area 5 council

KEY WORDS: Negative perceptions of mental illness, Medical student education, contact-based recovery model

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
Council on Education and Life Long Learning:
Developing strategies to improve the perception of psychiatry in medical students is a worthy goal (The action paper resolutions have been revised to incorporate the recommendations from the council).

Council on Advocacy and Government Relations:
Per Dr. Debra Pinals, CAGR Chair, favorable and constructive comments were received and the goals of the action paper were found to target important areas. Comments:

1. The paper should be targeted to first reach out to medical educators and assess the perception of need for assistance in this matter.
2. Stigma is same for or worse for patients with substance use disorders, so recommend addressing both mental illnesses and substance use disorders.

References:
Papish A, Kassam A, et al., Reducing the stigma of mental illness in undergraduate medical education. BMC Med Educ 2013; 13:141
Crapanzano K, Vath RJ. Observations: Confronting physician attitudes toward the mentally ill: A challenge to medical educators. J Grad Med Educ 2015 Dec; 7(4):686

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.I: Educational Strategies to Improve Mental Illness Perceptions of Medical Students
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
Phone/email:	smadakasira@hotmail.com
APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email	7039078637 kmoeller@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 40 hours of liaison and strategy development with ADMSEP. Cost estimate does not include program development or execution.	3,080
2	-
3	-
Total Staff Costs	**3,080**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,080**

Rvsd. Dec. 2016

Action Paper 12.I: Educational Strategies to Improve Mental Illness Perceptions of Medical Students

APA Administration Feedback:

Council on Medical Education and Lifelong Learning (CMELL):
Developing strategies to improve the perception of psychiatry in medical students is a worthy goal. ADMSEP (the Association of Directors of Medical Student Education in Psychiatry) might be the most logical organization where the development and use of such strategies would occur You might consider asking the CMELL to discuss the APA's interest regarding the development and use of such strategies with ADMSEP, ascertain the interest level at ADMSEP, and, if interest exists, CMELL might be able to partner with ADMSEP in research and development. Once developed, APA could reasonably support and advocate for the institution of such strategies.

Explanation of Cost:
40 hours of liaison and strategy development with ADMSEP. Cost estimate **does not include** program development or execution.

Item 2017A1 12.J
Reference Committee #3
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Educational Strategies to Improve Mental Illness Perceptions of Non- psychiatric Physicians

WHEREAS:

1. Negative perceptions of mental illness, also called stigma, are a major barrier to timely and accessible care, recovery and quality of life of individuals with mental illness;
2. Negative perceptions of mental illness are not uncommon among non-psychiatric physicians and can contribute to discriminating behaviors and practices, diagnostic overshadowing, fragmentation and marginalization, less timely and/or less adequate treatment for medical concerns of people with mental illness, and partly to excess mortality of these patients;
3. As APA embarks on a strategic initiative to educate and produce new resources in education on mental disorders and effective psychiatric care for physicians engaged in integrative and collaborative care, education to decrease the negative perceptions of non-psychiatric physicians regarding mental illnesses and psychiatry is critical to this initiative;
4. A promising evidence-based strategy for improving these negative perceptions in non-psychiatric physicians is exposure to successful recovery model of people who have experienced and lived with mental illness, that can diminish anxiety, heighten empathy and improve understanding regarding mental illness;
5. Another effective strategy is education and training to improve skills to comfortably assess, communicate with and treat persons with mental illness, that can lead to positive attitudes, diminished social and clinical distance and improved patient care.

BE IT RESOLVED:

That:

1. APA to charge the APA Department of Education to work with APA's AMA delegation and with American Academy of Family Physicians to ascertain their interest in implementing educational strategies to improve negative perceptions of mental illness across primary care fields; if there is sufficient interest,
2. APA, in partnership with interested professional organizations and in conjunction with American Psychiatric Association Foundation, American Psychiatric Association Publishing and mental health advocacy groups, support and develop educational curriculum and video series depicting and emphasizing successful recovery models of mental illness in authentic patients for use by non-psychiatric physicians;
3. APA support and develop, in conjunction with American Psychiatric Association Publishing and other educational organizations, a training curriculum and video series for non-psychiatric physicians on how to comfortably communicate with, assess, and treat mentally ill persons, and when to refer patients to psychiatrists;

4. APA to advocate to AMA, AAFP and other non-psychiatric physician organizations, as to the importance and availability of above educational strategies in improving perceptions and care of persons with mental illness.

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Lisa Catapano-Friedman, M.D., DLFAPA, Representative, Vermont Psychiatric Association
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Lawrence Miller, M.D., DLFAPA, Representative, Area 5
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Iqbal Ahmed, M.D., FRCPsych, Hawaii Psychiatric Medical Association
James West, MD, Uniformed Services Rep

ESTIMATED COST:
Author: $0
APA: $3,234

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: To be determined by American Psychiatric Association Publishing

ENDORSED BY: Mississippi Psychiatric Association, Area 5 Council

KEY WORDS: Negative perceptions of mental illness, Educating non-psychiatric physicians, Recovery model, Training curriculum

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
Council on Medical Education and Lifelong Learning:
This action paper has a worthy goal (The action paper resolutions have been revised to incorporate the recommendations from the council).

Council on Advocacy and Government Relations:
Per Dr. Debra Pinals, CAGR Chair, favorable and constructive comments were received and the goals of the action paper were found to target important areas. Comments:

1. Would add something about when to appropriately refer patients to psychiatrists as most non-psychiatric physicians have their limits of comfort (done).
2. The paper should be framed in the context of collaborative care.
3. Stigma is same or worse for substance use disorders, recommend addressing both mental illnesses and substance use disorders.

References:

Knaak S, Modgill G, et al., Key Ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. Can J Psychiatry 2014 Oct; 59(10 suppl): S19-S26.

Ungar T, Knaak S, et al., Theoretical and practical considerations for combating mental illness stigma in health care. Community Ment Health J 2016; 52:262-271.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.J: Educational Strategies to Improve Mental Illness Perceptions of Non-psychiatric Physicians
Action Paper Author(s):	Sudhakar Madakasira, M.D., DLFAPA, Representative, Mississippi Psychiatric Association
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APA Admin. Name:	Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 40 hours staff time. Does not include product development or execution.	3,080
2 APA-AMA Delegation staff time	154
3	-
Total Staff Costs	**3,234**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,234**

Rvsd. Dec. 2016

Action Paper 12.J: Educational Strategies to Improve Mental Illness Perceptions of Non-psychiatric Physicians

APA Administration Feedback:

Council on Medical Education and Lifelong Learning (CMELL):
Improving the perception non-psychiatrist physicians have of mental illness and its treatment is a worthy goal. However, rather than asking the APA to unilaterally develop an educational curriculum and a video series without knowing the interest level and specific needs of primary care physicians and their professional organizations, the author might consider asking the APA's AMA delegation, or appropriate liaison group, to ascertain the interest level across the primary care fields. If sufficient interest exists, then the APA could consider partnering with interested professional organizations to develop specific educational tools to meet specific needs.

Explanation of Cost: Education
40 hours to determine interest via engagement with primary care organizations, as well as examine APA's learning management system data and other product metrics to determine current usage by non-psychiatric MD's. Does not include program development or execution

APA AMA Delegation:
The primary task with regard to the 1st resolve is to engage leadership of the key organizations in a discussion of the issue to determine if there is mutual interest in addressing the concerns raised. This could occur thru the respective AMA delegations or through existing contacts with the respective leadership of the organizations involved. This could occur in person or by conference call and may take more than one discussion.

Explanation of Cost: APA AMA Delegation:
Staff time to arrange, develop background materials and participate in calls. Estimate time for APA AMA delegation as two hours.

Item 2017A1 12.K
Reference Committee #3
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships

WHEREAS:
Whereas: Psychiatric disorders including addictions are common, with an annual prevalence of at least 30%, and a lifetime prevalence of at least 45%, in the United States alone.

The burden of mental illness is extremely high, consistently ranked by the WHO as one of the costliest causes of disease burden. Psychiatric diseases are also costly, with both direct costs of treatment and loss of health and life, and indirect causes due to lost productivity, premature death, and other losses to society.

Patients with psychiatric disorders and symptoms are frequently seen in general medical and primary care settings. At least 70% of people who died from suicide were seen by generalists within a year of their death, and 40% within the month prior to their death.

Physicians of all specialties, particularly in general medical and primary care practices, will continue to treat patients with mental health issues, including those with severe and persistent mental illness.

Adequate training in psychiatry is a critical component of undergraduate medical education, as this will be the only dedicated training for most non-psychiatric physicians. The complex skills of psychiatric evaluation, diagnosis, and management are not quickly learned.

Whereas: There remains a national shortage of trained psychiatrists, particularly in underserved areas. Because psychiatry has one of the oldest average age of practitioners, there will remain a shortage as the number of graduating psychiatric residents will not surpass those leaving the profession.

Association of American Medical Colleges (AAMC) surveys of graduating medical students indicate that 85% of students who chose a career in psychiatry did not have an initial interest in psychiatry at the beginning of medical school.

Medical students entering the field of psychiatry consistently identify psychiatry clerkships as a fundamental component of deciding to pursue the specialty as a career.

The average length of United States medical school clerkships has been declining over the past 30 years.

Frequently clerkships are primarily inpatient based with limited exposure to other treatment areas and modalities across the field of psychiatry.

Certain medical schools have moved to a transformed curriculum resulting in a psychiatry clerkship that is significantly reduced in duration or eliminated.

Neither the Liaison Committee on Medical Education (LCME) nor the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) have a suggested or required timeframe for duration of psychiatry clerkships.

To continue to recruit medical students to psychiatric residency and practice, steps need to be taken to ensure an adequate and broad exposure to psychiatric practice. Further, ensuring adequate training in psychiatry during undergraduate medical education will improve trainee readiness for residency. Recommendations for the clerkship experience have been previously described in the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and Association of Academic Psychiatry (AAP) position statement on the length of the psychiatry clerkship.

BE IT RESOLVED:
That the APA tasks the Council on Medical Education and Lifelong Learning (CMELL) with drafting a position statement on recommended guidelines for the Psychiatry Clerkship. The CMELL should partner with other organizations invested in psychiatric education, such as ADMSEP and AADPRT, in the drafting of this position statement.
This statement should be used to provide recommendations to the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) on minimum requirements for psychiatric training. The statement should describe the importance of psychiatry clerkships as the key formative experience for all medical students, and best practices that promote medical student education and interest in psychiatry. Specific components integral to the psychiatry clerkship should include:

- A minimum duration of a six-week equivalent full-time experience in the evaluation and treatment of psychiatric patients.
- Exposure to both inpatient and ambulatory practice settings, ideally including exposure to subspecialty (e.g. – child and adolescent, addictions, geriatrics, consultation and liaison) and developing models of practice designed to better serve psychiatric populations (e.g. – collaborative or integrated care).

AUTHORS:
Edward Thomas Lewis, III, M.D., Representative, South Carolina Psychiatric Association
Michael J. Peterson, M.D., PhD, Representative, Wisconsin Psychiatric Association

SPONSORS:
Jack Bonner, M.D., ACROSS Representative, Senior Psychiatrists
Steven Daviss, M.D., Representative, Maryland Psychiatric Society
Mary Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Mark Haygood, M.D., Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rachel Houchins, M.D., Representative, South Carolina Psychiatric Association
James C. West, M.D., Representative, Society of Uniformed Services Psychiatrists
Clarence Chou, M.D., Representative, Wisconsin Psychiatric Association
Brian Hart, M.D., Representative, Indiana Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $3,080

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council, Assembly Committee of Early Career Psychiatrists (ECPs)

KEY WORDS: Psychiatry, Clerkship, Medical student, Education, Training

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:
Council on Medical Education and Lifelong Learning

Comments: “While the Council does not provide official endorsement of an action item, the Council is supportive. Your action seems reasonable and aligned with the ADMSEP position. We had an opportunity to discuss this again, and we do not have additional recommendations at this time.”

References:
The Psychiatry Clerkship: A Position Statement on the Length of the Psychiatry Clerkship
Academic Psychiatry, 2006; 30(2); 103.

Lyons Z. Attitudes of medical students toward psychiatry and psychiatry as a career: A Systematic review. Academic Psychiatry 2013; 37(3); 150-157

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.K: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student
Action Paper Author(s): Michael J. Peterson, M.D., PhD, Representative, Wisconsin Psychiatric Association
Phone/email: lewiset@musc.edu; 608-239-1640/mpeterson2@wisc.edu
APA Admin. Name: Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email 703-907-8637 kmoeller@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Authors are both Assembly members and would present this AP at the Assembly meeting. No additional travel or expenses is anticipated.	-
2	- -
3	- -
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Estimated staff time for assisting Council in drafting a position statement and providing recommendations to LCME and COCA	3,080
2	- -
3	- -
Total Staff Costs	**3,080**
Other Costs not included above:	
0	-
Total Administration Estimate	**$3,080**

Rvsd. Dec. 2016

Action Paper # 12.K: Fostering Medical Student Interest and Training in Psychiatry: The Importance of Medical Student Clerkships

APA Administration Feedback:

Division of Education:
The Council on Medical Education and Lifelong Learning (CMELL) briefly discussed this idea. In general, the Council is supportive of this idea but would like to see particulars. Author was connected with Greg Biscoe and Benoit Dube, both on CMELL and also in the organizational leadership at ADMSEP. Greg is the current President of that organization. They said that they would be available as a resource for discussing the issue. The 2006 ADMSEP position statement on clerkship length was provided. ADMSEP Action paper sent as an information attachment.

Explanation of Cost:
Cost of position statement development is 40 hours.

The Psychiatry Clerkship: A Position Statement on the Length of the Psychiatry Clerkship

The Membership and the Executive Council of the Association of Directors of Medical Student Education in Psychiatry, in recognition of the fact that:

Psychiatric disorders are common.

The annual prevalence of all psychiatric disorders, including addictions, is 30% in the United States (1). The lifetime prevalence of any psychiatric disorder in the United States is greater than 45% (2).

The disease burden of psychiatric disorders is high.

The WHO ranks depression as the second leading cause of disease burden in established economies, ahead of cardiovascular disease, and ranks all mental illness as the 2nd illness category of disease burden, ahead of all cancers (3).

Psychiatric disorders are costly.

Mental illness imposes on the U.S. economy an indirect cost—from lost productivity due to illness, premature death, and incarceration—of $79 billion a year, not counting an additional $99 billion in direct costs of mental health care (4).

Patients with psychiatric disorders and psychiatric symptoms are frequently seen in general medical and primary care practices.

Among patients who took their own lives, 70% saw a generalist in the year before their suicide and 40% did so in the month prior (5).

The complex skills of psychiatric evaluation, diagnosis, and management are not quickly learned.

Endorse the following:

1. The psychiatry clerkship must provide a full-time experience in the evaluation and care of psychiatric patients.
2. The psychiatry clerkship must be at least 6 weeks in length or longer.

This position statement was developed and endorsed by the Association of Directors of Medical Student Education in Psychiatry and then endorsed by the Executive Council of the Association of Academic Psychiatry in 2005.

References

1. Kessler RC, Berglund PA, Zhao S, et al. The 12-month prevalence and correlates of serious mental illness, in Mental Health, United States, 1996 (US Department of Health and Human Services Publ No [SNA] 96–3098). Ed. Manderschied RW, Sonnenschein MA. Washington DC, US Govt Printing Office, 59–70, 1996
2. Kessler RD, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of *DSM–IV* disorders in the national comorbidity survey replication. Arch Gen Psychiatry 2005; 62:593–602
3. Murray CJL, Lopez AD, (Eds.): The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, M.A: published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996
4. U.S. Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville MD, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999
5. Luoma JB, Martin CE, Pearson JL: Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 2002; 159:909–916

Item 2017A1 12.L
Reference Committee #3
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)

WHEREAS:

- According to the Center for Disease Control and Prevention (CDC), 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.
- From 2000 to 2014 nearly half a million persons in the United States died from drug overdoses, primarily prescription opioids and heroin.
- Between 2007 to 2012, opioid prescriptions per capita increased 7%.
- In 2013, 1.9 million persons with opioid use disorders were using prescription opioids.
- The American Psychiatric Association is a member of the American Medical Association Task Force to Reduce Opioid Abuse. The Task Force urges states and physicians to utilize prescription drug monitoring programs (PDMPs).
- PDMPs are state-level electronic databases.
- PDMPs collect, monitor, and analyze prescribing and dispensing data.
- Forty-nine (49) states have operational PDMPs, each with unique rules and regulations.
- PDMPs are proactive efforts to safeguard the public health and the safe medical use of controlled medications.
- PDMPs help ensure that if patients are prescribed controlled medications, the controlled medications are medically necessary and taken as directed.
- PDMPs help reduce harm from possible adverse drug actions and possible adverse drug-drug interactions.
- Physicians prescribing medications without access to PDMP data increase their patients risk of adverse drug actions, adverse drug-drug interactions, substance use disorders, and becoming a target for controlled medication diversion.
- The Comprehensive Addiction and Recovery Act of 2016 established a mechanism to provide grants to strengthen state PDMPs.

BE IT RESOLVED:

- That the American Psychiatric Association draft a position statement regarding Prescription Drug Monitoring Programs.
- That such PDMP position statement addresses PDMP best practices including design, operation, confidentiality, privacy, and utilization.

AUTHORS:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society
Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association

ESTIMATED COST:
Author: $616
APA: $2,310

ESTIMATED SAVINGS: $0.00

ESTIMATED REVENUE GENERATED: $0.00

ENDORSED BY:

KEY WORDS: Prescription Drug Monitoring Programs, Methadone, Opioid epidemic, patient safety

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Supporting Research, Education, Diversity

REVIEWED BY RELEVANT APA COMPONENT:
Concept and draft of possible APA position statement on PDMPs:
Council on Addiction Psychiatry
Council on Advocacy and Government Relations
Council on Psychiatry and Law

Action Paper 12.L: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs)

Author Explanation of Cost Estimate:

Drafting a position statement may be accomplished using conference calls.

Consequently, the cost estimate is limited to the time provided by APA staff to support six conference calls at one hour per conference call.

Additionally, the cost estimate includes two hours of APA staff time to assist in review of PDMPs and related issues.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.L: Requesting the APA Draft a Position Statement on Prescription Drug Monitoirng Programs (PDMPs)
Action Paper Author(s): Alexander von Hafften, M.D., Representative, Alaska Psychiatric Association
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APA Admin. Name: Beatrice Eld, Division of Education
Phone/email beld@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	24	-
Number of Staff	1	-
Number of Non-Staff	-	-
Total	**25**	**-**

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Assist review of state PDMPs and related issues (2 hours).	154
2 Coordinate conference calls (1 hour per conference call, 6 conference calls).	462
3 -	-
Total Staff Costs	616
Other Costs not included above:	
0	-
Total Author Estimate	**$616**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 Schedule and convene conference calls; research issues; discuss with content experts and other stakeholders.	770
2 develop and edit drafts and solicit input and recommendations of other relevant components and staff	1,540
3 -	-
Total Staff Costs	**2,310**
Other Costs not included above:	
0	**-**
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.L: Requesting the APA Draft a Position Statement on Prescription Drug Monitoring Programs (PDMPs):

APA Administration Feedback:

Council on Addiction Psychiatry, Department of Practice Management and Delivery Systems Policy:

A work group comprised of members from the above component and staff of relevant APA departments will work via email and conference calls to strategize and draft a position statement. Staffing for the work group efforts will be by liaisons to the Council on Addiction Psychiatry and the Department of Practice Management and Delivery Systems Policy.

Once developed, the work group's draft position statement will be shared with the full Council and then proceed through the governance process and be shared with other relevant organizations that share a similar interest.

No estimated savings or estimated revenue generation is anticipated by this action.

The Council on Addiction Psychiatry invited the Action Paper author, Dr. von Hafften, to attend its May 22 meeting to discuss possible position statement development.

Item 2017A1 12.M
Reference Committee #4
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Juvenile Solitary Confinement

WHEREAS:

1. Solitary confinement of juveniles continues to be used in correctional facilities for periods that exceed the acceptable use of behavioral interventions, such as “time out” (1 hour or less).

2. The brain is not fully developed until the early 20’s.

3. Solitary confinement has been associated and causative with adverse psychiatric consequences such as depression, anxiety, psychosis, or worsening of an existing psychiatric disorder.

4. The A.P.A. does not have an existing position statement regarding the solitary confinement of juveniles.

5. The following organizations DO have position statements on the solitary confinement of juveniles:
- American Academy of Child and Adolescent Psychiatry: “Solitary Confinement of Juvenile Offenders”, (approved April, 2012)
- American Medical Association: “Solitary Confinement of Juveniles in Legal Custody”, (2016)
- United Nations: “Rules for the Protection of Juveniles Deprived of Their Liberty”, section 67, (Dec. 14, 1990)
- National Commission of Correctional Healthcare: position statement (April 10, 2016)

6. The AACAP policy statement on the use of solitary confinement in juveniles has been used nationally by the AMA, ACLU, and others to set policy.

7. This does not affect the APA policy statement for adult seclusion.

BE IT RESOLVED:

That the APA support the AACAP policy statement (of 2012) * on the use of solitary confinement in juveniles.

AUTHORS:
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Louis Kraus, M.D., APA Member

SPONSORS:
Vincenzo Di Nicola, M.D., Representative, Quebec and Eastern Canada District Branch
Lisa Catapano-Friedman, M.D., Representative, Vermont Psychiatric Association
John M. de Figueiredo, M.D., Representative, Connecticut Psychiatric Society
David Fassler, M.D., APA Member
Reena Kapoor, M.D., Representative, Connecticut Psychiatric Society
Simha Ravven, M.D., Area 1 Deputy Representative, Assembly Committee of Early Career Psychiatrists
Michelle P. Durham, M.D., Representative, Massachusetts Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $2,156

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 1 Council, Area 2 Council, Assembly Committee on Public and Community Psychiatry

KEY WORDS: Solitary Confinement, Juveniles

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT: Council on Children, Adolescents and Their Families, Council on Psychiatry and Law

Feedback from the chair of the Council on Children, Adolescents, and Their Families:

- "Solitary confinement" is now known within correctional settings as restricted or restrictive housing.
- The action paper as written does not address the most current literature, real world issues, safeguards and correctional health standards that are promulgated within corrections to ensure safety, access to medical and mental health care by correctional staff and correctional health professionals, and must be attained to be in compliance with national accreditation standards under the National Commission on Correctional Health Care (NCCHC) and/or the American Correctional Association (ACA) or other types of accreditation.
- The AACAP document references Joint Commission and their definition and practice requirements regarding seclusion. Most correctional systems do not use or reference the Joint Commission (because the Joint Commission does not accredit juvenile, jail or prison settings, instead primarily inpatient or outpatient non-correctional settings).
- Below is a link to the most current NCCHC position statement (which is quite progressive within corrections) from 2016 and a position statement by the American College of Correctional Physicians created several years ago:

http://www.ncchc.org/solitary-confinement
http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates

Feedback from the Council on Psychiatry and Law:

- Do not disagree with intent and, in general, content of the AACAP PS. However, the following definition is flawed because it restricts solitary confinement (which basically no longer exists by this definition in contrast to segregation housing) to truly being solitary confined.

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

It is very common to be double celled in "solitary confinement" and even if single celled, there is at least minimal contact with other inmates in the same tier or pod as well as during outdoor

recreation with other inmates in the rec cages. It is very rare to have solitary confinement as defined in the PS, which limits the usefulness of the PS.

- Definition of solitary confinement may not apply to adult facilities but one youth per cell is the custom in juvenile facilities. Would statement speak to juveniles in juvenile facilities, or be revised to address solitary confinement of juveniles in both juvenile and adult facilities?

- Concern that endorsing AACAP PS would also be endorsement of Dr. Grassian's views, since his paper is referenced. Dr. Grassian's paper is attached.

Suggestion is that the AACAP PS be modified slightly and presented as an APA PS, which could also be modeled after the 2012 APA PS (second attachment to this message)

A few responses to the above feedback:
1. The term solitary confinement is still used in legal judgments, as seen in the current class action lawsuit in the state of New York.
2. Juveniles are never double bunked in solitary confinement.
3. A reference article supports a particular point, not all that is in the article.
4. This does not affect the APA policy statement for adult seclusion. We are not suggesting modification of the adult policy statement.

*AACAP Policy Statement:

Solitary Confinement of Juvenile Offenders

Approved by Council, April 2012

To be reviewed by June 2017 By the Juvenile Justice Reform Committee

Solitary confinement is defined as the placement of an incarcerated individual in a locked room or cell with minimal or no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment.

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis[1]. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions[2]. Furthermore, the majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.

Solitary confinement should be distinguished from brief interventions such as "time out," which may be used as a component of a behavioral treatment program in facilities serving children and/or adolescents, or seclusion, which is a short term emergency procedure, the use of which is governed by federal, state and local laws and subject to regulations developed by the Joint Commission, CARF and supported by the National Commission of Correctional Healthcare (NCHHC), the American Correctional Association (ACA) and other accrediting entities.

The Joint Commission states that seclusion should only be used for the least amount of time possible for the immediate physical protection of an individual, in situations where less restrictive interventions have proven ineffective. The Joint Commission specifically prohibits the use of seclusion "as a means of coercion, discipline, convenience or staff retaliation." A lack of resources should never be a rationale for solitary confinement.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty establish minimum standards for the protection of juveniles in correctional facilities. The UN resolution was approved by the General Assembly in December, 1990, and supported by the US. They specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rules states:

"All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned." In this situation, cruel and unusual punishment would be considered an 8th Amendment violation of our constitution[3].

Measurements to avoid confinement, including appropriate behavioral plans and other interventions should be implemented[4].

The American Academy of Child and Adolescent Psychiatry concurs with the UN position and opposes the use of solitary confinement in correctional facilities for juveniles. In addition, any youth that is confined for more than 24 hours must be evaluated by a mental health professional, such as a child and adolescent psychiatrist when one is available.

References:

2. Grassian, Stuart. "Psychiatric Effects of Solitary Confinement." Journal of Law and Policy. (2006): 325 383.

3. Mitchell, Jeff, M.D. & Varley, Christopher, M.D. "Isolation and Restraint in Juvenile Correctional Facilities." J.Am. Acad. Child Adolesc. Psychiatry, 29:2, March 1990.

4. Vasiliades, Elizabeth. "Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards." American University International Law Review 21, no. 1 (2005): 71-99. 4. Sedlak, Andrea, McPherson, Carla, Conditions of Confinement, OJJDP, May 2010.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.M: Juvenile Solitary Confinement
Action Paper Author(s): Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
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APA Admin. Name: Tatiana Claridad, Division of Diversity and Health Equity
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	-	-

Author Estimate:

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

Non-Staff Costs:

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

Staff Costs:

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

Other Costs not included above:

0		-
	Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Joint APA/AACAP workgroup should be developed to determine strategy. Work via email and conference calls. Staffed by liaisons to relevant councils (Council on Children, Psych and Law).	770
2	Workgroup's product will be shared with and edited by the relevant councils.	616
3	Final product will proceed through APA governance structure and processes.	770
	Total Staff Costs	**2,156**

Other Costs not included above:

n/a	-
Total Administration Estimate	**$2,156**

Rvsd. Dec. 2016

Action Paper 12.M: Juvenile Solitary Confinement

APA Administration Feedback:

Council on Children, Adolescent and Their Families
Council on Psychiatry and Law

Because the action paper has multiple perspectives, a joint work group comprised of the above components and AACAP representatives will work via email and conference call to strategize and determine whether to support the AACAP policy statement or draft a joint position for APA/AACAP. Staff liaisons from the above components will assist in joint work group efforts such as convening all parties, guiding deliberations via email and conference call, and other staff liaison duties as required.

Once a product is developed, the work group's product will be shared with the full Councils and then proceed through the governance process.

No estimated savings or estimated revenue generation is anticipated by this action.

Item 2017A1 12.N
Reference Committee #4
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond

WHEREAS:
Burnout is a "syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than as human beings," as defined by the Maslach Burnout Inventory Manual;

Rates of burnout among physicians, including psychiatrists, are estimated to be from 50% to 90%, suggesting a need for a public health approach to reduce burnout throughout the physician workforce;

Depression affects over 25% of resident physicians with a significant increase in depressive symptoms after the start of training, and physicians in general suffer from depression at high rates and are less likely than the general public to seek care or treatment;

Physicians are more likely to die by suicide than age-matched professionals, and such events have a profound impact on patients, other providers, and communities;

Physicians suffering from untreated mental illness or substance use disorders may be impaired and therefore perhaps more at risk for making medical errors that can compromise patient safety;

Promoting physician mental health may also enhance recognition of mental illness in patients;

Many institutions are beginning to look for evidence-based approaches to preventing burnout and depression among physicians, and there are programs being developed around the country whose efficacy can be studied;

Psychiatrists working within healthcare institutions are often local experts in depression and suicide as well as promoting wellness (e.g., process groups and supervision) and are well positioned to lead these efforts;

The APA and Dr. Anita Everett recently convened an Ad Hoc Workgroup on this topic chaired by Dr. Richard Summers;

Certain state licensing boards maintain potentially discriminatory reporting requirements for mental health conditions, as addressed in the APA Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing;

National organizations such as the Office of the Surgeon General, the Accreditation Council for Graduate Medical Education, and the Association of American Medical Colleges have recognized this problem as a national priority.

BE IT RESOLVED:
That the APA continue the mission of the Ad Hoc Workgroup on Physician Well-Being by developing resources for increasing awareness about physician burnout, depression and suicide, as well as interventions for promoting physician wellness, including recommendations for institutional response to physician suicide;

That the APA revise its 2011 "Position Statement on Physician Wellness" to affirm the APA's commitment to ensuring the well-being of its members and to encourage members to serve as leaders in promoting well-being initiatives within their institutions, training programs, and systems of care;

That the APA promote further investigation of the underlying causes of increased rates of burnout, depression and suicide among physicians and to expand the evidence base for innovative wellness interventions;

That the APA Government Relations staff work with stakeholder organizations including the Federation of State Medical Boards to remove questions about psychiatric or substance use disorder treatment from licensing applications (initial or renewal) as well as employment applications, instead focusing on relevant, current functional impairment due to either physical or mental illness;

That the APA's AMA delegation continue to collaborate with the AMA to develop joint initiatives to prioritize these issues; and

That APA members work with the ACGME to encourage residency programs to improve access to mental health treatment for residents and fellows, recognizing that such facilitation will likely take different forms and may vary based on a variety of program and institutional factors.

AUTHORS:
Jeremy D. Kidd, M.D., MPH, Area 2 Representative, Assembly Committee of Resident-Fellow Members
jeremy.kidd@gmail.com
David Roane, M.D., Representative, New York County District Branch
Matthew L. Goldman, M.D., MS, APA Member
Carol Bernstein, M.D., APA Member
Laurel Mayer, MD, APA Member

ESTIMATED COST:
Author: $2,310
APA: $4,235

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 2 Council, Assembly Committee of Resident-Fellow Members, New York County District Branch

KEY WORDS: Well-being, Physician Well-being, Burnout, Depression

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education

REVIEWED BY RELEVANT APA COMPONENT:

Council on Medical Education and Lifelong Learning and APA Division of Education

The Council on Medical Education and Lifelong Learning discussed the AP last night. In general, they are supportive of the idea and we discussed the numerous other initiatives which are occurring at other related organizations: ACGME, ABPN, AAMC, AADPRT, AMA. Anita's workgroup, which convened by phone for the first time on Monday, is tackling almost everything on your list. And it appears that in the new draft ACGME program requirements, the ACGME is going to make 24/7 access to MH and SU treatment a requirement for all residency programs. So, it's up to you if you want to move forward with the AP or hold on it until you see what the workgroup does. Rick Summers is the chair of the workgroup, by the way, and I'm sure he'd be happy to discuss with you as well.

Area 2 Council

The Council recommended several revisions to the Resolve concerning discriminatory reporting requirements. In particular, they recommended working with state medical boards to remove questions about mental health or substance use disorder treatment from initial or renewal licensing application as well as employment credentially applications. Instead, they recommended these questions should focused on assessing whether any physical or mental health condition poses a current impairment in fulfilling the responsibilities of that license or employment position.

Assembly Committee of Residents and Fellows

"..your AP has developed into something very well written. I am in full support of it. I think the be it resolved point of 'providing interventions for physician well being' is key. Including residents and fellows is very important. Nice job!"

"I am also in support of this action paper. I agree with the rest of the reps, it is a very well written paper. I am glad that Jeremy emphasized on physician burnout especially since ACGME is increasing the work hours for PGY1 to 24hrs and probably will increase hours for the others as well in 2017. The link below is to the CLER brochure which ACGME is adding focus on. I also included the link to ACGME's section on their physician well-being initiative: (1) http://www.acgme.org/Portals/0/PDFs/CLERBrochure.pdf (2) http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.N: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond
Action Paper Author(s): Jeremy D. Kidd, M.D., MPH, Area 2 Representative, Assembly Committee of Resident-Fellow Members
Phone/email: 540-921-7064/jeremy.kidd@gmail.com
APA Admin. Name: Kristen Moeller/Tristan Gorrindo, M.D., Division of Education
Phone/email 7039078637 kmoeller@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Liaise with the AMA to to develop joint initiatives to prioritize these issues (much of this work could be done by current AMA delegation)	770
2 Liase with the ACGME to encourage residency programs to improve access to mental health treatment for residents and fellows	770
3 Work with stakeholder organizations to encourage state medical boards to remove discriminatory reporting requirements for mental health and substance use disorder treatment	770
Total Staff Costs	2,310
Other Costs not included above:	
0	-
Total Author Estimate	**$2,310**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 update 2011 position paper on physician wellness	2,310
2 liaise with AMA to develop joint initiatives - AMA delegation	385
3 advocacy to work with state medical boards	770
Total Staff Costs	**3,465**
Other Costs not included above:	
Staff time (ranging from 7 to 10 hours) dedicated to reviewing and updating the position statement with the Council on Geriatric Psychiatry	**770**
Total Administration Estimate	**$4,235**

Rvsd. Dec. 2016

Action Paper 12.N: Addressing Physician Burnout, Depression, and Suicide—Within Psychiatry and Beyond

APA Administration Feedback:

- Regarding the position statement on Physician Wellness - Burnout workgroup is now working on this issue; recommend workgroup be involved in revising and updating position statement.
- (Licensing Board Questions about MH treatment) We would refer the author to the 2015 APA Position Statement on Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.
- AMA delegation can continue to collaborate
- A new ACGME requirement, beginning July 2017, mandates that all programs provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. This then completes one item listed in the action. (ACGME July 2017 requirement for MH treatment for trainees)

Council on Medical Education and Lifelong Learning (CMELL):
Feedback sent to author:
The Council on Medical Education and Lifelong Learning discussed the action paper. In general, the Council is supportive of the idea and the Council discussed the numerous other initiatives which are occurring at other related organizations: ACGME, ABPN, AAMC, AADPRT, AMA.
Anita Everett's APA workgroup, which convened by phone for the first time on Monday, February 27, is tackling almost everything on the list of this action. Rick Summers is the chair of the workgroup and could also discuss what that group is doing.

A new ACGME requirement, beginning July 2017, mandates that all programs provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (ACGME July 2017 requirement for MH treatment for trainees)

Explanation of Cost: Education
Cost not known for development of resources for increasing awareness about physician burnout, depression and suicide until task force makes recommendations.

AMA Delegation:
Members of the APA AMA Delegation routinely support resolutions and reports moving forward that touch on the issues of physician burnout, depression (and impact of other mental illness and substance use disorders), and suicide among practicing physicians including medical students, residents and fellows. This includes speaking in support of providing access to mental health care, reducing stigma that could be associated with seeking treatment, and issues of confidentiality. The Delegation will continue to monitor these issues at the AMA and would look to the Ad Hoc Workgroup to provide guidance as to taking any additional actions at the AMA based on the Ad Hoc Workgroups review of the issue.

Department of Government Relations:
Action paper ask for the Department staff (APA Government Relations staff work with stakeholder organizations).

(To my knowledge) APA has not engaged FSMB at a national level to address the issue. I can say that various DBs have been working in their states to remove such questions from applications, including renewals, as they run counter to APA's position and federal directives. It's been an ongoing battle in some states. Part of the problem—like that found in Ohio—is that there are non-physicians on the Medical Board and some of the Board members lack an understanding or appreciation of mental health and substance use and treatment. Our SA in Ohio continues to try to educate them. If staff were tasked with this, it would take a great deal of staff time.

Division of Diversity and Health Equity (DDHE):

The action paper includes an ask to revise and update the position statement on physician wellness which was developed by the Council on Geriatric Psychiatry. The council falls under the purview of DDHE.

Explanation of Cost: DDHE

The cost estimate includes staff time (ranging from 7 to 10 hours) dedicated to reviewing and updating the position statement with the Council on Geriatric Psychiatry. The staff will assist in the development of a workgroup, partake in workgroup meetings via email and/or conference calls, in addition to other related staff liaison duties as required. Once a product is developed, the workgroup's draft will be shared with every member of the Council, and then sent to governance for approval.
No estimated savings or estimated revenue generation is anticipated by this action. Cost Estimate: 10 Hours = $770.00

Item 2017A1 12.O
Reference Committee #4
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Health Care Is a Human Right

WHEREAS:
Whereas,
Life, liberty, and the pursuit of happiness are intrinsic American values enshrined in the American Declaration of Independence

Whereas,
Health is essential for quality and longevity of life

Whereas,
Health of individuals and populations is an essential asset for robust economies and democracies

Whereas,
Health is essential to a nation's security and prosperity

BE IT RESOVLED:
That the American Psychiatric Association advocates for *Health Care*, inclusive of mental health care, as a *Human Right for all Americans.*

AUTHORS:
Eliot Sorel, M.D., DLFAPA, Representative, Washington Psychiatric Society
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SPONSORS:
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Joseph P. Collins, Jr., M.D., FAPA, APA Member
Eindra Khin Khin, M.D., FAPA, APA Member
Elizabeth M. Morrison, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $3,542
APA: $7,700

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Access to Health Care, Human Rights

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Education, Diversity

REVIEWED BY RELEVANT APA COMPONET: Council on International Psychiatry

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.O: Health Care Is a Human Right
Action Paper Author(s): Eliot Sorel, M.D., Representative, Washington Psychiatric Society
Phone/email:
APA Admin. Name: Glenn O'Neal, Office of Communications
Phone/email goneal@psych.org

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

Author Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Produce Press Release	462
2	Responding to media queries and conducting interviews	3,080
3		-
	Total Staff Costs	3,542

Other Costs not included above:

0		-
	Total Author Estimate	**3,542**

APA Administration Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:	
1	Produce press release.	462
2	Media relations and promotion.	3,080
3	DGR lobbying activities on Capitol hill and DBSA collaboration	4,158
	Total Staff Costs	**7,700**

Other Costs not included above:

0		-
	Total Administration Estimate	**7,700**

Rvsd. Dec. 2016

Action Paper 12.O: Health Care is a Human Right

APA Administration Feedback:

Office of Communications:

The APA Administration is mindful of the authors' concerns and agrees that health care is essential to the well-being of all Americans. A 1 week media campaign to promote this idea would, at a minimum, entail a press release, social media posts, and press outreach. APA Communications staff estimates that 40 hours of staff time at a cost of $3,542 would be necessary to successfully conduct a media campaign of this nature.

Department of Government Relations:

The action paper addresses the human right to receive the highest attainable standards of health care, a priority of APA and APA's Department of Government Relations. The Department reviewed the action paper taking in consideration the authors' request for advocacy efforts. The Department of Government Relations would evaluate federal and state legislation and leverage existing advocacy efforts, as appropriate. The Department projects time and cost associated with an advocacy campaign based on the premise of the action paper may entail 25 to 30 hours of Capitol Hill meetings (roughly the interested members of the relevant House and Senate committees), 10 hours of meeting follow-up (both internal and external stakeholders), 8 hours of research and materials creation, 3 hours of DB/SA collaboration, 3 hours of Executive Branch meetings, and 5 hours of partnership activity.

Item 2017A1 12.P
Reference Committee #5
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Making Access to the Voting Page a Default Action During Elections

WHEREAS:

The percentage of eligible APA members who vote in the annual election has dropped from an average of 33% in the first five years of the last decade to an average of 19% in the last 5 years;

Of the 19.5% of eligible members who voted in the 2017 election, 92% of them voted electronically, with 83% of these electronic voters doing so via a link sent to them via email;

Thus, only one-sixth of the voters accessed the elections page by clicking on a link on the APA website, which amounts to only 3% of eligible members doing so;

The field of behavioral economics has found that one of the methods for increasing a desired action (like saving for retirement) in the face of mass inertia is to make the desired action the default action;

Having the voting webpage be automatically served to an APA member when they go to any of the APA websites would be expected to significantly increase the percent of members who complete the balloting process; and

Increasing the voting rate among APA members is a valuable goal towards maintaining an effective, involved, and healthy organization; therefore

BE IT RESOLVED:

That a Work Group be established to determine the best options for making the voting webpage appear by default when an eligible APA member who has not yet voted accesses any of the APA websites during the open election period, or an alternative default method to increase the proportion of members voting via the website;

That the President, the CEO and Medical Director, and the Assembly Speaker jointly designate individuals to serve on this Work Group;

That the Workgroup include representatives from the APA Communications, Membership, and Information Technology Divisions; Association Governance; as well as the APA Elections and Tellers Committees and the Assembly Executive Committee;

That the Work Group report interim results to the Recorder for distribution to the Assembly prior to the deadline for Fall Action Papers, and report final results to the Speaker prior to the Fall Assembly meeting; and

That the Speaker provide an oral report back to the Assembly on the Work Group's results at the November 2017 Assembly meeting.

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

SPONSORS:
Mary Anne Albaugh, M.D., Representative, Pennsylvania Psychiatric Society
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Marvin Koss, M.D., Representative, Central New York District Branch
Rahul Malhotra, M.D., Area 3Representative, Assembly Committee of Early Career Psychiatrists
Gabrielle Shapiro, M.D., DFAPA, Representative, New York County Psychiatric Society
James Curt West, M.D., Representative, Society of Uniformed Services Psychiatrists
Lily Arora, M.D., Representative, New Jersey Psychiatric Association
Debra Atkisson, M.D., DFAPA, Texas Society of Psychiatric Physicians
Jeffrey Bennett, M.D., Representative, Illinois Psychiatric Society

ESTIMATED COST:
Author: $924
APA: $2,310

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: Unknown amount from increase in membership

ENDORSED BY:

KEY WORDS: Elections, Voting, Website, Membership

APA STRATEGIC PRIORITIES: Advancing Psychiatry

REVIEWED BY RELEVANT APA COMPONENT:
Elections Committee: *The Election Committee indicated they were supporting of efforts to increase the degree of member participation in elections.*

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title:	12.P: Making Access to the Voting Page a Default Action During Elections
Action Paper Author(s):	Steven Daviss, M.D., DFAPA, Representative, Maryland Psychiatric Society
Phone/email:	410-782-0077 / steve@fusehealth.org
APA Admin. Name:	Margaret C. Dewar, Association Governance
Phone/email	mdewar@psych.org

Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	3	-
Number of Staff	4	-
Number of Non-Staff	-	-
Total	**7**	**-**

Author Estimate:

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

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

Staff Costs:

	Description:		
1	Discussion with group about options to achieve goal of Action Paper, develop options, and report out.		924
2		-	-
3		-	-
	Total Staff Costs		924

Other Costs not included above:	
0	-
Total Author Estimate	**$924**

APA Administration Estimate:

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

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

Staff Costs:

	Description:		
1	Staffing Work Group, conference calls, drafting reports, etc.		2,310
2		-	-
3		-	-
	Total Staff Costs		**2,310**

Other Costs not included above:	
0	-
Total Administration Estimate	**$2,310**

Rvsd. Dec. 2016

Action Paper 12.P: Making Access to the Voting Page a Default Action During Elections

APA Administration Feedback:

The action paper requests a work group that would consider changes to the APA election voting process. Specifically, it requests that a workgroup be established to review methods to set up the APA website to direct members who log in during the election period, but who have not yet voted, to the election homepage. This action paper specifically asks for the workgroup to be established, but during the development of the action paper, the APA Administration reviewed the underlying concept of revising the website to achieve the goal of redirecting website traffic. Given that the workgroup would be tasked with that review, we wanted to provide the findings from the Administration's research into that topic.

The proposal suggests that, during the month of January, when voting is taking place, any member who attempts to log into the website to access any locked page would be taken to the election homepage instead of the page they were logging into, after checking with the election vendor that they had not yet voted. This would require two technical enhancements:

1. Creating a direct connection between our election vendor and the APA's membership database, which does not currently exist. We have maintained separate systems to create a firewall during the election process
2. Manually changing coding on each locked webpage page at the start of January to redirect traffic and then changing that coding back at the conclusion of the election period.

Both of these processes will require substantial financial investments (likely $80,000 for the first year and $40,000+ each year thereafter, much of it from staff time required to code and recode webpages), either one time or ongoing for each election year.

Further, the Administration's research indicated that approximately 16% of voters accessed the election page by logging in through the APA website, which is where the effort underlying this action paper would be focused. The other 84% voted by clicking the link in the election email they received or by visiting the election vendor's website.

Finally, from a member experience perspective, there is a concern that members who are attempting to access a locked APA page and then log in, but who are re-directed to the election webpage, may experience frustration from the involuntary re-direct. This will also impact dues revenue since members are directed through various recruitment campaigns to the online payment system. Instead of being brought to that online payment system during the grace period for payment in January, they will instead be redirected to the election page and be forced to find their way to the dues payment system. Moreover, this may interrupt the revenue producing efforts of communications and publishing in the same way.

It may also raise unfounded concerns questions about the firewall between the members' voting information and membership information.

Understanding that the goal is to enhance election turnout, we should note that this has been a focus of both the Elections and Nominating Committees who are tasked with key elements of the APA election

and continually implement new ideas (personalized voting links, candidate videos, candidate biographies, etc.) to offer members comprehensive voter information and easy access to voting.

Item 2017A1 12.Q
Reference Committee #5
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico

WHEREAS:
There has been a mass exodus of members from the APA from the Commonwealth of Puerto Rico during the past two decades. In 1998, there were 200 members; in 2005 there were 175. Two years ago, there were 138 members and this past year, 2016, there were 135.

Because of economic differences between Puerto Rico, a Commonwealth of the United States, and the 50 States of the Union, APA members in Puerto Rico actually pay proportionally more of their salary for their membership than other Psychiatrists; their rates of Medicaid and Medicare reimbursement are significantly lower. Third party insurance payers follow the Medicare example and are known to pay as little as $20 a session. Also, members are obligated to pay a fixed amount, $300 to the College of Physicians and Surgeons. The past president of APA has publicly stated that the doctors in Puerto Rico are the lowest paid physicians in the USA.

The APA available benefits for psychiatrists practicing in Puerto Rico are fewer. There is no PAC support for psychiatric issues in Puerto Rico. APA-sponsored malpractice insurance is not available to psychiatrists practicing in Puerto Rico. Pragmatically, they receive essentially equivalent services to our Canadian members. Thus, it would seem appropriate that their membership rate should be similar.

As APA general members, Canadian psychiatrists, from a country much more prosperous than the Commonwealth of Puerto Rico, pay $375 in annual dues.

BE IT RESOLVED:
That general member psychiatrists who are members of the Puerto Rico Psychiatric Society, a District Branch of the APA shall be granted the same annual dues as our Canadian counterparts, which is $375 per general member per year for the next five years.

AUTHORS:
Harold Ginzburg, M.D., Representative, Oklahoma Psychiatric Physicians Association
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SPONSORS:
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Mary Jo Fitz-Gerald, M.D., Representative, Louisiana Psychiatric Medical Association
Judy Glass, M.D., Representative, Quebec and Eastern Canada District Branch
Joseph Napoli, M.D., Representative, Area 3

James Polo, M.D., Representative, Washington State Psychiatric Association
Debra Atkisson, M.D., Representative, Texas Society of Psychiatric Physicians
Jose De La Gandara, M.D., Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists
Sarah Huertas-Goldman, M.D., Representative, Puerto Rico Psychiatric Society
Gabrielle Shapiro, M.D., Representative, New York County District Branch

ESTIMATED COST:
Author: (**lost revenue**) $30,375 in the first year [$575-$350=$225x135 members=$30,375]
APA: $31,950

ESTIMATED SAVINGS: The loss of more than 60 general psychiatrists represents a loss of approximately $35,000 per year. The more members we can recruit/retain the more we will be saving.

ESTIMATED REVENUE GENERATED: None at first but with more joining, there will be more revenue. If we could get back to 200, which means 65 more general members, we would break even within two years and from then on there would be a "profit." If only 9 more members join, break-even is at 10 years.

ENDORSED BY: Area 5 Council – by unanimous vote

KEY WORDS: Membership, District Branch

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT: Resubmission with additional economic data and Area 5 support

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.Q: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico
Action Paper Author(s): Harold Ginzburg, M.D., Representative, Oklahoma Psychiatric Physicians Association
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APA Admin. Name: Jon Fanning, Chief Membership & Strategy Officer
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Attendance Summary:	**Author**	**APA Administration**
Number of Component Members	-	-
Number of Staff	-	-
Number of Non-Staff	-	-
Total	**-**	**-**

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1 none	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
Lost revenue costs only - as noted in action paper, initially, $ 30,375, as members rejoin/join the DB in Puerto Rico the lost revenue will decrease and if 20 members join and stay five years - the lost revenue becomes zero and then it will be an income generating action as more members rejoin/join and retention of membership occurs	30,375
Total Author Estimate	**30,375**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
It is uncertain if any of the loss revenue per year would be recaptured, or if the loss revenue would become exponentially higher as other groups demanded reduced dues based on economic factors. The action paper also does not indicate how many non-members are in Puerto Rico or the alternative approach that would be used by the DB to recruit if relief were granted. Once dues are lowered, it is nearly impossible to raise them to previous levels if the intended result is not achieved.	**31,950**
Total Administration Estimate	**$31,950**

Rvsd. Dec. 2016

Action Paper 12.Q: Dues Relief for District Branch Members from the Commonwealth of Puerto Rico

APA Administration Feedback:

Membership Department:

In February 2014, various American credit rating agencies downgraded the government of Puerto Rico's debt to non-investment grade. On August 3, 2015, Puerto Rico defaulted on a $58 million bond payment to the Public Financing Corporation, a subsidiary of the Government Development Bank, while other financial obligations were met. The island has continued to struggle financially (Source: Wikipedia).

However, total APA membership in Puerto Rico increased as follows:

Year (January)	# of Members
2013	108
2014	132
2015	147
2016	142
2017	142

This is an increase of 31.5% during the time of the debt crisis.

Moreover, according to the US Bureau of Labor statistics, the mean salary of a psychiatrists in San Juan, Puerto Rico is $182,650. The following states have mean salaries that are lower than this amount.

State	Annual mean Salary
Arkansas	110880
Idaho	112910
District of Columbia	128460
Louisiana	135640
Maine	137570
West Virginia	141310
Hawaii	154040
Oklahoma	170040
Nevada	171430
Illinois	172560
Montana	177380
Massachusetts	180960
Florida	181080

Lowering dues based on economic factors can quickly cascade into a call to reduce dues for reasons such practice setting, geographic region, personal circumstances, etc. In turn, this could quickly put the

organization, which relies on dues revenue, on an unsustainable financial trajectory in which the organization cannot sustain activities related to its mission.

Explanation of Cost: $31,950 per year ($575-$350=$225 X 142).

Item 2017A1 12.R
Reference Committee #5
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: Streamlining the Application Process for Former APA Members

WHEREAS:
The American Psychiatric Association (APA) had a membership increase in 2016.

The APA continues to explore modalities to increase membership including ways to have former APA members rejoin the organization.

Currently, former APA members interested in rejoining the APA have to complete the same extensive application process as a new, non-former member. The redundancy in the reapplication process may be a barrier for former members to reestablish membership. The application main categories include biographical information, academic training, training, board certification, demographic data, primary practice setting, ethics, professional service, documentation, and agreement.

As a result, streamlining the process for re-applicants may further increase APA membership, demonstrate to former members that the APA values their participation in the organization, and a way to demonstrate to former members that the APA "wants them back."

BE IT RESOLVED:
That the APA staff streamline the application process for former APA members on the website as follows:

1. Once an applicant answers yes to being a former member of the APA on the website, the individual is given an online, pre-filled application.
2. Remove the requirement for the applicant to resubmit the residency training certificate (this can be verified by APA staff from previous membership records).
3. Remove the requirement for the applicant to submit a valid medical license (this can be verified by APA staff from online, public databases).

That the APA staff advertise the changes to the streamlined application process for former APA members.

AUTHORS:
Mark Haygood, D.O., MS, Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Rahul Malhotra, M.D., Area 3 Representative, Assembly Committee of Early Career Psychiatrists
Baiju Gandhi, M.D., Area 3 Deputy Representative, Assembly Committee of Early Career Psychiatrists

ESTIMATED COST:
Author: $616
APA: $616

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Former APA members; Membership; Membership application process

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.R: Streamlining the Application Process for Former APA Members
Action Paper Author(s): Mark Haygood, DO, MS, Area 5 Representative, Assembly Committee of Early Career Psychiatrists
Phone/email: mhaygood78@gmail.com
APA Admin. Name: Stephanie Auditore, Membership Department
Phone/email 703-907-7833/sauditore@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Creating pre-filled applications for all lapsed but alive members.	616
2	-
3	-
Total Staff Costs	616
Other Costs not included above:	
0	-
Total Author Estimate	**$616**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	-
Staff Costs:	
Description:	
1 Creating the functionality to pre-fill applications for former members.	616
2	-
3	-
Total Staff Costs	**616**
Other Costs not included above:	
0	-
Total Administration Estimate	**$616**

Rvsd. Dec. 2016

Action Paper 12.R: Streamlining the Application Process for Former APA Members

APA Administration Feedback:

Membership Department:

The Membership team wholly supports the mission to make the reinstatement process as seamless and easy for former members as possible. Our new database system, which was deployed in March 2017 and designed based on member feedback like that in the action paper, presents a pre-populated membership application when a former member uses their email address on file with the APA. Membership also supports the second and third parts of this action paper, and will plan to implement them in the new membership application.

Explanation of Cost:

We agree that it would be a light lift (estimated 8 hours of staff time) to allow members to complete an online, pre-filled application. These changes will result in a more user friendly online experience, save time, and reduce errors.

Item 2017A1 12.T
Reference Committee #5
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: APA Referendum Voting Procedure

WHEREAS:

Whereas: The referendum process is a critical component in maintaining the American Psychiatric Association as a member driven organization and allows the membership to determine the need for even major structural or policy changes in the organization, similar to the purpose of the amendment process in the U. S. Constitution.

Whereas: The referendum process was considered a fundamental component of the governing structure of the APA as testified to by its long tenure in the bylaws.

Whereas: The referendum process is currently operationalized by attaching the referendum for membership vote to the APA national officer election ballot.

Whereas: The election of officers occurs by a simple majority of those eligible members who choose to vote, while the passing of a referendum requires a majority of at least 40 percent of all eligible voters.

Whereas: Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only 15 percent voting in the 2016 election. Thereby, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011. In distinction, in the 2016 officer election, a candidate for office could have won with the votes of 8 percent of eligible voters.

Whereas: A referendum to change the voting procedure would, itself, have to go through the above-referenced process which has clearly been shown to not be functional for establishing the predominant will of the membership in regard to proposals.

Whereas: There is a stipulation in the American Psychiatric Association bylaws §8.4, which states that referenda are "to be voted on in the next annual ballot." It does not specifically stipulate that this "annual ballot" refers to, or only to, the national election ballot.

Whereas: A yearly mailing, both paper and electronic, is distributed which includes the dues statement and/or solicitation for contributions (for non-dues paying but voting members). Obviously, all dues paying members must respond to this mailing to maintain their membership. All non-dues paying but voting members may, and, in fact, are encouraged to respond to the contribution/solicitation aspect of the mailing.

Whereas: This action paper is not calling for a lowering of the percentage of voting members who would have to vote to allow a referendum to pass (40 percent) and it therefore is not in violation of the Washington, D.C. code.

Whereas: A separate envelope could be included with the dues/solicitation mailing, or a separate link or secure form appended to the electronic option, to allow for voter confidentiality.

Whereas: Virtually identical action papers, as originally amended by Reference Committee 5, have been passed now by the Assembly on four separate occasions at four separate Assembly meetings.

Whereas: The cost of attaching referendum voting ballots to the dues/solicitation notice process should not be inherently more expensive than the current practice of attaching them to the officer election ballot process, beyond that of establishing the transition.

BE IT RESOLVED:

1. That for the fifth time the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly election ballot, but with the yearly dues statement/solicitation of contributions which then be sent to all voting members, and/or

2. That an alternative for a viable referendum process be prepared by the Board of Trustees and presented to the Assembly at the Fall 2017 meeting.

AUTHOR:
John P. D. Shemo, M.D., DLFAPA, Representative, Psychiatric Society of Virginia
(shemojohn@pabrcrc.com)

ESTIMATED COST:
Author: $35,000
APA: $41,160

ESTIMATED SAVINGS: Not relevant for this paper.

ESTIMATED REVENUE GENERATED: Not relevant for this paper

ENDORSED BY: Psychiatric Society of Virginia, Area 5 Council

KEY WORDS: APA Referendum/membership driven organization

APA STRATEGIC PRIORITIES: Advancing psychiatry, diversity

REVIEWED BY RELEVANT APA COMPONENT: Submitted to the Bylaws Committee and the Elections Committee.

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.T: APA Referendum Voting Procedure
Action Paper Author(s): John Shemo, M.D., Representative, Psychiatric Society of Virginia
Phone/email:
APA Admin. Name: Jon Fanning, Chief Membership & Strategy Officer, RFM-ECP Liaison
Phone/email jfanning@psych.org

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

Author Estimate:

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

Non-Staff Costs:

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

Staff Costs:

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

Other Costs not included above:

I accept prior APA staff estimate of $35,000 total cost. Work should be doable by existing committeer in the course of their ongoing work.	35,000
Total Author Estimate	**35,000**

APA Administration Estimate:

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

Non-Staff Costs:

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

Staff Costs:

	Description:		
1	Additional admin time b/w IT, Membership, Communications, and Governance to carry out the option for electronic voting		6,160
2		-	-
3		-	-
Total Staff Costs			**6,160**

Other Costs not included above:

Cost of contract with third-party management firm to conduct a referendum process	**35,000**
Total Administration Estimate	**41,160**

Rvsd. April 2017

Action Paper #12.T: APA Referendum Voting Procedure

APA Administration Feedback:

Membership Department:
Regarding including the ballot with the dues renewal mailing: The membership department mails dues renewal materials for 2018 to the third-party printing and mailing company in September 2017 so that the first batch of invoices are postmarked by the first week of October 2017. To be included in the mailing, the ballot for a referendum would have to be finalized and printed by the first week of September 2017. The current APA bylaws state that: "The voting members may initiate referenda or change an action of the Board by submitting a petition signed by at least 500 voting members to the Secretary by October 15 to be voted on in the next annual ballot." Consequently, this part of the APA bylaws would need to be changed since changing the dues process would substantially disrupt APA and District Branch dues revenue collection. Also, if the ballot has to be tied to specific individuals, this could increase costs substantially, the lead times mentioned above would need to be increased by a few weeks, and there would need to be an expected margin of error as the mail house attempts to match 30,000 plus invoices with ballots. Membership sends out material to all members and cannot exceed 6 pieces in the envelope without switching to a larger envelop. Currently, 1 invoice, 1 letter, 1 payment plan sign-up form, 1 flyer, and 1 return envelope is included (5 total pieces). To include a ballot and a return envelope for the ballot, if required, would increase postage and envelop costs. If another envelope addressed to a third-party vendor facilitating the elections is included, members are likely to confuse the envelops which will disrupt both the processing of the ballots and dues invoices. Membership would prefer not to be responsible for the management of incoming ballots either through one envelop with dues or by receiving the wrong envelop from members given the confidential and political sensitivity of the process. The increase in hard and soft costs are difficult to calculate until additional clarity pertaining to the above factors are better known.

Association Governance:
The cost of a contract with a third-party management firm to conduct a referendum process (now with the option to vote electronically) is at least $35K.

The option to vote electronically requires approx. 80 hours of additional administration time/salary among IT, membership, communications and governance departments not only to ensure confidentiality of voting and clear and proper communication between APA and membership, but also to develop and provide multiple distribution lists or membership data to both third-party companies: 1. Voting members who are eligible to vote electronically (for election management firm), 2. Non-dues voting members who don't have an email address (for election management firm), 3. Dues paying voting members who don't have an email address (for membership printing and mailing company). The administration cost is approx. $6,160.

The total cost estimate to implement this proposal is over $41K.

<u>Minor corrections of factual information in the Action Paper:</u>

- Fifth paragraph, first sentence: *"Forty percent of all eligible voters have not voted in an APA national election in almost 20 years with only <u>18</u> ~~15~~ percent voting in the 2016 election.*"
- Fifth paragraph, last sentence: *"In distinction, in the 2016 officer election, a candidate for office could have won with the votes of <u>9</u> ~~8~~ percent of eligible voters. "*

Background/History on Action paper submissions:
Submitted: **May, 2013; November 2013; May 2014; May 2016**

May 2013: The authors submitted the Action Paper "APA Referendum Voting Procedure" in May 2013. The Assembly approved the action paper and referred it to the Joint Reference Committee.

In June 2013, the Joint Reference Committee held a lengthy and thoughtful discussion of this action paper. A motion was made to refer the action paper to the Board of Trustees and failed. The action paper was referred to the Assembly Executive Committee for discussion. The AEC discussed the paper at its July 2013 meeting. No action was taken.

November 2013: [*Paper resubmitted*] REFERENCE COMMITTEE #5 recommended: Referral of this action paper to an Ad Hoc Work Group of the Assembly, created by the Speaker of the Assembly, which will include a BOT representative, to address feasible implementation of this action paper. [*Paper was referred to the AEC.*]

At the January 2014 AEC meeting, Dr. Young (Speaker of the Assembly) referred this paper to the Speaker-Elect, Dr. Jenny Boyer, who will work with Dr. David Scasta on the issues outlined in this paper and report back to the AEC at an upcoming meeting.

May 2014: [*Paper resubmitted*] The paper was approved by the Assembly, and referred to the Joint Reference Committee.

The JRC did not support the initial Assembly action to amend the referendum process but believed that the Board would be the appropriate body to consider the larger issue of the importance of the voice of the membership being heard on important or controversial issues.

At the July 2014 Board of Trustees meeting, the Board of Trustees voted to appoint a Work Group (WG) which could consider both the APA referendum process and weigh options available for change or improvement in the current process. The Ad hoc Work Group on APA Referendum Voting Procedures is chaired Dr. Renee Binder with Drs. Jenny Boyer, Glenn Martin and Melinda Young serving as members. [*Board Ad Hoc Work Group report is below.*]

Board Ad Hoc Work Group on APA Referendum Voting Procedures
The Work Group (WG) met by conference call on October 1, 2014. The group noted that the action paper "APA Referendum Voting Procedures" was approved by the Assembly in May 2014 and referred to the JRC meeting later that month. The JRC did not support the action to amend the referendum process but referred it to the Board of Trustees to consider the issue of the importance of the members voices' being heard on important issues, even if the referendum doesn't meet the required numbers to pass.

The WG agreed on the importance of the Board giving thoughtful consideration to concerns raised by large numbers of members on important issues, and considered the best ways to address these concerns. The following options were proposed during the call:

Option 1: Changing the bylaw concerning the referendum process. It was noted, however, that per DC statute, any change to lower the voting percentages for referendum passage would have to be approved by the members at the same percentages contained in the current APA bylaws. It was felt that this was highly unlikely to succeed, given the lower voting percentages for all APA elections over the last decade. The lower voting trend has been seen across many organizations.

Option 2: The Board could consider making a change to the *APA Operations Manual* to add a procedure concerning referenda that reach a minimum designated percentage of affirmative member votes. If this percentage (lower than the APA bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees. If the Board supports this option the following actions should also take place:

a. Information concerning the referendum would be contained within the Tellers Report to the Board of Trustees so members may easily access the information.
b. The Operations Manual would be amended to note the new process and requirement concerning the addition to the Board agenda and appropriate Board discussion.
c. The member communication process on referenda will be addressed by Dr. Levin and Chief of Communications and Public Affairs, Jason Young.
d. General Counsel Coyle will provide any additional legal advice

Option 3: Do not make any changes in the *APA bylaws* or the *Operations Manual*. The Tellers Report will contain information about the referendum and this will serve as notice to the Board of Trustees and encourage the Board Chair (APA President) to have this as an agenda item.

The Work Group did not support Option 1 and presents Option 2 and 3 to the Board for decision making by the Board.

From December 2014 Board of Trustees Meeting:
The Board of Trustees voted to approve option #2 of the report of the Ad Hoc Work Group on APA Referendum Process. The Action Paper was subsequently addressed at the December 2014 Board meeting.

OPTION #2: The Board could consider making a change to the APA Operations Manual to add a procedure concerning referenda that reach a minimum designated percentage of affirmative member votes. If this percentage (lower than the APA bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees.

Approved amendment to the *APA Operations Manual* as follows:

Procedure concerning Referenda that reach a minimum designated percentage of affirmative members votes:
If this percentage (lower than the APA Bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees. If the Board supports this option, the following actions should also take place:

- *Information concerning the referendum would be contained within the Tellers Report to the Board of Trustees so members may easily access the information.*
- *The CEO/Medical Director and the Chief of Communications and Public Affairs will address the member communication process.*
- *The General Counsel will provide an additional legal advice.*

May 2016: The Assembly approved the action paper and referred it to the Joint Reference Committee.

June 2016: The Joint Reference Committee reviewed the history of the requests for changes to the APA Referendum voting procedures. After an extensive discussion of the issues, the JRC determined that implementing this action paper is unfeasible and not in the best interests of the APA. The JRC therefore recommended that the Board of Trustees reaffirm the JRC's action. Dr. Miskimen, the Speaker-elect of the Assembly will follow-up with the originators of the paper.

July 2016: The Board of Trustees reaffirmed the JRC decision that approval and implementation of action paper APA Referendum Voting Procedure (ASMMAY1612.FF) is not feasible.

Item 2017A1 12.U
Reference Committee #5
Assembly
May 19-21, 2017

ACTION PAPER

TITLE: November Assembly Dates

WHEREAS:
Many APA members are active politically locally and nationally, and Election Day in the United States is the first Tuesday in November that follows a Monday, and

The APA Assembly usually meets the first weekend in November,

THEREFORE, when the Assembly meeting happens prior to Election Day, especially in the years with national elections, Assembly members must choose between participating in some early voting and last minute election activity in their home town or state OR attending the November Assembly,

BE IT RESOLVED:
That except for already scheduled Assembly meetings, the APA Assembly will meet the first weekend in November after the US Election Day, whenever possible.

AUTHOR:
Margie Sved, M.D., DLFAPA, ACROSS Representative, Association of Gay and Lesbian Psychiatrists

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 5 Council

KEY WORDS: Assembly meetings

APA STRATEGIC PRIORITIES: Advancing Psychiatry, Diversity

REVIEWED BY RELEVANT APA COMPONENT:

AMERICAN PSYCHIATRIC ASSOCIATION

Action Paper Worksheet
2017 Action Paper Budget Estimate

Action Paper Title: 12.U: November Assembly Dates
Action Paper Author(s): Margie Sved, M.D., DLFAPA, ACROSS Representative, Association of Gay and Lesbian Psychiatrists
Phone/email: -
APA Admin. Name: Allison Moraske, Margaret C. Dewar, Association Governance
Phone/email amoraske@psych.org

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

Author Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Author Estimate	**$0**

APA Administration Estimate:

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

Non-Staff Costs:	
LCD Projector	-
Laptop	-
Screen	-
Flipchart	-
Microphones	-
Total Non-Staff Costs:	**-**
Staff Costs:	
Description:	
1	-
2	-
3	-
Total Staff Costs	-
Other Costs not included above:	
0	-
Total Administration Estimate	**$0**

Action Paper 12.U: November Assembly Dates

APA Administration Feedback:

Association Governance:
Per the *Procedural Code of the Assembly*, "There shall be at least two meetings of the Assembly annually. The Annual Meeting shall be at the time and place of the Annual Meeting of the Association; the other shall be a Fall Meeting at the time and place designated by the Assembly. The interval between the Fall APA Component Meetings and the Fall Assembly will be at least four weeks to allow adequate time for reproduction and distribution of reports prior to the convening of the Assembly."

The APA currently has a contract with the Omni Shoreham in Washington, D.C., through 2019 with the Assembly meeting on the following dates: November 3-5, 2017; November 2-4, 2018; and November 15-17, 2019. When developing contracts with the hotel, the APA's primary consideration is hotel availability. Given its size and meeting requirements, there are a limited amount of properties that can accommodate the Assembly. In addition, the Association must be mindful of other association meetings taking place in November (such as the AMA) as well as the Thanksgiving holiday weekend.

When the contract process begins for meetings after 2019, the APA can consider scheduling after the US Election day but (given the factors outlined above) cannot guarantee that this will be feasible each year.