Assembly
November 7-9, 2014

Assembly Meeting Materials

PLEASE CLICK ON ITEM/ITEM NUMBER TO VIEW ITEM

Final Agenda

Draft Summary of Actions

1. Remarks of the Board of Trustees
   - 1.C Treasurer's Report
     - 1.C.1 Statement of Activities

2. Report of the CEO and Medical Director

3. Report of the Speaker
   - 3.A General Report
   - 3.B Reports of the Meetings of the Board of Trustees
     - 3.B.1 Final Summary of Actions, May 2014
     - 3.B.2 Final Summary of Actions, July 2014
     - 3.B.3 Draft Summary of Actions, September 2014

4. Report of the Speaker-Elect
   - 4.A General Report
   - 4.B Report of the Joint Reference Committee
     - 4.B.1 Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist
     - 4.B.2 Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services
     - 4.B.3 Retain Position Statement: Relationship Between Treatment and Self Help
     - 4.B.4 Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions
     - 4.B.5 Retain Position Statement: Elder Abuse, Neglect and Exploitation
     - 4.B.6 Retain Position Statement: Discriminatory Disability Insurance Coverage
     - 4.B.7 Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations
     - 4.B.8 Retain Position Statement: State Mental Health Services
     - 4.B.9 Retain Position Statement: Universal Access to Health Care
     - 4.B.10 Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion
     - 4.B.11 Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment
     - 4.B.12 Retire Position Statement: Psychotherapy and Managed Care

4.B.13 Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks

4.B.14 Retire Position Statement: Active Treatment

4.B.15 Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter

4.B.16 Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded

4.B.17 Retain Position Statement: Abortion and Women's Reproductive Health Care Rights

4.B.18 Retain Position Statement: Xenophobia, Immigration and Mental Health

4.B.19 Retire Position Statement: Juvenile Death Sentences

4.B.20 Retain Position Statement: Peer Review of Expert Testimony

4.B.21 Retain Position Statement: Joint Resolution Against Torture

4.B.22 Retain Position Statement: Moratorium on Capital Punishment in the United States

4.B.23 Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment

4.B.24 Retain Position Statement: Insanity Defense

4.B.25 Retain Position Statement: Psychiatric Participation in Interrogation of Detainees

4.B.26 Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury

4.B.27 Retain Position Statement: Mentally Ill Prisoners and Death Row

4.B.28 Retain Position Statement: Diminished Responsibility in Capital Sentencing

4.B.29 Retain Position Statement: Endorsement of the Physician-Patient Covenant

4.B.30 Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents

5. Report of the Recorder

5.A Final Minutes of the May 2-4, 2014 Assembly Meeting *(approved at November 2014 Assembly meeting)*

5.A.1 Final Summary of Assembly Actions, May, 2014 *(approved at November 2014 Assembly meeting)*

5.B List of Members and Invited Guests

5.C Voting

5.C.1 Voting Strength 2014-2015

5.C.2 Audience Response System (ARS) Voting Instructions

5.D Report of the Assembly Executive Committee (AEC) meetings
5.D.1 Report of the AEC meetings, May 2014
5.D.2 Report of the AEC meeting, July, 2014 *(approved at November 2014 AEC meeting)*

6. Report of the Rules Committee
   - 6.A Action Assignments and Reference Committee Rosters
   - 6.B Consent Calendar
   - 6.C Special Rules of the Assembly

7. Reports From Assembly Committees –*Assembly Committees may submit reports onsite which would be included in onsite distributions*
   - 7.A Nominating Committee
   - 7.B Committee on Procedures
   - 7.C Committee on Public & Community
   - 7.D Committee of Minority and Underrepresented Groups
   - 7.E Committee of Early Career Psychiatrists
   - 7.F Committee of Resident-Fellow Members (*formerly Members-in-Training*)
   - 7.G Committee of Assembly Allied Organization

8. Reports from APA Councils
   - 8.A Council on Addiction Psychiatry
   - 8.B Council on Advocacy and Government Relations
   - 8.C Council on Children, Adolescents and Their Families
   - 8.D Council on Communications
   - 8.E Council on Geriatric Psychiatry
   - 8.F Council on Healthcare Systems and Financing
   - 8.G Council on International Psychiatry
   - 8.H Council on Medical Education and Lifelong Learning
   - 8.I Council on Minority Mental Health and Health Disparities
   - 8.J Council on Psychiatry and Law
   - 8.K Council on Psychosomatic Medicine
   - 8.L Council on Quality Care
     Memo RE: Approval of new APA Clinical Practice Guidelines
   - 8.M Council on Research

9. Standing Committees

   9.A Ethics Committee: Ethics Annotation: Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"

10. Reports from Special Components
    - 10.A AMA APA Delegation

11. Reports from Area Councils
    - 11.A Area 1 Council
    - 11.B Area 2 Council
    - 11.C Area 3 Council
    - 11.D Area 4 Council
    - 11.E Area 5 Council
    - 11.F Area 6 Council
    - 11.G Area 7 Council

12. Final Action Papers

APPROVED

12.A Direct to Consumer Advertising

12.B E-prescribing of Controlled Substances

12.C Telepsychiatry

12.D Critical Psychiatrist Shortages at Federal Medical Centers

12.E EHR for Psychiatrists

12.G Integrating Buprenorphine Maintenance Therapy with Primary Mental Health

12.K Standardization of Psychiatric Nurse Practitioner Training

12.L Conversion of the Components Directory to an Online-only Format

12.M ASM DSM Component

12.N Exploration: Whether to Add Some Symptoms to the Next DSM

12.P Neurodevelopmental

12.S Assembly Allied Organizations and Sections Liaison (AAOSL) Committee Name Change

FAILED

12.F Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders

12.O Medical Term for “Lack of Physical Exercise”

12.Q Replacing “Personality Disorder” with “Syndrome”

WITHDRAWN

12.H Production and Distribution of The APA Mini Reference to Inform Patient Care During Training and Lifelong Practice

12.I Addressing the Educational Specifics and Training Needs of International Medical Graduates

12.J The Impact of the Diminishing Number of IMGs on the Care of the Underserved Populations

12.R District Branch President-Elect Orientation

POSTPONED

13.A: Action Paper: Psychiatric Treatment of High Risk Patient-Community Role

13.B: Action Paper: Allow Deputies to Vote

American Psychiatric Association

Assembly

Grand Ballroom III/IV
JW Marriott, Washington, D.C.
November 7-9, 2014

AGENDA

1st PLENARY— FRIDAY, November 7, 2014, 2:00 PM- 3:00 PM

2:00 p.m. **Call to Order- 81st Meeting of the APA Assembly** — Jenny L. Boyer, MD, JD, PhD, Speaker

2:05 p.m. **Speaker's Welcome and Report** — Jenny L. Boyer, MD, JD, PhD, Speaker

Introduction of New Assembly Members
Jenny L. Boyer, MD, JD, PhD, Glenn Martin, MD, and Daniel Anzia, MD

2:20 p.m. **5. Report of the Recorder** — Daniel Anzia, MD

Quorum Declaration

A. Minutes of the previous Assembly meeting
Action: Will the Assembly vote to approve the minutes of its May 2-4, 2014 meeting?

B. List of Members and Invited Guests (see written report for information)

C. Voting Strength (see written report for information)
1. **Voting strength for November 2014 and May 2015**
2. **Electronic Voting**

D. Report of the Assembly Executive Committee (see written report for information)
1. **AEC meeting notes, May 2 and May 5, 2014**
2. **AEC meeting notes, July 25-26, 2014**

cc Indicates item is on the Consent Calendar

1st PLENARY — FRIDAY, November 7, 2014, 2:00 PM- 3:00 PM- CONTINUED

2:30 p.m. **6.** **Report of the Rules Committee** — Melinda Young, MD

A. Action Assignments & Reference Committee Rosters
(see written report for information)

B. Consent Calendar

1. Request to remove items from and add items to the Consent Calendar
   Action: Will the Assembly vote to approve the Consent Calendar?

C. Special Rules of the Assembly

Action: Will the Assembly vote to approve the Special Rules of the Assembly?

2:40 p.m. **10.** **Report of Special Components**

B. American Psychiatric Association Political Action Committee (APA*PAC*) — Charles Price, MD, Member, American Psychiatric Association Political Action Committee

2:50 p.m. **Assembly Reorganization** —
Jenny L. Boyer, MD, JD, PhD, Glenn Martin, MD, and Daniel Anzia, MD

3:00 p.m. **Recess**

cc Indicates item is on the Consent Calendar

2nd PLENARY — SATURDAY, November 8, 2014, 10:00 AM- 12:00 noon

10:00 a.m. **2. Report from the APA CEO and Medical Director** — Saul Levin, MD, MPA

10:20 a.m. **APA Communications** — Jason Young, Chief of Communications

10:30 a.m. **The Assembly and the District Branches/State Associations** — Bonnie Cook, Executive Director, Arkansas Psychiatric Society & Kentucky Psychiatric Medical Association, Chair, DB/SA Executive Staff

10:45 a.m. **Report on APA Finances**
1.C. Treasurer — Frank Brown, MD, Treasurer

12. Action Papers/Items

11:00 a.m. **Reference Committee 1** — Lawrence Gross, MD, Chair

Advocating for the Patient

	2014A2 4.B.2	Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services
cc	2014A2 4.B.29	Retain Position Statement: Endorsement of the Patient-Physician Covenant
cc	2014A2 4.B.30	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents
	2014A2 12.A	Direct to Consumer Advertising

11:20 a.m. **Reference Committee 2** — Robert Roca, MD, Chair

Advocating for the Profession

2014A2 12.B	E-prescribing of Controlled Substances
2014A2 12.C	Telepsychiatry
2014A2 12.D	Critical Psychiatrist Shortages at Federal Medical Centers
2014A2 12.E	EHR for Psychiatrists
2014A2 12.F	Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders

11:40 a.m. **3. Reports and Dialogue with the APA President and Assembly Speaker** — Paul Summergrad, MD, and Jenny L. Boyer, MD, JD, PhD

B. Reports of the Meetings of the Board of Trustees
(see written report for information)

1. **Board of Trustees Summary of Actions, May 2014**
2. **Board of Trustees Summary of Actions, July 2014**
3. **Board of Trustees Draft Summary of Actions, September 2014**

12:00 pm — 12:55 pm Assembly Luncheon — Grand Ballroom I

cc Indicates item is on the Consent Calendar

3rd PLENARY — SATURDAY, November 8, 2014, 1:00 PM- 3:00 PM

1:00 p.m. **7. Report from Assembly Committees**

A. Nominating Committee — Melinda Young, MD, Chair

Opportunity to nominate "from the floor"

1:15 p.m. **Veteran's Affairs Psychiatry** — Marsden McGuire, MD, Deputy Chief Consultant for Mental Health Standards of Care, Veterans Health Administration

12. Action Papers/Items — continued

1:45 p.m. **Reference Committee 3** — Leslie Gise, MD, Chair

Supporting Education, Training, Career Development

2014A2 4.B.1	Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist
2014A2 12.G	Integrating Buprenorphine Maintenance Therapy with Primary Mental Health
2014A2 12.H	Production and Distribution of The APA Mini Reference to Inform Patient Care during Training and Lifelong Practice
2014A2 12.I	Addressing the Educational Specifics and Training Needs of International Medical Graduates
2014A2 12.J	The Impact of the Diminishing Number of IMGs on the Care of the Underserved Populations
2014A2 12.K	Standardization of Psychiatric Nurse Practitioner Training

2:05 p.m. **Reference Committee 4** — John de Figueiredo, MD, Chair

Defining and Supporting Professional Values

2014A2 8.L.1	Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation
2014A2 8.L.2	Substance Use Assessment
2014A2 8.L.3	Assessment of Suicide Risk
2014A2 8.L.4	Assessment of Risk for Aggressive Behaviors
2014A2 8.L.5	Assessment of Cultural Factors
2014A2 8.L.6	Assessment of Medical Health
2014A2 8.L.7	Quantitative Assessment
2014A2 8.L.8	Involvement of the Patient in Treatment Decision-Making
2014A2 8.L.9	Documentation of the Psychiatric Evaluation
2014A2 13.A	Psychiatric Treatment of High Risk Patient-Community Role

2:25 p.m. **Reference Committee 5** — Melvin P. Melnick, MD, Chair

Enhancing the Scientific Basis of Psychiatric Care/Governance Issues

cc	2014A2 12.L	Conversion of the Components Directory to an Online-only Format
	2014A2 12.M	Assembly DSM Component
	2014A2 12.N	Exploration: Whether to Add Some Symptoms to the Next DSM
	2014A2 12.O	Medical Term for "Lack of Physical Exercise"
cc	2014A2 12.P	Neurodevelopmental
	2014A2 12.Q	Replacing "Personality Disorder" with "Syndrome"
	2014A2 12.R	District Branch President-Elect Orientation
	2014A2 12.S	Assembly Allied Organization and Sections Liaison (AAOSL) Committee Name Change
	2014A2 13.B	Allow Deputies to Vote

cc Indicates item is on the Consent Calendar

3rd PLENARY — SATURDAY, November 8, 2014, 1:00 PM- 3:00 PM- CONTINUED

2:45 p.m. **4. Report and Dialogue with the APA President-Elect and Assembly Speaker- Elect** —
Renée Binder, MD, and Glenn Martin, MD

B. Reports of the Meetings of the Joint Reference Committee
(see written report for information)

1. **Joint Reference Committee, Summary of Actions, May 2014**
2. **Joint Reference Committee, Draft Summary of Actions, October 2014**

3:00 p.m. **Recess of Plenary**

3:00 p.m. - 4:00 p.m. **Assembly Work Group/Committee Meetings**

Assembly Work Group on Access to Care — Capitol Ballroom E
Assembly Work Group on Communications — Grand Ballroom I
Assembly Work Group on Legislative Affairs — Capitol Ballroom D
Assembly Work Group on Long Range Planning — Grand Ballroom II
Assembly Work Group on Maintenance of Certification (MOC) — Capitol Ballroom F
Assembly Work Group on Mentorship — Capitol Ballroom K
Assembly Work Group on Public Affairs — Capitol Ballroom H/J
Assembly Committee on Public & Community Psychiatry — Congressional, Lobby Level
Assembly Liaisons to the Steering Committee on Practice Guidelines — Commerce Room

4:00 p.m. - 5:30 p.m. **Area Councils**

Area 1 — Capitol Ballroom D
Area 2 — Capitol Ballroom E
Area 3 — Capitol Ballroom F
Area 4 — Grand Ballroom I
Area 5 — Grand Ballroom II
Area 6 — Capitol Ballroom K
Area 7 — Capitol Ballroom H/J

6:00 p.m. - 7:30 p.m. **Assembly Reception** — Foyer, Ballroom Level

cc Indicates item is on the Consent Calendar

4th Plenary — SUNDAY, November 9, 2014, 8:00 AM- 11:00 AM

8:00 a.m. **Profile of Courage Presentation** — R. Scott Benson, MD

8:20 a.m. **Assembly Survey Results** — Jenny L. Boyer, MD, JD, PhD, Speaker

8:45 a.m. **12. Action Papers/Items — continued**

Area Council and Assembly Group Action Assignments

cc	2014A2 4.B.3	Retain Position Statement: Relationship between Treatment and Self Help All Areas: Primary – Area 2, Secondary – Area 6
cc	2014A2 4.B.4	Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions All Areas: Primary – Area 1, Secondary – ECPs
cc	2014A2 4.B.5	Retain Position Statement: Elder Abuse, Neglect and Exploitation All Areas: Primary – RFMs, Secondary – Area 4
cc	2014A2 4.B.6	Retain Position Statement: Discriminatory Disability Insurance Coverage All Areas: Primary – Area 7, Secondary – M/URs
cc	2014A2 4.B.7	Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations All Areas: Primary – AAOLs, Secondary – Area 3
cc	2014A2 4.B.8	Retain Position Statement: State Mental Health Services All Areas: Primary – Area 5, Secondary – ECPs
cc	2014A2 4.B.9	Retain Position Statement: Universal Access to Healthcare All Areas: Primary – Area 6, Secondary – Area 1
cc	2014A2 4.B.10	Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion All Areas: Primary – Area 3, Secondary – Area 2
cc	2014A2 4.B.11	Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment All Areas: Primary – AAOLs, Secondary – Area 5
cc	2014A2 4.B.12	Retire Position Statement: Psychotherapy and Managed Care All Areas: Primary – ECPs, Secondary – RFMs
cc	2014A2 4.B.13	Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks All Areas: Primary – M/URs, Secondary – Area 1
cc	2014A2 4.B.14	Retire Position Statement: Active Treatment All Areas: Primary – Area 3, Secondary – Area 7
cc	2014A2 4.B.15	Retire Position Statement: Endorsement of *Medical Professionalism in the New Millennium: A Physician Charter* All Areas: Primary – ECPs, Secondary – Area 2
cc	2014A2 4.B.16	Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded All Areas: Primary – Area 1, Secondary – RFMs
cc	2014A2 4.B.17	Retain Position Statement: Abortion and Women's Reproductive Health Care Rights All Areas: Primary – Area 4, Secondary – Area 6
cc	2014A2 4.B.18	Retain Position Statement: Xenophobia, Immigration and Mental Health All Areas: Primary – RFMs, Secondary – Area 3
cc	2014A2 4.B.19	Retire Position Statement: Juvenile Death Sentences All Areas: Primary – Area 6, Secondary – AAOLs
cc	2014A2 4.B.20	Retain Position Statement: Peer Review of Expert Testimony All Areas: Primary – M/URs, Secondary – Area 4

cc Indicates item is on the Consent Calendar

cc	2014A2 4.B.21	Retain Position Statement: Joint Resolution against Torture of the American Psychiatric Association and the American Psychological Association All Areas: Primary – Area 5, Secondary – ECPs
cc	2014A2 4.B.22	Retain Position Statement: Moratorium on Capital Punishment in the United States All Areas: Primary – Area 7, Secondary – M/URs
cc	2014A2 4.B.23	Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment All Areas: Primary – Area 2, Secondary – Area 5
cc	2014A2 4.B.24	Retain Position Statement: Insanity Defense All Areas: Primary – Area 7, Secondary – Area 6
cc	2014A2 4.B.25	Retain Position Statement: Psychiatric Participation in Interrogation of Detainees All Areas: Primary – RFMs, Secondary – AAOLs
cc	2014A2 4.B.26	Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury All Areas: Primary – Area 5, Secondary – Area 1
cc	2014A2 4.B.27	Retain Position Statement: Mentally Ill Prisoners on Death Row All Areas: Primary – M/URs, Secondary – Area 7
cc	2014A2 4.B.28	Retain Position Statement: Diminished Responsibility in Capital Sentencing All Areas: Primary – Area 1, Secondary – Area 2
	2014A2 9.A	Ethics Annotation: Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" All Areas: Primary – Area 3, Secondary – Area 4

9:05 a.m. **7. Report from Assembly Committees**

A. Assembly Committee on Procedures — A. David Axelrad, MD, Chair

9:25 a.m. **Committee on RBRVS, Codes and Reimbursements Report** — Ronald Burd, MD, Chair

9:45 a.m. **Report of the Assembly Liaisons to the Steering Committee on Practice Guidelines** — Daniel Anzia, MD, Chair

10:00 a.m. **Next Steps from the Assembly Work Groups/Committees**

Access to Care — Joseph Mawhinney, MD, Chair
Communications — Steven Daviss, MD, Chair
Legislative Affairs — John Bailey, MD, Chair
Long Range Planning — Melinda Young, MD, Chair
Maintenance of Certification — James R. Batterson, MD, Chair
Mentorship — Ludmila De Faria, MD, Chair
Public Affairs — Jeffrey Borenstein, MD, Chair
Assembly Committee on Public & Community Psychiatry — Laurence Miller, MD, Chair

10:45 a.m. **Summary and Next Steps** — Jenny L. Boyer, MD, JD, PhD, Speaker

10:50 a.m. **Unfinished Business** (if not addressed earlier on the Assembly floor)

10:55 a.m. **New Business**

11:00 a.m. **Adjournment**

cc Indicates item is on the Consent Calendar

******ACTION PAPER DEADLINE FOR MAY ASSEMBLY: March 26, 2015**

Future Meeting:
May Assembly
May 15-17, 2015
Toronto, Ontario, CANADA

cc Indicates item is on the Consent Calendar

Assembly
November 7-9, 2014
Washington, D.C.

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 4.B.1	Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist	The Assembly voted to approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.2	Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services	The Assembly voted to approve the Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services. **[Note: The position statement was approved after a motion to reconsider with section 1.D removed from the document.]**	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.3	Retain Position Statement: Relationship between Treatment and Self Help	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Relationship between Treatment and Self Help*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.4	Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.5	Retain Position Statement: Elder Abuse, Neglect and Exploitation	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Elder Abuse, Neglect and Exploitation*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.6	Retain Position Statement: Discriminatory Disability Insurance Coverage	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Discriminatory Insurance Coverage*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 4.B.7	Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 4.B.8	Retain Position Statement: State Mental Health Services	The Assembly voted to retain the Position Statement: State Mental Health Services and refer the Position Statement to the Assembly Committee on Public and Community Psychiatry for review.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives Assembly Executive Committee, January 2015
2014 A2 4.B.9	Retain Position Statement: Universal Access to Healthcare	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Universal Access to Healthcare*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.10	Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.11	Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.12	Retire Position Statement: Psychotherapy and Managed Care	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Psychotherapy and Managed Care*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.13	Retire Position Statement: Proposed Guidelines for Handling the Transfer of Provider Networks	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.14	Retire Position Statement: Active Treatment	The Assembly voted to <u>retain</u> the Position Statement: *Active Treatment* and refer it to the Council on Healthcare Systems and Financing for review and possible updating.	Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.15	Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.16	Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A2 4.B.17	Retain Position Statement: Abortion and Women's Reproductive Health Rights	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Abortion and Women's Reproductive Health Rights*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.18	Retain Position Statement: Xenophobia, Immigration and Mental Health	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Xenophobia, Immigration and Mental Health*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.19	Retire Position Statement: Juvenile Death Sentences	The Assembly voted, on its Consent Calendar, to retire the Position Statement: *Juvenile Death Sentences*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.20	Retain Position Statement: Peer Review of Expert Testimony	The Assembly voted, on its Consent Calendar, to retire the Position Statement*: Peer Review of Expert Testimony*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.21	Retain Position Statement: Joint Resolution against Torture	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Joint Resolution against Torture*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.22	Retain Position Statement: Moratorium on Capital Punishment in the United States	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Moratorium on Capital Punishment in the United States*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.23	Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.24	Retain Position Statement: Insanity Defense	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Insanity Defense*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.25	Retain Position Statement: Psychiatric Participation in the Interrogation of Detainees	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A2 4.B.26	Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.27	Retain Position Statement: Mentally Ill Prisoners on Death Row	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Mentally Ill Prisoners on Death Row*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.28	Retain Position Statement: Diminished Responsibility in Capital Sentencing	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Diminished Responsibility in Capital Sentencing*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.29	Retain Position Statement: Endorsement of the Patient-Physician Covenant	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Endorsement of the Patient-Physician Covenant*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014A2 4.B.30	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents	The Assembly voted, on its Consent Calendar, to retain the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*.	Board of Trustees, December, 2014 FYI- Joint Reference Committee, January 2015 FYI – Melvin Sabshin Library and Archives
2014 A2 5.A	Will the Assembly vote to approve the minutes of the May 2-4, 2014, meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the May 2-4, 2014 meeting.	Chief Operating Officer • Association Governance
2014 A2 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2014A2, 4.B.3, 4.B.14, 12.L, and 12.P were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2014 A2 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2014 A2 7.A	The Assembly voted to accept the report of the Nominating Committee.	The Assembly voted to accept the report of the Nominating Committee. The slate of candidates for the May 2015 Assembly election is as follows: Speaker-Elect: Daniel Anzia, M.D., Area 4 Robert Roca, M.D., Area 3 Recorder: Ludmila De Faria, M.D., Area 5 Theresa Miskimen, M.D., Area 3	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 7.B.1	Will the Assembly vote to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 9.c. Committee on Procedures* on page 9, which identifies and highlights essential core elements/requirements for DB/SA Bylaws to serve in the best interest of the APA, and emphasizes that the Committee on Procedures is responsible for the procedural review of the DB/SA Bylaws rather than a legal review?	The Assembly voted to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 9.c. Committee on Procedures* on page 9, which identifies and highlights essential core elements/requirements for DB/SA Bylaws to serve in the best interest of the APA. The change also clarifies that the Committee on Procedures is responsible for the procedural review of individual DB/SA Bylaws and that each DB/SA is responsible for appropriate legal review in keeping with the laws within their individual jurisdiction.	Chief Operating Officer • Association Governance FYI Chief of Membership & RFM-ECPs • DB/SA & Ethics Office
2014 A2 7.B.2	Will the Assembly vote to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 9.c. Committee on Procedures* on page 9 to eliminate the process of "certification" requirements from the DB/SA?	The Assembly voted to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 9.c. Committee on Procedures* on page 9 to eliminate the process of "certification" requirements from the DB/SA.	Chief Operating Officer • Association Governance
2014 A2 7.B.3	Will the Assembly vote to approve the revised language to the *Procedural Code in Article II: Area Councils, 8.c Nomination of Trustees* on page 14 to reflect current APA Operations Manual language that a member of the APA Nominating Committee cannot accept nomination for a position on the Board of Trustees during their two-year term on the committee?	The Assembly voted to approve the revised language to the *Procedural Code in Article II: Area Councils, 8.c Nomination of Trustees* on page 14 to reflect current APA Operations Manual language that a member of the APA Nominating Committee cannot accept nomination for a position on the Board of Trustees during their two-year term on the Nominating Committee.	Chief Operating Officer • Association Governance
2014A2 7.B.4	Will the Assembly vote to approve the revised language to the Procedural Code in Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs, on page 14 to reflect the current APA Bylaws, noting that the procedures for filling vacancies of Area Trustee position are determined by the Board of Trustees?	The Assembly voted to postpone voting on the revised language to the Procedural Code (*Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs) until the May 2015 Assembly.* *Note:* The APA Bylaws, state that the Board may select any voting member of the Association to fill an Area Trustee vacancy for the remainder of the term. The bylaws also require that there be one Area Trustee from each Assembly-designated Area.	Assembly, May 2015 Chief Operating Officer • Association Governance APA General Counsel

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A2 7.B.5	Will the Assembly vote to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 8.f. Executive Sessions* on page 8 to clarify that legal advice given by the APA General Counsel does not require exposure to the membership?	The Assembly voted to approve the proposed amendment to the *Procedural Code in Article I: The Assembly, 8.f. Executive Sessions* on page 8 to clarify that legal advice given by the APA General Counsel does not require exposure to the membership.	• Chief Operating Officer Association Governance APA General Counsel
2014A2 7.B.6	Will the Assembly vote to approve the proposed amendment to the *Procedural Code in Article II: Area Councils, 8. Area Nominating Committee* on page 14 to leave it at the discretion of the Area Councils whether or not the Area Trustee have a vote in the Area Council meeting?	The Assembly voted to approve the proposed amendment to the *Procedural Code in Article II: Area Councils, 8. Area Nominating Committee* on page 14 to leave it at the discretion of the Area Councils whether or not the Area Trustee has a vote within Area Council meetings.	Chief Operating Officer • Association Governance
2014A2 7.B.7	Will the Assembly vote to approve the set of proposed amendments to the *Procedural Code in Article V: Allied Organizations* on page 19 listing the procedures to become an Assembly Allied Organization, their application requirements, the procedures for exceptions to providing those application requirements, the approval process for application, and the obligations of the liaison and their organization to the APA?	The Assembly voted to approve the set of proposed amendments to the *Procedural Code in Article V: Allied Organizations* on page 19 listing the procedures to become an Assembly Allied Organization, their application requirements, the procedures for exceptions to providing those application requirements, the approval process for application, and the obligations of the liaison and their organization to the APA.	Chief Operating Officer • Association Governance
2014A2 8.L.1	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 1- Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 1- Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.2	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.3	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.4	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors.	FYI: Chief of Policy, Programs &, Partnerships • Research

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A2 8.L.5	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5-Assessment of Cultural Factors	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5-Assessment of Cultural Factors.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.6	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6-Assessment of Medical Health	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6-Assessment of Medical Health.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.7	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7-Quantitative Assessment	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7-Quantitative Assessment.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.8	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8-Involvement of the Patient in Treatment Decision-Making	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8-Involvement of the Patient in Treatment Decision-Making.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 8.L.9	Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9-Documentation of the Psychiatric Evaluation	The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9-Documentation of the Psychiatric Evaluation.	Board of Trustees, December, 2014 FYI: Chief of Policy, Programs &, Partnerships • Research
2014A2 9.A	Will the Assembly approve the proposed annotations to Section 9 of "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry?"	The Assembly did not approve the proposed annotations to Section 9 of "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry".	Chief of Membership & RFM-ECP • Office of Ethics, DB/SA Relations & Strategic Development (For information)
2014 A2 12.A	Direct to Consumer Advertising	The Assembly voted to approve action paper 2014A2 12.A which asks that: 1. The American Psychiatric Association shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010. 2. The American Psychiatric Association shall adopt the Position Statement on Direct to Consumer Advertising, 2014.	Joint Reference Committee, January 2015
2014 A2 12.B	E-prescribing of Controlled Substances	The Assembly voted to approve action paper 2014A2 12.B which asks: 1. That the APA refer this issue to our delegation to the AMA to support the option for electronically prescribed controlled substances as aligned with federal regulations and express the importance of adopting such standards to allow for this to the relevant components of the e-prescribing chain. 2. The APA will develop a position statement supporting the options of electronic prescribing of controlled substances.	Joint Reference Committee, January 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 12.C	Telepsychiatry	The Assembly voted to approve action paper 2014A2 12.C which asks: That the Council on Quality Care be charged to develop and recommend a plan to the Board of Trustees facilitating the defining of, adoption and use of telepsychiatry, including but not limited to research priorities, standardization of regulation, training, development of evidence based treatment guidelines, resolution of impediments, and addressing incentives/disincentives to its adoption. That the Board of Trustees of the American Psychiatric Association act to review, revise, approve and implement said plan.	Joint Reference Committee, January 2015
2014 A2 12.D	Critical Psychiatrist Shortages at Federal Medical Centers	The Assembly voted to approve action paper 2014A2 12.D which asks that the American Psychiatric Association's Council on Advocacy and Government Relations design and implement a plan to best address the compensation and benefits of Bureau of Prisons psychiatrists that is substantially below community levels including other federally employed physicians as it prevents recruitment and retention of medical providers.	Joint Reference Committee, January 2015
2014 A2 12.E	EHR for Psychiatrists	The Assembly voted to approve action paper 2014A2 12.E which asks: 1. That the APA Administration assist the Committee on Mental Health Information Technology to explore the feasibility of sending out a Request for Proposal to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of one or more products for consideration by members. 2. That the APA Administration report their progress to the Assembly via the Assembly listserv by March 1, 2015.	Joint Reference Committee, January 2015 Chief Operating Officer • Information Systems & Technology
2014 A2 12.F	Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders	The Assembly did not approve action paper 2014A2 12.F.	N/A
2014 A2 12.G	Integrating Buprenorphine Maintenance Therapy with Mental Health	The Assembly voted to approve action paper 2014A2 12.G which asks that APA create a task force composed of appropriate council membership to focus on issues salient to integrated Substance Use Disorders and MI treatment including buprenorphine therapy.	Joint Reference Committee, January 2015
2013 A2 12.H	Production and Distribution of The APA Mini Reference to Inform Patient Care during Training and Lifelong Practice	The paper was withdrawn by the author.	N/A
2014 A2 12.I	Addressing the Educational Specifics and Training Needs of International Medical Graduates	The paper was withdrawn by the author.	N/A
2014 A2 12. J	The Impact of the Diminishing Number of IMGs on the Care of Underserved Populations	The paper was withdrawn by the author.	N/A

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 12.K	Standardization of Psychiatric Nurse Practitioner Training	The Assembly voted to approve action paper 2014A2 12.K which asks that the American Psychiatric Association (APA) liaise with the American Nurses Credentialing Center and American Psychiatric Nurses Association to standardize Psychiatric Nurse Practitioner Programs to ensure consistent training across programs.	Office of the CEO and Medical Director • Chief of Policy, Programs & Partnerships
2014 A2 12.L	Conversion of the Components Directory to an Online-only Format	The Assembly voted to approve action paper 2014A2 12.L which asks: That the APA transitions the component directory information to a printable online-only format, beginning with the creation of a fully functional online version. That staff create a simple "user guide" for member instructions on accessing directory information via the online-only format. That APA members would have the option to print the directory from the online version That the APA staff report progress on this action paper to the November 2015 Assembly.	Chief Operating Officer • Association Governance • Information Systems & Technology
2014 A2 12.M	Assembly DSM Component	The Assembly voted to approve action paper 2014A2 12.M which asks that: 1] The Assembly establishes a DSM eleven person Committee composed of: • each of the seven Areas, • an M/UR Representative • an RFM Representative • an ECP representative • an AAOL representative 2] That the above representatives be chosen by the Members they represent, i.e., Area 1 selects their representative. 3] The Speaker shall recommend that the Chair and Vice-chair be appointed as full members to the APA's DSM Steering Committee.	Assembly Executive Committee, January 2015
2014 A2 12.N	Exploration: Whether to Add Some Symptoms to the Next DSM	The Assembly voted to approve action paper 2014A2 12.N which asks that the DSM Steering Committee explores adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5.	Joint Reference Committee, January 2015
2014 A2 12.O	Medical Term for "Lack of Physical Exercise"	The Assembly did not approve action paper 2014A2 12.O.	N/A
2014 A2 12.P	Neurodevelopmental	The Assembly voted, on its Consent Calendar, to approve action paper 2014A2 12.P which asks that future printings of DSM use "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" throughout DSM-5.	Joint Reference Committee, January 2015
2014 A2 12.Q	Replacing "Personality Disorder" with "Syndrome"	The Assembly did not approve action paper 2014A2 12.Q.	N/A
2014 A2 12.R	District Branch President-Elect Orientation	The action paper was withdrawn by the author.	N/A
2014 A2 12.S	Assembly Allied Organizations and Sections Liaison (AAOSL) Committee Name Change	The Assembly voted to approve action paper 2014A2 12.S which asks that the Assembly Allied Organizations and Sections Liaisons will be renamed the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS). Members of ACROSS shall be called Subspecialty Representatives or Section Representatives, as appropriate.	Assembly Executive Committee, January 2015

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A2 13.A	Psychiatric Treatment of High Risk Patient-Community Role	The Assembly voted to postpone action paper 2014A2 13.A until its May 2015 meeting.	Assembly, May 2015
2014 A2 13.B	Allow Deputies to Vote	The Assembly voted to postpone action paper 2014A2 13.B until its May 2015 meeting.	Assembly, May 2015

AMERICAN PSYCHIATRIC ASSOCIATION
REPORT OF THE TREASURER
TO THE
Assembly
Frank Brown, MD, Treasurer

The Financial Review for August 2014 is attached to this summary as *Appendix 1.*

APA Unrestricted Revenue is lower than prior year by $15.3M but above budget by $5.3M due primarily to sales of DSM.

Membership Revenues – Dues receipts are greater than prior year receipts and year to date receipts are higher than the budget.

Non-DSM Publishing – Publishing revenues are $1.1M above budget due to advertising sales in Psych News.

DSM – Sales for DSM are above budget by $2.9M.

Continuing Medical Education – Annual Meeting revenue is $10.8M which is above budget. Professional attendance at the New York meeting was almost 15,000, the highest since 2006. Exhibitor attendance was also higher than it had been in recent years.

Unrestricted Expenses are lower than prior year by $1.8M, and higher than budget by $502K, due primarily to timing. Vacancy rates are higher in the first quarter; the savings is approximately $1.5M year to date.

Foundation – Revenues for the Research, Public Education, and Fund Raising activities of the Foundation are $511K above budget. Expenses are $178K higher than budget due primarily to timing.

Non-operating Activity reflects investment increases or decreases in both the short term and long term portfolio, net of investment fees. The APA's long term funds are invested along with the Foundation reserve. The total amount in the long-term portfolio is $126M, of which $71.3M is held by the APA. A joint APA-APF Investment Oversight Committee monitors the portfolio return, managers, and activity on a regular basis with the assistance of outside investment advisors. Since December 31, 2013, the APA has experienced a net gain of $2.8M.

Statement of Financial Position

APA Assets increased $3.1M over December 2013 balances, primarily due to the increase in the portfolio. APA's share of the long term investment portfolio is $71.3M, which is 55% of the total portfolio. APF holds $56M. Total investments are $128M.

APA's liabilities decreased approximately $11.2M, due primarily to the recognition of deferred membership dues and subscription revenue.

American Psychiatric Association
Summary Financial Review

January 1, 2014 to August 31, 2014

Prepared by the Office of the Chief Financial Officer
September 23, 2014

Distribution:

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Y. Davison	S. Levin	A. Schatzberg	Executive Committee

American Psychiatric Association and Affiliates
For the Eight Months Ended August 31, 2014

Unrestricted Net Income **APA - Operating**	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Revenue	60,765	45,499	40,187	5,312	51,069	54,875	3,806	81,053
Expense	35,647	33,806	33,304	(502)	51,326	51,428	(102)	52,677
APA Net Unadjusted	25,118	11,693	6,883	4,810	(257)	3,447	3,704	28,376
APF - Operating								
Revenue	892	1,651	1,140	511	1,678	1,829	151	1,288
Expense	2,904	3,282	3,104	(178)	5,236	5,423	(187)	5,345
APF Net Unadjusted	(2,012)	(1,631)	(1,964)	333	(3,558)	(3,594)	(36)	(4,057)
Consolidated - NonOperating								
Investment Income - LT	7,475	5,474	57	5,417	85			14,384
Investment Income - ST	3	3	0	3	0			4
Less: Portfolio Management Fees	(132)	(84)	(70)	(14)	(105)			(223)
Net Consolidated - Non Operating	7,346	5,393	(13)	5,406	(20)			14,165

Comments:

APA:

Revenue is above budget YTD by $5.3M, primarily due to Membership revenue by $527k, Publishing by $1.1M, DSM sales $3M, and Annual Meeting Registration (meeting and CME courses) by $744k.

Expenses are above budget YTD by $502k. DSM expenses are $600k greater than budgeted YTD. Publishing overhead costs are above YTD budget by $553k, and CME and meetings expenses are $756k above YTD budget. This is offset by Advocacy---expenses are down by $340k, Division of Communications by $286k, Division of Policy, Programs and Partnerships by $791k and Division of Operations by $294k.

APA adjusted net income is expected to be above budget by $3.4M, due primarily to DSM Sales and Annual Meeting registration.

APF:
Revenue (unrestricted) is above YTD budget by $511K.
Expenses are above budget by $178k, due to timing.
The Foundation is projected to end the year on target.

APA - Operating	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Revenue	60,765	45,499	40,187	5,312	51,069	54,875	3,806	81,053
Expense	35,647	33,806	33,304	(502)	51,326	51,428	(102)	52,677
APA Net Unadjusted (A)	25,118	11,693	6,883	4,810	(257)	3,447	3,704	28,376
DSM Revenue	29,947	10,725	7,804	2,921	11,622	14,050	2,428	42,091
DSM Expenses	7,414	3,110	2,510	(600)	3,789	4,843	(1,054)	12,982
Net, DSM (B)	22,533	7,615	5,294	2,321	7,833	9,207	1,374	29,109
APA Net without DSM (A-B)					(8,090)	(5,760)	2,330	(733)
Normalized DSM Net Income					5,800	5,800	0	5,800
Adjusted Net Income					**(2,290)**	**40**	**2,330**	**5,067**

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
UNRESTRICTED REVENUE:								
Membership								
Membership Dues	$9,120	$9,211	$8,958	$253	$9,690	$9,690		$9,713
Insurance Program	1,375	1,250	1,250		1,500	1,500		1,625
Membership Affinity Programs	79	73	78	(5)	81	81		110
APA Job Bank	414	612	435	177	650	650		660
APA Store	11	6	10	(4)	11	11		11
List Sales	21	49	53	(4)	80	60	(20)	50
Board Funds		110		110				
Membership Subtotal	***11,020***	***11,311***	***10,784***	***527***	***12,012***	***11,992***	***(20)***	***12,169***
Advocacy								
PAC	4	4	5	(1)	7	7		6
Advocacy Leadership Conference		10	10		15	22	7	19
Healthcare Systems & Financing								53
Advocacy Subtotal	***4***	***14***	***15***	***(1)***	***22***	***29***	***7***	***78***
Communications								
OCPA	22							38
Let's Talk Facts		22	31	(9)	46	46		
Communications Subtotal	***22***	***22***	***31***	***(9)***	***46***	***46***		***38***
Publishing								
American Journal of Psychiatry	2,880	3,505	3,515	(10)	5,272	5,372	100	5,118
Journal of Psychiatric Services	396	653	600	53	900	893	(7)	806
Psychiatric News	2,078	2,839	2,125	714	3,187	3,384	197	3,344
Books	3,008	3,716	3,819	(103)	5,684	5,549	(135)	4,803
Specialty Journals	359	198	234	(36)	351	351		564
Psychiatry Online	504	349		349				6
Electronic Publishing	11	42		42				8
Legacy content	34	139	33	106	50	150	100	23
Publishing Subtotal	***9,270***	***11,441***	***10,326***	***1,115***	***15,444***	***15,699***	***255***	***14,672***
DSM								
DSM IV	392	125	12	113	20	125	105	707
DSM 5	29,555	10,600	7,792	2,808	11,602	13,925	2,323	41,384
DSM Subtotal	***29,947***	***10,725***	***7,804***	***2,921***	***11,622***	***14,050***	***2,428***	***42,091***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Continuing Medical Education								
Annual Meeting	8,981	10,762	10,126	636	10,126	11,063	937	9,414
CME Products and Accreditation	376	150	200	(50)	230	330	100	795
Institute on Psychiatric Services	157	188	90	98	350	375	25	393
Focus Journal	812	815	755	60	1,132	1,206	74	1,272
Continuing Medical Education Subtotal	***10,326***	***11,915***	***11,171***	***744***	***11,838***	***12,974***	***1,136***	***11,874***
Research								
Practice Guidelines	39	67	53	14	80	80		84
Research Subtotal	***39***	***67***	***53***	***14***	***80***	***80***		***84***
Other Income								
Miscellaneous Income	137	4	3	1	5	5		47
Other Income Subtotal	***137***	***4***	***3***	***1***	***5***	***5***		***47***
Total Unrestricted Revenue	***60,765***	***45,499***	***40,187***	***5,312***	***51,069***	***54,875***	***3,806***	***81,053***
UNRESTRICTED EXPENSES:								
Membership Direct Expenses								
Membership Services	1,029	1,162	1,164	2	1,797	1,797		1,709
Division of Membership		186	177	(9)	279	285	(6)	
Membership Recruitment	108	112	99	(13)	174	174		126
Insurance Program		13		(13)		50	(50)	
Membership Affinity Programs			9	9	14	14		13
APA Job Bank (membership)	4	15	17	2	19	19		4
APA Store	15	12	10	(2)	13	13		18
Ethics/DB Relations	155	138	159	21	250	250		248
Library & Archives	62	86	92	6	140	140		96
International Programs	3	67	64	(3)	128	128		28
Membership Direct Expenses Subtotal	***1,376***	***1,791***	***1,791***		***2,814***	***2,870***	***(56)***	***2,242***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Advocacy								
APA PAC Operating Expenses	107	121	109	(12)	148	148		159
Division of Advocacy	243	3	208	205	328	316	12	367
Government Relations	1,035	783	983	200	1,545	1,545		1,643
Leadership Conference		177	202	25	202	180	22	163
CALF	50	195	117	(78)	175	195	(20)	85
Advocacy Subtotal	***1,435***	***1,279***	***1,619***	***340***	***2,398***	***2,384***	***14***	***2,417***
Communications								
Communications & Public Affairs	585	759	950	191	1,442	1,502	(60)	992
Association Marketing	64	153	226	73	370	370		121
Let's Talk Facts		3	5	2	7	7		
Communications Subtotal	***649***	***915***	***1,181***	***266***	***1,819***	***1,879***	***(60)***	***1,113***
Publishing								
American Journal of Psychiatry	1,233	1,265	1,378	113	2,104	2,112	(8)	1,959
Journal of Psychiatric Services	430	389	450	61	694	694		700
Psych News	1,532	1,444	1,360	(84)	2,088	2,370	(282)	2,391
Unrelated Business Income Tax	333	133	133		200	200		88
Books	571	881	768	(113)	1,598	1,548	50	1,163
Specialty Journals	157	151	88	(63)	131	131		247
Psychiatry Online	(60)	28		(28)				
Electronic Publishing	(48)	87		(87)				(67)
Publishing Subtotal	***4,148***	***4,378***	***4,177***	***(201)***	***6,815***	***7,055***	***(240)***	***6,481***
Publishing Overhead								
Publishing Administration	440	444	402	(42)	632	632		657
Publishing Overhead	(503)	(133)	(338)	(205)	(507)	(507)		(745)
Sales & Marketing	637	657	561	(96)	879	979	(100)	1,152
Customer Service	979	802	671	(131)	1,028	1,028		1,276
Advertising Sales	509	581	434	(147)	650	750	(100)	787
Periodical Services	16	6		(6)		6	(6)	27
Editorial Development	688	737	808	71	1,248	1,250	(2)	1,220
Editorial Production	572	605	608	3	965	819	146	843
Publishing Overhead Subtotal	***3,338***	***3,699***	***3,146***	***(553)***	***4,895***	***4,957***	***(62)***	***5,217***
DSM								
DSM IV	119	3	12	9	20	3	17	268
DSM 5 Publishing Costs	1,384	987	1,053	66	1,601	1,637	(36)	2,714
DSM 5 Development	5,911	2,120	1,445	(675)	2,168	3,203	(1,035)	10,000
DSM Subtotal	***7,414***	***3,110***	***2,510***	***(600)***	***3,789***	***4,843***	***(1,054)***	***12,982***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Continuing Medical Education								
Annual Meeting	3,139	4,246	3,522	(724)	3,611	4,569	(958)	3,176
CME Products & Accreditation	312	300	186	(114)	296	325	(29)	509
Department of Meetings & Conventions	513	437	466	29	740	740		730
Office of Scientific Programs	208	292	346	54	537	537		427
Institute on Psychiatric Services	44	37	33	(4)	416	416		355
Focus Journal	105	151	154	3	231	231		181
Continuing Medical Education Subtotal	***4,321***	***5,463***	***4,707***	***(756)***	***5,831***	***6,818***	***(987)***	***5,378***
Policy, Plans, and Partnerships								
Division of Policy, Programs, & Partnership		207	199	(8)	315	315		
Division of Education	581	563	711	148	1,099	1,099		877
Healthcare Systems and Financing	638	832	1,073	241	1,611	1,566	45	1,201
Office of Diversity & Health Equity	364	289	352	63	605	605		610
Research - Director's Office	425	599	739	140	736	736		633
Office of QIPS	306	169	347	178	551	551		461
Practice Guidelines	143	182	200	18	358	358		209
DSM Other	1,243	(11)		11				1,630
Board Funds - Diversity and Health Equity	1							
Policy, Plans, and Partnerships Subtotal	***3,701***	***2,830***	***3,621***	***791***	***5,275***	***5,230***	***45***	***5,621***
Operations								
Division of Operations		216	241	25	385	385		
APA Answer Center	179	89	210	121	323	323		301
Human Resources	248	599	391	(208)	636	863	(227)	445
Information Technology	1,759	1,780	2,190	410	3,444	3,444		3,235
Association Mgmt System	263	273	211	(62)	323	323		363
Association Governance Office	508	511	519	8	821	821		810
Operations Subtotal	***2,957***	***3,468***	***3,762***	***294***	***5,932***	***6,159***	***(227)***	***5,154***
Foundation - Programs								
Practice Research Network								5
Foundation - Programs Subtotal								***5***
Foundation								
Foundation Operating	262	290	290		435	435		312
Foundation Subtotal	***262***	***290***	***290***		***435***	***435***		***312***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Administration								
Office of the CEO	1,183	1,285	1,475	190	2,133	2,133		2,350
Staff Strategic Planning		7	10	3	200	200		15
Finance and Administrative Services	1,549	1,561	1,542	(19)	2,470	2,470		2,488
Building Operations	1,819	1,906	2,055	149	3,083	3,089	(6)	2,777
Employee Benefits	3,478	3,651	3,453	(198)	5,360	5,385	(25)	1,579
Fringe Benefits Allocation	(3,192)	(3,221)	(3,699)	(478)	(5,900)	(5,900)		(5,197)
Legal Office	377	395	773	378	1,248	848	400	752
Budget Reallocation					286	(1,814)	2,100	
Proposed Merit (COLA)			29	29	292	292		
Administration Subtotal	***5,214***	***5,584***	***5,638***	***54***	***9,172***	***6,703***	***2,469***	***4,764***
Organization-Wide Expenses								
General	503	551	672	121	809	759	50	704
APA Overhead	(995)	(1,174)	(1,175)	(1)	(1,763)	(1,794)	31	(1,926)
Recovered OH Costs	(36)	(28)	(30)	(2)	(45)	(45)		(41)
Organization-Wide Expenses Subtotal	***(528)***	***(651)***	***(533)***	***118***	***(999)***	***(1,080)***	***81***	***(1,263)***
Governance & Components Expenses								
Assembly	485	594	481	(113)	879	879		830
Board, Operating	453	538	502	(36)	836	836		613
Standing Committees	123	126	157	31	334	334		205
Direct DB Support								
DB Leadership	53	232	56	(176)	293	293		191
DB StateAssociation Funds	120							120
BD DB Infrastructure Grants	24	8	23	15	61	61		48
Components	66	86	71	(15)	422	422		204
Board Funds	36	18		(18)		25	(25)	43
Board Strategic Planning		48	105	57	325	325		
Governance & Components Expenses Subtotal	***1,360***	***1,650***	***1,395***	***(255)***	***3,150***	***3,175***	***(25)***	***2,254***
Total Unrestricted Expenses	***35,647***	***33,806***	***33,304***	***(502)***	***51,326***	***51,428***	***(102)***	***52,677***
Unrestricted Operating Net Income/(Loss)	***25,118***	***11,693***	***6,883***	***4,810***	***(257)***	***3,447***	***3,704***	***28,376***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
Statement of Activities - New Version

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
TEMPORARILY RESTRICTED ACTIVITY								
Total Temp Restricted Revenue	82	43	97	(54)	122	122		104
Total Temp Restricted Expenses	186	142	152	10	217	217		221
Temp Restricted Net Income/(Loss)	***(104)***	***(99)***	***(55)***	***44***	***(95)***	***(95)***		***(117)***
NON-OPERATING ACTIVITY:								
Investment Income - LT	2,450	2,814	57	2,757	85			5,709
Investment Income - ST	3	3		3				4
Less: Portfolio Management Fees	(41)	(38)	(57)	19	(85)			(78)
Non-Operating Net Income/(Loss)	2,412	2,779	0	2,779	0			5,635

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Membership								
Membership Dues Revenue	$9,120	$9,211	$8,958	$253	$9,690	$9,690		$9,713
Insurance Program Revenue	1,375	1,250	1,250		1,500	1,500		1,625
List Sales Revenue	21	49	53	(4)	80	60	(20)	50
Membership Revenue	10,516	10,510	10,261	249	11,270	11,250	(20)	11,388
Membership Services Expense	1,029	1,162	1,164	2	1,797	1,797		1,709
Insurance Program		13		(13)		50	(50)	
Division of Membership		186	177	(9)	279	285	(6)	
Membership Recruitment	108	112	99	(13)	174	174		126
Ethics/DB Relations	155	138	159	21	250	250		248
Library & Archives	62	86	92	6	140	140		96
International Programs	3	67	64	(3)	128	128		28
Membership Expense	1,357	1,764	1,755	(9)	2,768	2,824	(56)	2,207
Contribution	***9,159***	***8,746***	***8,506***	***240***	***8,502***	***8,426***	***(76)***	***9,181***
Membership Affinity Programs Revenue	79	73	78	(5)	81	81		110
Direct Expense			9	9	14	14		13
Contribution	***79***	***73***	***69***	***4***	***67***	***67***		***97***
APA Job Bank Revenue	414	612	435	177	650	650		660
Direct Expense	4	15	17	2	19	19		4
Contribution	***410***	***597***	***418***	***179***	***631***	***631***		***656***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
APA Store Revenue	11	6	10	(4)	11	11		11
Direct Expense	15	12	10	(2)	13	13		18
Contribution	***(4)***	***(6)***		***(6)***	***(2)***	***(2)***		***(7)***
Membership Subtotal	***9,644***	***9,410***	***8,993***	***417***	***9,198***	***9,122***	***(76)***	***9,927***
Advocacy								
PAC	4	4	5	(1)	7	7		6
APA PAC Operating Expenses	107	121	109	(12)	148	148		159
Contribution	***(103)***	***(117)***	***(104)***	***(13)***	***(141)***	***(141)***		***(153)***
Advocacy Leadership Conference		10	10		15	22	7	19
Expense		177	202	25	202	180	22	163
Contribution		***(167)***	***(192)***	***25***	***(187)***	***(158)***	***29***	***(144)***
Advocacy Subtotal	***(103)***	***(284)***	***(296)***	***12***	***(328)***	***(299)***	***29***	***(297)***
Communications								
OCPA & Let's Talk Facts	22	22	31	(9)	46	46		38
Expense		3	5	2	7	7		
Communications Subtotal	***22***	***19***	***26***	***(7)***	***39***	***39***		***38***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Publishing								
American Journal of Psychiatry	2,880	3,505	3,515	(10)	5,272	5,372	100	5,118
Direct Expense	1,233	1,265	1,378	113	2,104	2,112	(8)	1,959
Contribution	***1,647***	***2,240***	***2,137***	***103***	***3,168***	***3,260***	***92***	***3,159***
Journal of Psychiatric Services	396	653	600	53	900	893	(7)	806
Direct Expense	430	389	450	61	694	694		700
Contribution	***(34)***	***264***	***150***	***114***	***206***	***199***	***(7)***	***106***
Psychiatric News	2,078	2,839	2,125	714	3,187	3,384	197	3,344
Direct Expense	1,532	1,444	1,360	(84)	2,088	2,370	(282)	2,391
Unrelated Business Income Tax	333	133	133		200	200		88
Contribution	***213***	***1,262***	***632***	***630***	***899***	***814***	***(85)***	***865***
Books	3,008	3,716	3,819	(103)	5,684	5,549	(135)	4,803
Direct Expense	571	881	768	(113)	1,598	1,548	50	1,163
Contribution	***2,437***	***2,835***	***3,051***	***(216)***	***4,086***	***4,001***	***(85)***	***3,640***
Specialty Journals	359	198	234	(36)	351	351		564
Direct Expense	157	151	88	(63)	131	131		247
Contribution	***202***	***47***	***146***	***(99)***	***220***	***220***		***317***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Psychiatry Online	504	349		349				6
Direct Expense	(60)	28		(28)				
Contribution	***564***	***321***		***321***				***6***
Electronic Publishing	11	42		42				8
Direct Expense	(48)	87		(87)				(67)
Contribution	***59***	***(45)***		***(45)***				***75***
Legacy content Revenue	***34***	***139***	***33***	***106***	***50***	***150***	***100***	***23***
Publishing Administration	440	444	402	(42)	632	632		657
Publishing Overhead	(503)	(133)	(338)	(205)	(507)	(507)		(745)
Sales & Marketing	637	657	561	(96)	879	979	(100)	1,152
Customer Service	979	802	671	(131)	1,028	1,028		1,276
Advertising Sales	509	581	434	(147)	650	750	(100)	787
Periodical Services	16	6		(6)		6	(6)	27
Editorial Development	688	737	808	71	1,248	1,250	(2)	1,220
Editorial Production	572	605	608	3	965	819	146	843
Publishing Overhead Subtotal	***3,338***	***3,699***	***3,146***	***(553)***	***4,895***	***4,957***	***(62)***	***5,217***
Publishing Contribution	***1,784***	***3,364***	***3,003***	***361***	***3,734***	***3,687***	***(47)***	***2,974***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
DSM								
DSM IV	392	125	12	113	20	125	105	707
DSM 5	29,555	10,600	7,792	2,808	11,602	13,925	2,323	41,384
DSM IV Direct Expense	119	3	12	9	20	3	17	268
DSM 5 Publishing Costs	1,384	987	1,053	66	1,601	1,637	(36)	2,714
DSM 5 Development	5,911	2,120	1,445	(675)	2,168	3,203	(1,035)	10,000
DSM Contribution	***22,533***	***7,615***	***5,294***	***2,321***	***7,833***	***9,207***	***1,374***	***29,109***
Continuing Medical Education								
Annual Meeting	8,981	10,762	10,126	636	10,126	11,063	937	9,414
Direct Expense	3,139	4,246	3,522	(724)	3,611	4,569	(958)	3,176
Department of Meetings & Conventions	513	437	466	29	740	740		730
Office of Scientific Programs	208	292	346	54	537	537		427
Contribution	***5,121***	***5,787***	***5,792***	***(5)***	***5,238***	***5,217***	***(21)***	***5,081***
CME Products and Accredition	376	150	200	(50)	230	330	100	795
Direct Expense	312	300	186	(114)	296	325	(29)	509
Contribution	***64***	***(150)***	***14***	***(164)***	***(66)***	***5***	***71***	***286***
Institute on Psychiatric Services	157	188	90	98	350	375	25	393
Direct Expense	44	37	33	(4)	416	416		355
Contribution	***113***	***151***	***57***	***94***	***(66)***	***(41)***	***25***	***38***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Focus Journal	812	815	755	60	1,132	1,206	74	1,272
Direct Expense	105	151	154	3	231	231		181
Contribution	***707***	***664***	***601***	***63***	***901***	***975***	***74***	***1,091***
Continuing Medical Education Contribution	***6,005***	***6,452***	***6,464***	***(12)***	***6,007***	***6,156***	***149***	***6,496***
Practice Guidelines								
Practice Guidelines	39	67	53	14	80	80		84
Direct Expense	143	182	200	18	358	358		209
Contribution	***(104)***	***(115)***	***(147)***	***32***	***(278)***	***(278)***		***(125)***
Other Income	***137***	***4***	***3***	***1***	***5***	***5***		***47***
Foundation Expense	***262***	***290***	***290***		***435***	***435***		***312***
Total Contribution	***39,656***	***26,175***	***23,050***	***3,125***	***25,775***	***27,204***	***1,429***	***47,857***

American Psychiatric Association
For the Eight Months Ending August 31, 2014
APA Contribution Margin Report

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Association Initiatives:								
Advocacy Subtotal	1,328	981	1,308	327	2,048	2,056	(8)	2,095
Communications Subtotal	649	912	1,176	264	1,812	1,872	(60)	1,113
Policy Plans Programs Subtotal	3,558	2,648	3,421	773	4,917	4,872	45	5,412
Governance & Components Expenses Subtotal	1,360	1,650	1,395	(255)	3,150	3,175	(25)	2,254
Association Initiatives	***6,895***	***6,191***	***7,300***	***1,109***	***11,927***	***11,975***	***(48)***	***10,874***
Overhead Costs:								
Operations Subtotal	2,957	3,468	3,762	294	5,932	6,159	(227)	5,154
Administration Subtotal	5,214	5,584	5,638	54	9,172	6,703	2,469	4,764
Organization-Wide Expenses Subtotal	(528)	(651)	(533)	118	(999)	(1,080)	81	(1,263)
Overhead costs	***7,643***	***8,401***	***8,867***	***466***	***14,105***	***11,782***	***2,323***	***8,655***
Unrestricted Operating Income (Loss)	***25,118***	***11,583***	***6,883***	***4,700***	***(257)***	***3,447***	***3,704***	***28,328***

American Psychiatric Association

Statements of Financial Position

	08/31/13	12/31/13	08/31/14
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$7,591	$11,236	$2,078
Accounts Receivable, Net	11,911	10,091	6,582
Pledges Receivable		125	
Advances to Affiliates	349	1,373	1,068
Publications Inventory, Net	1,643	1,567	1,263
Prepaid Expenses and Other Current Assets	935	1,147	1,670
Total Current Assets	*22,429*	*25,539*	*12,661*
Investments in Marketable Securities	37,228	52,908	71,284
Property and Equipment, Net	2,031	2,161	2,055
Intangible	5,827	5,749	5,593
Development Costs	15,969	11,843	9,724
TOTAL ASSETS	***83,484***	***98,200***	***101,317***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	9,061	7,761	5,740
Dues Payable (DB & Other)	251	1,341	238
Deferred Revenue:			
Membership Dues	86	5,057	76
Grants and Contracts			
Other	4,120	7,690	4,696
Total Current Liabilities	*13,518*	*21,849*	*10,750*
Deferred Rent Liability	1,400	1,345	1,191
TOTAL LIABILITIES	***14,918***	***23,194***	***11,941***
NET ASSETS			
Beginning Balance			
Unrestricted, Undesignated	44,149	24,971	39,348
Unrestricted, Designated	23,521	49,184	49,276
Temporarily Restricted	864	851	752
Permanently Restricted	32		
ENDING BALANCE, NET ASSETS	***68,566***	***75,006***	***89,376***
TOTAL LIABILITIES AND EQUITY	***83,484***	***98,200***	***101,317***

Statement of Activities - APF

For the Eight Months Ending August 31, 2014

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
UNRESTRICTED REVENUE:								
D&HE Federal Awards	$404	$855	$537	$318	$805	$876	$71	$594
Research Federal Awards	217	326	315	11	473	473		363
General Unrestricted	271	470	288	182	400	480	80	331
Total Unrestricted Revenue	***892***	***1,651***	***1,140***	***511***	***1,678***	***1,829***	***151***	***1,288***
UNRESTRICTED EXPENSES:								
Research Federal Awards	280	353	306	(47)	473	473		442
D&HE Federal Awards	427	876	517	(359)	805	876	(71)	631
Office of Diversity & Health Equity	217	236	296	60	413	480	(67)	387
Institute on Research & Educ	164	178	205	27	251	251		265
Practice Research Network	394	312	294	(18)	465	465		647
Office of AIDS/HIV	70	66	97	31	173	173		116
Programs	1	28	10	(18)	14	41	(27)	105
National Partnership	134	125	125		186	186		203
Library & Archives	60	43	55	12	93	93		95
Board Funds	2	2	1	(1)	397	308	89	3
Subtotal, Program	***1,749***	***2,219***	***1,906***	***(313)***	***3,270***	***3,346***	***(76)***	***2,894***
New Initiatives Fund					100	65	35	
Foundation Grants	51	46	103	57	150	150		170
Subtotal, Grants and Other	***51***	***46***	***103***	***57***	***250***	***215***	***35***	***170***

Statement of Activities - APF

For the Eight Months Ending August 31, 2014

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
Foundation Operating	122	104	83	(21)	182	182		364
Fund Raising	205	184	212	28	335	335		310
Subsidiary Boards	50	27	43	16	63	63		79
Old C3 Administration								20
Subtotal, Administration	***377***	***315***	***338***	***23***	***580***	***580***		***773***
APA Overhead	995	1,174	1,175	1	1,763	1,794	(31)	1,926
Recovered OH Costs	(268)	(472)	(418)	54	(627)	(512)	(115)	(418)
Subtotal, Overhead	***727***	***702***	***757***	***55***	***1,136***	***1,282***	***(146)***	***1,508***
Total Unrestricted Expenses	***2,904***	***3,282***	***3,104***	***(178)***	***5,236***	***5,423***	***(187)***	***5,345***
Unrestricted Operating Net Income/(Loss)	***(2,012)***	***(1,631)***	***(1,964)***	***333***	***(3,558)***	***(3,594)***	***(36)***	***(4,057)***

Statement of Activities - APF

For the Eight Months Ending August 31, 2014

	August 2013 Actual YTD	August 2014 Actual YTD	August 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Annual Budget Vs. Projection Fav (Unfav)	2013 Annual Actual
TEMPORARILY RESTRICTED ACTIVITY:								
Temp Restricted Revenue	517	615	1,301	(686)	1,945	1,509	(436)	2,193
Temp Restricted Expenses	1,646	1,478	1,597	119	2,367	2,011	356	2,199
Temp Restricted Net Income/(Loss)	***(1,129)***	***(863)***	***(296)***	***(567)***	***(422)***	***(502)***	***(80)***	***(6)***
NON-OPERATING ACTIVITY:								
Investment Income - LT	5,025	2,660		2,660				8,675
Less: Portfolio Management Fees	(91)	(45)	(13)	(32)	(20)	(20)		(144)
Non-Operating Grant								(2)
Non-Operating Income/(Loss)	***4,934***	***2,615***	***(13)***	***2,628***	***(20)***	***(20)***		***8,529***

American Psychiatric Foundation

Statements of Financial Position

	08/31/13	12/31/13	08/31/14
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$2,787	$8,704	$4,299
Accounts Receivable, Net	4		
Pledges Receivable	15	207	6
Grant Receivable, Net	193	122	692
Prepaid Expenses and Other Current Assets	6		
Total Current Assets	*3,005*	*9,033*	*4,997*
Investments in Marketable Securities	54,743	52,466	56,358
Property and Equipment, Net	90	75	45
TOTAL ASSETS	***57,838***	***61,574***	***61,400***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	203	225	237
Advances to Affiliates	337	1,352	1,045
Deferred Revenue			7
TOTAL LIABILITIES	***540***	***1,577***	***1,289***
NET ASSETS			
Beginning Balance			
Unrestricted, Undesignated	21,833	13,740	14,720
Unrestricted, Designated	31,040	40,593	40,591
Temporarily Restricted	3,531	4,570	3,673
Permanently Restricted	894	1,094	1,127
ENDING BALANCE, NET ASSETS	***57,298***	***59,997***	***60,111***
TOTAL LIABILITIES AND EQUITY	***57,838***	***61,574***	***61,400***

INVESTMENTS

APA and Subsidiaries
Investment Balances as of July, 2014
Use in August CFO Report
(Dollars are in Thousands)

CASH & CASH EQUIVALENTS

	Held by	COST	MKT VALUE
CASH & CASH EQUIVALENTS			
Cash and Cash Equivalents	B of A, SunTrust LB	$6,215	$ 6,215
APA c6 ST Invest Account	SunTrust	179	179
TOTAL CASH & CASH EQUIVALENTS		**$ 6,394**	**$ 6,394**

INVESTMENTS IN MARKETABLE SECURITIES

		COST	Market VALUE	APA Jun 2014 YTD Returns *	Benchmark 06-14 YTD Returns *	Index Name	Current Portfolio Allocation	Target Allocation +/- 10%
EQUITIES								
All Cap Equities - Core	Vanguard Total Stock Fnd	35,953	47,221	7.0%	7.0%	Wilshire 5000 Total Mkt	37.6%	
Int'l All-Cap Core	Vanguard Int'l Stock	8,093	8,941	5.9%	5.6%	MSCI ACWI ex US	7.1%	
Small Cap Int'l Equities	Brandes Intl Small Cap	6,014	5,964		4.8%	MSCI EAFE	4.7%	
Int'l Equity Mutual Fund	Dodge & Cox	7,147	9,301	7.9%	5.6%	MSCI ACWI ex US	7.4%	
SUBTOTAL EQUITIES		**$ 57,207**	**$ 71,427**				56.8%	70%
MUTUAL & FIXED INCOME FUNDS								
Intermediate Term Bond	Baird FDS Inc	12,961	12,847	4.8%	3.9%	Barclay's Aggregate	10.2%	
High Yield Bonds	Delaware Pooled	2,372	2,564	5.7%	5.5%	Barclay's High Yield	2.0%	
Floating Rt CL I Mutual Fund	Eaton Vance	6,482	6,879	4.3%	2.2%	CSFB Leverated	5.5%	
Bond Index Mutual Fund	Vanguard Bond Fund	9,530	9,670	3.9%	3.9%	Barclay's Aggregate	7.7%	
SUBTOTAL MUTUAL FUNDS		**31,345**	**31,960**				25.4%	30%
Liquidity								
SunTrust Money Market		515	515				0.4%	
SUBTOTAL CASH		**$ 515**	**$ 515**				0.4%	0%
TOTAL PORTFOLIO IN SUNTRUST CUSTODY		**$ 89,067**	**$ 103,902**				82.7%	
HEDGE & Real Estate Funds								
Common Sense Long **		232	264	0.9%	1.3%	HFRX Equity Hedge Ind	0.2%	
Pinehurst	May	9,400	10,715	4.6%	1.8%	HFRX Global Hedge Ind	8.5%	
Prime Property LT Real Estate		9,325	10,785	5.6%	5.0%	NFI	8.6%	
SUBTOTAL HEDGE & RE FUNDS		**18,957**	**21,764**				17.3%	
LONG TERM POOLED APA, APF Total		**$ 108,024**	**$ 125,666**	5.7%	5.0%	Composite Benchmark	100.0%	
OTHER LT INVESTMENT ACCOUNTS								
CRUT and Pooled Income Trusts	MS, SunTrust	107	131					
Rabbi Trust/Def. Exec. Comp. Accts	NY Life/State Street	1,845	1,845					
Insurance Trust	Wilmington Trust	521	521					
TOTAL INVESTMENTS IN MARKETABLE SECURITIES		**$ 110,497**	**$ 128,163**					
TOTAL CASH AND INVESTMENTS		**$ 116,891**	**$ 134,557**					

* NOTE: (1) returns are shown annualized and net of fees

Statement

Advocacy - reflects costs associated with the Departments of Government Relations, the APA PAC, the Fund to Defeat Psychologist Prescribing, the CALF, and the Office of Communications & Public Affairs. In addition, the division expenses include the costs for the activities of Healthcare Systems and Financing, Managed Care Newsletter, and the Business & Industry Initiative.

Education - includes revenues and costs associated with the Division of Education, the Departments of Graduate and Undergraduate Education, Women's Programs, Continuing Medical Education, Ethics, the publication of PSA-R prior to 2003, and the Focus Journal beginning in 2003.

Minority/National Affairs - includes the Office of Minority/National Affairs as well as the costs associated with the newly created Spurlock Office.

Practice Guidelines - revenue is from sales of Practice Guidelines.

Private Awards - includes Revenues and Expenses related to temporarily restricted contributions. Please note that the transfer to/(from) reserves on the Income Statement does not include the Indirect Cost Recovery.

Research - includes Expenses associated with APIRE and PRN, QIPS, Children's Programs, Practice Guidelines, and HIV/AIDS. Research Revenues include temporarily restricted contributions from Private Awards and sales of Practice Guidelines.

Business Operations - includes expenses associated with sales of membership lists and labels. In addition, it includes costs associated with Accounting & Finance, Human Resources, Information Systems, Membership Services, and Governance Support.

Other Income - represents income that is received throughout the year but is not identified to a specific project or activity by year-end.

Organization-wide Expenses - include costs for the Office of the CEO, employee benefits, facilities, legal, insurance program, general insurance, costs for the bad debt expense, portfolio management fees, interest expense for the line of credit, special needs fund, and credit card sales fees. We are exploring the feasibility of being reimbursed out of the Insurance Program for the legal costs associated with Legion.

Governance - represents costs associated with the Board of Trustees, Assembly, Constitutional Committees and component related activities.

Operating Income/Loss - reflects the amount of surplus or (deficit) from operating activities.

4/26/2010

Balance Sheet

Assets

Cash and Cash Equivalents - includes the cash accounts held at Bank of America, M&T Bank and SunTrust Bank.

Accounts Receivable - represents amounts billed to customers of APA publications (e.g. books and advertising sales).

Pledges Receivable - represents the unconditional promises to give and are recorded on a monthly basis.

Grants Receivable – reflects actual activity that has been billed but the funds have not yet been received.

Advances to Affiliates - reflects intercompany activity.

Publications Inventory - the cost of the APA/APPI book inventory, including DSM. It will be expensed when the inventory is sold.

Prepaid Expenses and Other Current Assets - reflects deposits paid in advance for meetings (hotels, air fare, exhibit space). This amount is expensed when the activity is held.

Investment in Marketable Securities - includes the investment accounts held by State Street, Sanford Bernstein, Morgan Stanley, and Private Capital.

Property and Equipment - the cost of APA assets such as computers, software, and furniture, less depreciation to date.

Deferred Expenses – represents costs for DSM-V, that will be expensed at the time of sales, and software development costs which will be depreciated when the software is put into use.

Investment in Medem - Represents the long-term investment in Medem.

Liabilities

Accounts Payable – represents unpaid vendor payments, accrued salaries, accrued vacation and pension benefits.

Dues Payable – represents the dues which APA has collected on behalf of affiliated organizations but have not yet paid the affiliate organization. Payments are made in the month following APA collecting the dues.

Assets Held for Other Organizations - represents monies received by the Insurance Trust in an insurance settlement that are due to other parties to the insurance claim.

Deferred Revenues – Membership Dues – reflects the lump sum dues program from members and dues payments received in the year prior to the dues year. APA accounts for the receipts from members in the fourth quarter of each year as deferred membership revenue and recognizes them as revenue in January of subsequent year.

Deferred Revenues – Other – represents payments received for journal subscriptions and funds received in advance for meetings, such as meeting exhibit spaces. APA accounts for the receipts from Annual Meeting in the fourth quarter of each year as deferred revenue and recognizes them as revenue in January of subsequent year.

Advances from Affiliates – reflects intercompany activity

Deferred Rent Liability – represents the difference between cash rent paid and the accrued rent expense. This line amount will increase until approximately half way through the lease agreement at which point it will begin to decrease.

Capital Lease Obligation – APA purchased furniture for the space in Rosslyn under a capital lease. At the time that the furniture was accepted by APA, the furniture asset was recorded as was the corresponding liability equal to the lease obligation as of the end of the year.

Net Assets

Net Assets are made up of the Unrestricted, Board designated, and Externally restricted funds.

Report of the
CEO and Medical Director
to the
APA Assembly

November 7-9, 2014

J.W. Marriott
Washington, DC

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

As the APA Administration implements this vision, the Association's governing bodies have begun to see robust successes for the association in these areas. Over the past year, APA underwent a Communications Audit conducted by Porter-Novelli. In its assessment, Porter-Novelli recommended that the APA hire a Chief Communications Officer who would not only oversee media relations and public affairs, but who would also lead integrated marketing and client and member communications.

To carry out this vision, the APA hired Jason Young, who started on July 1, 2014, to be APA's Chief Communications Officer. Jason previously worked at APA from 2003 until 2007 as the Office of Communications and Public Affair's Deputy Director. After his tenure at APA, Jason served in the senior leadership of two public affairs firms, ASGK Public Strategies, founded by David Axelrod and the Glover Park Group, founded by White House Press Secretary Joe Lockhart. Jason was an adjunct professor of communications at Georgetown University until 2012 when President Obama appointed him as the Deputy Assistant Secretary for Public Affairs at the U.S. Department of Health & Human Services.

Additionally, APA recently hired Rodger Currie as its Chief of Government Affairs, who started on October 6th. As of recent, Rodger served as the Executive Vice President of Government Affairs for West Health, a philanthropic medical research organization dedicated to lowering health care costs through technology and innovation. While at West Health, he was named one of Washington's "Top Lobbyists" by The Hill newspaper in 2012, which was the 11th consecutive time he earned this distinction. Rodger also served as Vice President for Global Government Affairs for Amgen and Senior Vice President for Law and Federal Affairs at PhRMA, where he

lead the association's highly successful advocacy efforts in developing and enacting the landmark 2003 Medicare prescription drug benefit legislation. Among these accomplishments, Rodger also served as Majority Counsel with the Committee on Energy and Commerce playing a role in the FDA Modernization Act as well as for the Medicare, Medicaid, and Children's Health Insurance provisions of the Balanced Budget Act of 1997.

As the association continues on through 4Q2014, APA will continue to focus on strategic issues, pursue more partnership opportunities, and continue to serve the needs and enhance the experience of APA members. The report outlines the APA Administration's progress in doing so for 3Q2014.

Strategic Issues

On September 30, the Centers for Medicare and Medicaid Services (CMS) posted data on specific payments or transfers from pharmaceutical companies to physicians in accordance with the Physician Sunshine Payment Act, part of the Affordable Care Act (ACA). CMS said in total there were 4.4M transactions recorded in the five-month period, about 550,000 physicians involved and about $3.5B in payments. But CMS also said 40% of the data was deidentified for various reasons and some data were simply unreported by the agency if, for example, it involved a "trade secret" or ongoing research. APA worked closely with the American Medical Association to address with CMS the many concerns over accuracy and the cumbersome process. We also monitored CMS's posting process, kept the leadership and membership involved through alerts and updates, provided information to the District Branches/State Associations (DBSAs) and the Call Center, and monitored news clips and social media to track how psychiatry and the APA was represented in the data. In the end, few mentions of specialties or specialists were cited in news coverage.

Also, APA is currently working on extending the Medicaid Bump for psychiatry. The ACA matched Medicaid payments for certain evaluation and management services to Medicare rates for 2013 and 2014 – hence providing a Medicaid payment "bump." While the original intent of this provision was to target primary care, the CMS expanded eligibility to include all subspecialists accredited by the American Board of Internal Medicine. This arbitrary regulatory decision excluded psychiatry, and other specialties, which play a pivotal role in providing evaluation and management services to patients enrolled under Medicaid. The Medicaid Bump policy expires in December, and APA is ramping up advocacy efforts that will begin immediately after the mid-term elections in order to push for our inclusion in the Medicaid Bump during the lame-duck session.

In conjunction with advocacy for the Medicaid Bump, APA recently launched *Engage2014!,* which is a grassroots initiative for members to connect with their congressional representatives during the congressional recess when APA members' representatives are visiting their home districts. Through this initiative, APA members are able contact their representatives through email or snail mail. APA Department of Government Relations (DGR) and the Department of Ethics, DB/SAs, and Strategic Development are coordinating this effort and can provide locations and times for town hall meetings or local political events with congressional representatives for members to attend. Additionally, APA DGR staff will readily assist APA

members in scheduling meetings with representatives in their home districts, and provide talking points and background information to assist them in conversations with their representatives.

Enhancing Partnerships

Since the May Assembly Meeting, the APA began a partnership with the National Association of Social Workers (NASW) in offering a "Social Workers" Track during the Institute on Psychiatric Services, which will hopefully increase attendance numbers of non-physicians at the conference. Additionally, APA leadership and administration has recently reached out to the American Psychological Association, and we are in the process of creating a collaborative ad campaign with the National Ad Council around suicide.

Membership

Total membership is 35,918 as of September 2014. This is an increase of 5.0% compared to the same time last year. To serve the needs of members and the Assembly, a new searchable, policy finder database was created and is located on the governance page at http://www.psychiatry.org/about-apa--psychiatry/governance. A link is also posted on the Newsroom page. Also, a new members-only resource was recently posted to the APA's website titled Building a Career in Psychiatry. Its purpose is to help medical students, residents, fellows and early career physicians successfully prepare for transition points in their medical career. The guide covers non-clinical topics that often emerge in conversations with younger members but are not typically covered in training. The resource has been posted on the newly reorganized resident page at http://www.psychiatry.org/residents and medical student page at http://www.psychiatry.org/medical-students.

Vision: Strategic Issues and Membership

Item: **Reorganization of the Communications Division**

Chief: **Jason Young, Chief Communications Officer**

A. <u>Division/Department Head</u>: Cathy Brown, Executive Editor, Psych News, and two vacant director posts

B. <u>Division/Offices Involved</u>: Office of Communications & Public Affairs, Office of Integrated Marketing, Psychiatric News

C. <u>Front-Burner Issue Background for 3Q 2014</u>: In its audit of the APA, Porter Novelli recommended that our three existing communications-oriented offices – OCPA, Integrated Marketing and Psychiatric News – transition to meet four functional needs: corporate communications; public affairs & public education; brand marketing; and membership & internal communications. After a careful review of the Porter Novelli audit, many discussions with directors and team members in APA's newly formed Communications Division, and two months of direct observation, the Administration is undertaking an action plan for reorganizing, clarifying and strengthening the work of the offices that make up the APA Communications Division.

D. <u>Staff Action/Response</u>: The Administration reconciled the audit recommendations with APA's staffing, culture, resources and requirements. Going forward, APA will have a "Corporate Communications & Public Affairs" office to serve as the organizational voice to external audiences – the media, opinion and policy elites and other stakeholders; a "Member Communication" office to serve as our voice, in writing and through other engaging media, to internal constituencies, current and prospective members, and District Branches/State Associations; and an "Integrated Marketing" office to manage and boost the APA brand and the organization's marketing of membership in the APA, products (meetings, education and publications) and social action.

The benefits of this more centralized communications model are many: a focus on an improved member experience where the APA's extent and value are clearer; a consistent message; better coordination; less duplication of effort; and stronger integration not only within the Division but also across the organization.

Vision: Strategic Issues and Membership

Item: **APA Real Estate Workgroup**

Chief: **Terri Swetnam, Chief Financial Officer**

A. Division/Department Head: Terri Swetnam, Finance

B. Division/Offices Involved: Office of the CEO and Medical Director, Office of General Counsel

C. Background: The APA's lease for its office space expires December 31, 2017. Because new space could require a 24-30 month build-out timeframe, the process to identify and select space is underway.

D. Staff Action/Response: A team of outside experts has been assembled to assist the Association in its exploration of options – including a real estate attorney, brokers, and architects. Given the project timeline, optimally a general "purchase or lease" decision would be made by year-end. To assist the Board in its review and decision-making, it is proposed that a Board Workgroup be established to work with staff on this project, with representation from the APA Board, APF Board, Assembly, and members at large.

1. Frank Brown, MD (Chair)
2. David Fassler, MD
3. Altha Stewart, MD (former APF BOD and President)
4. Gary Jacobson, MD
5. Carlos Pato, MD
6. Shastri Swaminathan, MD
7. Richard Harding, MD (Treasurer of APF)

A report from the workgroup on its final recommendations for "purchase or lease" in Virginia or Washington, D.C. is expected to be delivered at the December 2014 Board of Trustees meeting.

Vision: Strategic Issues and Membership

Item: **APA Liability Insurance Workgroup**

Chief: **Terri Swetnam, Chief Financial Officer**

A. <u>Division/Department Head</u>: Terri Swetnam, Chief Financial Officer

B. <u>Division/Offices Involved</u>: Office of the CEO and Medical Director, Membership Department, Division of Finance, and Office of General Counsel

C. <u>Front-Burner Issue Background</u>: APA's contract with American Professional Agency, Inc. expires in May 2015. The workgroup was established to work with the CEO, administration, and outside consultants on the issues related to the May 2015 expiration of the professional liability insurance program APA currently endorses; and to report and make initial recommendations to the Board of Trustees no later than December 2014. Workgroup members are:

William Arroyo, MD (Chair)
Rahn Bailey, MD
Lama Bazzi, MD
Frank Brown, MD
David Fassler, MD
Richard Harding, MD
Paul O'Leary, MD
Carolyn Robinowitz, MD
Ravi Shah, MD

D. <u>Staff Action/Response</u>: The ALS Group has been hired to provide consultation to the workgroup and administration for this project. It is an independent risk management and insurance consultant that does not sell insurance, nor is it affiliated or associated with any firms that sell insurance. The APA has worked with Al Sica, President of The ALS Group in the past two negotiations (with PRMS and APA, Inc.) for this program.

Vision: Strategic Issues, Membership and Partnership

Item: **Mental Health Parity**

Chief: **Colleen Coyle, General Counsel and Kristin Kroeger, Chief of Policy, Programs, and Partnerships**

A. <u>Division/Department Head</u>: Sam Muszysnki, Director, Director of the Office of Healthcare Systems and Financing.

B. <u>Division/Offices Involved</u>: Office of the General Counsel and Office of Healthcare Systems and Financing.

C. <u>Front-Burner Issue Background</u>: On September 25th, the federal court in Connecticut dismissed APA's case against Anthem. In its reasoning for dismissing the case, the judges determined that APA's did not have standing to bring the cases rather than the merits of APA's claim in the Connecticut case.

D. <u>Staff Action/Response</u>: APA is currently addressing the issue of standing in an amicus brief in the Second Circuit Court of Appeals which we filed in support of NYSPA's lawsuit against United. Additionally, the APA is developing a strategy to continue the fight to enforce the Mental Health Parity and Addiction Equity Act, including:

- Advocacy with state attorneys general and insurance departments in conjunction with DB/SAs;
- Advocacy in Congress for a Mental Health/Substance Use Disorders Bill of Rights; and
- Support of legal challenges around the country.

Vision: Strategic Issues and Membership

Item: **PsychiatryOnline Platform Migration**

Chief: **Shaun Snyder, Esq.**

A. Division/Department Head: Rebecca Rinehart

B. Division/Offices Involved: Publishing

C. Front-Burner Issue Background: The contract for the current platform host of PsychiatryOnline ends October 2014. After a thorough assessment of the technological capabilities of other vendors, the decision was made to switch to a new technology partner. The new platform will launch on October 29.

D. Staff Action/Response: The new platform offers a cost-effective, flexible way to deliver existing content and develop new products and features. It allows editors to set up new pages devoted to specific content areas to highlight emerging topics such as integrated care, and will showcase APP's increasing collection of video. The platform accommodates automated loading of new and revised content, which allows book content to be updated and expanded more easily and quickly. Publishing staff, working with IT and the vendor, have developed a plan for migration of the content to the new platform, replicating the functionality and features of the existing platform and providing new book content. This plan includes messaging to inform members, sales partners, and customers with regular updates and Customer Call Center training to respond to inquiries. For most customers this move will be transparent and will require no action on their part. The CME component will be transferred to a new Learning Management System also in development that will host journal CME as well as independent self-assessment programs.

Vision: Membership

Item: **Membership Update**

Chief: **Jon Fanning, Chief Membership and RFM-ECP Officer**

A. Division/Department Head: Susan Kuper, Director, Membership Department

B. Division/Offices Involved: All departments are involved.

C. Front-Burner Issue Background:

Total membership is 35,918 as of September 2014. This is an increase of 5.0% compared to the same time last year. The following are the specifics by segment:

- Medical Student membership has increased by 32.4% compared to the same time last year.
- Resident and Fellow membership has increased by 8.4% compared to the same time last year.
- Early Career physician membership has increased by 2.7% compared to the same time last year.
- International membership has increased by 27.0% compared to same time last year.
- Members in dues paying categories have increased by 3.8% compared to the same time last year.

D. Staff Action/Response

Recent Initiatives

- A new searchable, Policy Finder was developed and is now available at http://www.psychiatry.org/about-apa--psychiatry/governance.

- New membership campaigns were initiated to recruit medical students and residents by promoting newly developed resources located at http://www.psychiatry.org/residents. Moreover, both the medical student and resident webpages were reorganized for the campaigns.

- A special promotion was offered by Membership, in coordination with Publishing, to international psychiatrists who signed up to join the APA during the World Psychiatric Association (WPA) meeting in Madrid. A total of 18 international members joined from the

following countries: Nigeria: 6, South Africa: 3, Australia: 2, India: 2, Iran: 2, China: 1, Netherlands: 1, Spain: 1.

On the Horizon

- APA Administration is currently exploring a concept to develop a web-based educational series that will deliver just-in time learning modules for residents around the ACGME Psychiatry Milestones and business of medicine topics. This is intended to be a member benefit that assists training programs to deliver content to residents that would complement and reinforce lectures and ease the administrative burden of delivering and tracking these activities.

- APA Administration is also capturing information from the various meetings, including the upcoming IPS meeting, that can be delivered online to increase membership value for both domestic and international psychiatrists.

Item 2014A2 3.A
Assembly
November 7-9, 2014

Report of the Speaker
Jenny L. Boyer, M.D., JD, PhD

This year we have been trying to focus on APA goals and specifically on how the Assembly can to a greater degree implement those goals. The APA goals that we have focused on have been diverse member recruitment and retention, state voice, and communication with general members.

In July we completed a survey of Assembly Representatives and Executive Directors with a response rate of 62%. The survey demonstrated that we can communicate among ourselves and with general members, although with challenges. The results of the survey confirmed that members and Executive Directors are concerned with our psychiatry workforce, especially funding and scope which are the issues of access to care. The survey provided a guide for members in writing particularly relevant action papers.

We have also communicated among ourselves using Assembly Alerts and improved list serves. We have communicated better with general members with the assistance of Executive Directors. Some have used templates developed by a work group of the Assembly for outreach to general members.

We have addressed diverse recruitment/retention of APA members while conducting local training with Assembly monies. Evidence of state voice was notable at the Illinois State Legislature where three of our Assembly members who had received local advocacy training wrote the bill requiring medical training for psychologists who wished to prescribe.

We have added goals and members to some of our Assembly work groups while sunsetting others which had accomplished their missions. We have tried to promote diversity of viewpoint and represent more adequately the face of general membership within the work groups by offering opportunity to serve to those who represent all types of diversity and not just geographic diversity. The current work groups are as follows: Access to Care, Joe Mawhinney, M.D., Chair; Communication, Steve Daviss M.D., chair through November Assembly, then Jake Behrens, M.D. Legislative, John Bailey M.D., Chair; Maintenance of Certification, James Batterson, M.D., Chair; Long Range Planning, Melinda Young, M.D., Chair; and two new work groups: Mentorship/Diversity, Ludmilla DeFaria M.D., and Stephen McLeod-Bryant, M.D., Co-Chairs and Public Affairs, Jeffrey Borenstein, M.D., Chair. For the first time an Executive Director will be an Invited Guest to each of the Assembly work groups in an effort to promote communication with general members. Bonnie Cook has been instrumental in finding Executive Directors to participate on the work groups. Additionally there is a new Invited Guest for the Public Affairs work group, Paul Burke, representing the APA foundation. Mr. Burke's addition is an attempt to integrate the Foundation and the Assembly in the area of Public Affairs. I want to thank the Chairs and members of all the workgroups including sunsetted, ongoing and new. The work groups have been actively meeting via phone conferences and e- mail so the efforts are truly year round.

We have proposed an increase in the Assembly budget for the coming year and presented the request to the Finance and Budget Committee. The proposed increase is specifically tied to the Assembly role in meeting APA goals of diverse recruitment/retention of members and state voice.

The Assembly was strongly represented by me and Dr. Glenn Martin, Speaker-Elect, in the Strategic Planning for the APA. While the planning is ongoing, it is recognized that the Assembly could be uniquely poised to help APA be a more "member driven" medical association. The planning is focused on identifying three to five most important issues for our APA.

Dr. Glenn Martin, Speaker-Elect, and I have been communicating some of the Assembly ideas and concerns to the Board of Trustees. We have attended the Area meetings and are grateful for all of the feedback presented to us at those meetings. We also want to say that it is good to see you at the Area meetings where we are able to have more informal conversations with you individually.

The Assembly Executive Committee met in July and began the process of recommending priorities for the "reorganization" of the Assembly which will occur as a result of the reversion of the Assembly in June 2015 to its 2010 composition. The Procedures Committee, chaired by the very able David Axelrad, M.D., has been charged by the AEC to develop a plan for the transition. One of the determining factors for our plan is the budget for the Assembly to be approved by the BOT in December 2014.

Dan Anzia, M.D., Recorder, has been working actively with the Areas to secure review of the new practice guidelines and also of the paper on guns and violence from the Committee on Psychiatry and the Law. We hope that you benefitted from the opportunity to have input on these documents which will be before the Assembly in November.

We are actively planning the November Assembly meeting. We will have an orientation to the Assembly conducted Friday morning by Dr. Benson. We will have an Assembly reception for the first time in years but at a cost of not being able to fund individual dinners for that evening. We are trying to have a way for members who attend the reception to informally visit with one another in the spirit of collaboration and friendship that has characterized our meetings.

I thank Allison Moraske and Margaret Dewar for their terrific work for the Assembly. I thank Dr. Paul Summergrad for his leadership and friendship to me personally and for inclusiveness of Assembly priorities. I thank Dr. Saul Levin for his commitment to APA goals. I thank Dr. Melinda Young, Dr. Scott Benson, Dr. Renee Binder, and Dr. Gary Weinstein for their mentorship. I thank Dr. Glenn Martin and Dr. Dan Anzia for exceptional team leadership. Finally, I thank Dr. Harold Ginzburg for his sense of humor.

I am anticipating a successful year! I am thinking about all the volunteer time that members of the Assembly contribute to the APA and am humbled with the realization of its meaning to our colleagues and patients. The Assembly members are the best.

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

SUMMARY OF ACTIONS
FINAL

New York Marriott Marquis
May 19, 2013

Agenda Item #	**Title/Action**	**Office/Component Responsible for Follow-up**
2.A	**Requests to Remove Items from the Consent Calendar** No items were removed.	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar.	Chief Operating Officer • Association Governance
3.B	**Report of the President** The Board of Trustee voted to sunset, with appreciation, the following Board Ad Hoc Work Groups which have completed their charge: **[cc]** • Board - Assembly Ad Hoc Work Group on Minority/Underrepresented Issues • DSM Planning Ad Hoc Work Group • ECP/RFM Membership Work Group	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
3.C	**Report of the President** The Board of Trustee voted to continue the following Board Ad Hoc Work Groups until they have completed their charge: **[cc]** • Board Healthcare Reform Strategic Action Ad Hoc Work Group (report by March 2015 BOT Meeting) • Board Ad Hoc Committee on APA Research Review (report by July 2014 BOT Meeting) • Ad Hoc Work Group on International Psychiatrists (report by September 2014 BOT Meeting) • Ad Hoc Work Group on Strategic Planning (report by March 2015 BOT Meeting)	Chief Operating Officer • Association Governance
5.A	**Minutes of the March 8-9, 2014 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its March 8-9, 2013 meeting. **[cc]**	Chief Operating Officer • Association Governance
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Jeste, Dr. Lieberman, and Dr. Summergrad. **[cc]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Office/Component Responsible for Follow-up
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the report of the status of the Assembly's New Initiative Fund. **[cc]**	Chief Financial Officer and • Finance & Business Operations Chief Operating Officer • Association Governance

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES MEETING
July 12-13, 2014

Final Summary of Actions

Agenda Item #	Title/Action	Responsible Office/Component
2.A	**Requests to Remove Items from the Consent Calendar** Item 5.A was removed from the Consent Calendar to ensure that Dr. Jenny Boyer's COI disclosure comments are reflected accurately in the May 2014 Board of Trustees Minutes.	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar as amended.	Chief Operating Officer • Association Governance
3.A	**Report of the President** The Board of Trustees voted to sunset the Task Force to Update the Ethics Annotations.	Chief of Membership & RFM-ECP Ethics Chief Operating Officer • Association Governance
4.A.1	**The Helping Families In Mental Health Crisis Act: HR. 3717 aka "The Murphy Bill"** The Board of Trustees reviewed and discussed the recommended changes and additions to HR. 3717, as suggested by the Council on Advocacy and Government Relations and the Board Executive Committee. The Board expressed concern for the need for stronger clinician leadership at SAMHSA.	Chief of Policy, Programs and Partnerships • Government Relations Council on Advocacy and Government Relations
4.A.2	**Diversity Mental Health Month** The Board of Trustees discussed ways that it can support and promote APA's first Diversity Mental Health Month.	Deputy Medical Director Chief of Policy, Programs and Partnerships • Diversity & Health Equity

Agenda Item #	Title/Action	Responsible Office/Component
4.A.3	**Quality Measures** The Board of Trustees discussed the importance of both the stewardship of the following quality measures (major depressive disorder, major depressive disorder in children and adolescents, substance use disorders, and dementia) and future initiatives to develop and maintain quality measures for psychiatry.	Chief of Policy, Programs and Partnerships • QIPS • Research
4.A.4	**Public Policy Statement** The Board of Trustees considered a public policy statement in the near future on how and where psychiatry fits in each of the new models of care, as well as psychiatry's clinical roles and responsibilities within each model. The Board asks that the Council on Healthcare Systems and Financing consider these issues as soon as possible but no later than their fall meeting and bring forward recommendations.	Chief of Policy, Programs and Partnerships • Healthcare Systems & Financing • Research General Counsel Council on Healthcare Systems and Financing BOT - September 9-10 2014
5.A	**Minutes of the May 4, 2014 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its May 4, 2014 meeting.	Chief Operating Officer • Association Governance
5.B	**Policy on Conflicts of Interest** The Board voted to approve the Policy on Conflicts of Interest for the DSM Steering Committee and DSM Review Committees as proposed by the COI Committee.	Chief Operating Officer • Association Governance Conflict of Interest Committee
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder**. [cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Responsible Office/Component
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
7.A.1	**Joint Reference Committee** Elimination of Tobacco Products Sold by National Retailers The action asks that the American Psychiatric Association publicly support all national pharmacies or retailers that discontinue the sale of tobacco products to support health and wellness instead of contributing to disease and death caused by tobacco use. **[cc]** The Board of Trustees referred this action to the APA AMA Delegation asking them to convey this message to AMA.	Chief Executive Officer and CEO Chief Operating Officer • Association Governance APA AMA Delegation
7.A.2	**Joint Reference Committee** Will the Board of Trustees discuss the APA referendum voting procedures and weigh the variety of options available to them? 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. After discussion on the issue, the Board of Trustees voted to appoint Drs. Renee Binder, Jenny Boyer, Glenn A. Martin, and Melinda Young as members of an ad hoc Board subcommittee and asked them to discuss the issue further.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
7.A.3	**Joint Reference Committee** **Budgeted support for PsychSIGN in the amount of $40,000 for 2015.** The PsychSIGN leaders requested continued APA support of its programs and activities. The Council on Medical Education and Lifelong Learning supported the request. It was noted that the APA-budgeted support for PsychSIGN was $40,000 until 2014, when it was reduced to $35,000. The Board voted to approve a budget increase (to $40,000) beginning in FY 2015.	Chief of Policy, Programs & Partnerships • Education Chief Financial Officer (CFO) Council on Medical Education and Lifelong Learning
7.A.4	**Joint Reference Committee** The Board of Trustees voted to approve the establishment of the American Leadership Fellowship Selection Committee**. [cc]** This group will carry out the task of the prior ad hoc work group in selecting the American Leadership Fellows.	Chief of Policy, Programs & Partnerships • Education Deputy Medical Director • Diversity and Health Equity Chief Operating Officer • Association Governance
7.A.5	**Joint Reference Committee** The Board of Trustees referred the action to the Conflict of Interest Committee for their review and development of recommendations for potential revision of the APA's Disclosure of Interests and Affiliations policy. **[cc]**	Conflict of Interest Committee Chief Operating Officer • Association Governance General Counsel
7.A.6	**Joint Reference Committee** The Board of Trustees approved updated language to item number five of the APA's Choosing Wisely® campaign list, which identifies targeted, evidence-based recommendations that can prompt conversations between patients and physicians about what care is really necessary. **[cc]**	Chief of Policy, Programs & Partnerships • Education
8.A.1	**Membership Committee Report** The Board of Trustees voted to approve a recommendation from the Membership Committee to award $2,727 to each district branch or state association listed in Attachment D as part of the DB Grant process**.**	Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
8.A.2	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members listed in Attachment F for failure to meet the requirements of membership. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.3	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members listed in Attachment G for non-payment of 2014 APA dues if dues are not paid by the deadline. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.4	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the members listed in Attachment H, who will be dropped by their district branch if dues are not paid by the deadline. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.5	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment I for International Membership. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.6	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment J. [cc]	Chief of Membership & RFM-ECP • Membership
8.B.1	**Finance and Budget Committee Report** The Board of Trustees voted to approve the establishment of a Board Designated Fund for Member Recruitment and Retention Projects.	Chief Financial Officer • Finance & Business Operations Chief of Membership & RFM-ECP • Membership
8.B.2	**Finance and Budget Committee Report** The Board of Trustees voted to approve an increase for CME course registration fees in 2015, including that the Buprenorphine course fee be $100 more at each registration point for non-members than for members.	Chief Financial Officer • Finance & Business Operations Chief Operating Officer ▪ Meetings & Conventions Chief of Membership & RFM-ECP ▪ Education

Agenda Item #	Title/Action	Responsible Office/Component
8.B.3	**Finance and Budget Committee Report** The Board of Trustees voted to approve the rate adjustments for Annual Meeting registration fees for 2015, and that proposed rate adjustments be amended to reflect that any non-member, unless a member of PsychSIGN, medical student, or undergraduate student, pay no less than the discounted fee of a dues-paying member.	Chief Financial Officer • Finance & Business Operations Chief Operating Office ▪ Meetings & Conventions Chief of Membership & RFM-ECP ▪ Education
8.B.4	**Finance and Budget Committee Report** The Board of Trustees voted to approve changes to the fees for the 2015 IPS as proposed in Attachment C.	Chief Financial Officer • Finance & Business Operations
9.A.1	**Speaker's Report** The Board of Trustees voted to approve the proposed Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists*.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.2	**Speaker's Report** The Board of Trustees voted to approve the proposed Position Statement: *Prior Authorizations for Psychotropic Medications* with a minor change.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.3	**Speaker's Report** The Board of Trustees voted to approve the Proposed Position Statement: *The Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana*.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
10.A.1	**Report from American Psychiatric Foundation** The Board of Trustees voted to approve the change to the bylaws of the American Psychiatric Foundation to expand the total number of APF Board of Directors from thirteen to sixteen members.	CEO/MDO Office • American Psychiatric Foundation

Agenda Item #	Title/Action	Responsible Office/Component
10.A.2	**Report from American Psychiatric Foundation** The Board of Trustees voted to approve the appointment of Ms. Maureen O'Gara Hackett and Dr. Owen Garrick to the APF Board of Directors, each for a term of three years, commencing in 2014.	American Psychiatric Foundation Office of the CEO and Medical Director
10.A.3	**Report from American Psychiatric Foundation** The Board of Trustees voted to approve the proposed changes in the APF Bylaws including a requirement that the APF Nominating Committee propose all new Board Member candidates to the APF Board of Directors, which will have the authority to recommend to the APA Board of Trustees for approval. The Board of Trustees also requested that the APF Board review and make appropriate editorial updates to the APF bylaws and bring back a revised version to the Board of Trustees for consideration at its September 9-10, 2014 Board meeting.	American Psychiatric Foundation Board of Directors Office of the CEO and Medical Director APF Report to the BOT: September 9-10, 2014
11.A	**Research Review Committee Work Group** The Board of Trustees voted to approve the report of the Research Review Committee Work Group.	Office of the CEO and Medical Director Chief of Policy, Programs and Partnerships • Research
12.A	**Report of the President** The Board of Trustees voted to approve the WPA/WMA/APA statement regarding equal status for mental health when compared to physical health. This is a draft document under development by three organizations: *World Psychiatric Association; World Medical Association; American Psychiatric Association*. Please note that the document is not considered final until all three organizations have indicated their support for a final statement. Drs. Summergrad and Levin will bring the document to the World Psychiatric Association Congress in Madrid in September 2014.	APA President: Paul Summergrad, MD CEO and Medical Director Saul M. Levin, MD, MPA Chief of Membership & RFM-ECP ▪ International Affairs

Agenda Item #	Title/Action	Responsible Office/Component
EX.1	***Psychiatric Services* Editorial Board** The Board of Trustees voted to approve the appointment of Ramin Mojtabai, M.D., Ph.D., to the *Psychiatric Services* Editorial Board for a four-year term to expire in May 2019.	Chief Operating Officer • Publishing • Association Governance
EX.2.1	***Psychiatric News* Editorial Advisory Board** The Board of Trustees voted to approve the reappointment of Joseph Cerimele, M.D., for a three-year term (2014-2017) to the *Psychiatric News* Editorial Advisory Board.	Chief of Communications • *Psychiatric News* • Association Governance
EX.2.2	***Psychiatric News* Editorial Advisory Board** The Board of Trustees voted to approve the reappointment of Altha J. Stewart, M.D., for a three-year term (2014-2017) to the *Psychiatric News* Editorial Advisory Board.	Chief of Communications • *Psychiatric News* • Association Governance
EX. 3	**CALF Grant** The Board of Trustees voted to approve the recommendation from the Committee on Advocacy and Litigation Funding and the Council on Advocacy and Government Relations to award the New Jersey Psychiatric Association $102,000 from the CALF fund to defeat psychologist prescribing legislation.	Chief of Policy, Programs and Partnerships • Government Relations ▪ State Advocacy

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES MEETING
September 9-10, 2014

Draft Summary of Actions

Agenda Item #	Title/Action	Responsible Office/Component
2.A	**Requests to Remove Items from the Consent Calendar** None	Chief Operating Officer • Association Governance
2.B	**Approval of Items on the Consent Calendar** The Board of Trustees voted to approve the Consent Calendar as presented.	Chief Operating Officer • Association Governance
3.A.1	**Report of the President** The Board of Trustees voted to rescind the action passed at the July 2014 Board of Trustees Meeting to approve a series of rate adjustments for the Annual Meeting registration fees for non-physician attendees.	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Meetings and Convention
3.A.2	**Report of the President** The Board of Trustees voted to approve the Annual Meeting registration fees for non-physician categories as originally recommended by administration and proposed by the Finance & Budget Committee at the July 2014 Board meeting.	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Meetings and Convention
5.A	**Minutes of the July 12-13, 2014 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its July 12-13, 2014 meeting. **[cc]**	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Responsible Office/Component
6.B	**Status of the Board Contingency Fund** The Board of Trustees voted to accept the report of the status of the Board Contingency Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.C	**Presidential New Initiative Fund** The Board of Trustees voted to accept the report of the status of the President's New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder**. [cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
6.D	**Assembly New Initiative Fund** The Board of Trustees voted to accept the status report of the Assembly's New Initiative Fund. **[cc]**	Chief Financial Officer • Finance & Business Operations Chief Operating Officer • Association Governance
8.A.1	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Members listed in Attachment F for failure to meet the requirements of membership. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.2	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment G for International Membership. **[cc]**	Chief of Membership & RFM-ECP • Membership
8.A.3	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment H. **[cc]**	Chief of Membership & RFM-ECP • Membership
10.A	**Report from American Psychiatric Foundation** The APA Board of Trustees voted to approve the editorial changes in the APF Bylaws as presented. **[cc]**	Office of the CEO and Medical Director • American Psychiatric Foundation

Agenda Item #	Title/Action	Responsible Office/Component
11.A	**International Psychiatrists Work Group** The Board of Trustees voted to accept the report of the Ad Hoc Work Group on International Psychiatrists with thanks and forward it to the Council on International Psychiatry for appropriate review. **[cc]**	Chief of Membership and RFM-ECP • International Affairs
11.C	**Ad Hoc Work Group on Real Estate** The Board of Trustees voted to delegate to the Executive Committee the authority to authorize the CEO and Medical Director to enter into a nonbinding letter of intent for the lease or purchase of a new location provided the opportunity meets the agreed-upon parameters.	CEO and Medical Director: Saul M. Levin, MD, MPA Chief Financial Officer
14.A	**New Business** The Board of Trustees voted to endorse two mental health goals development by the World Health Organization. The July 19th 2014 United Nations draft of the Post-Millennium Goals includes an overall Health Goal: *'Proposed goal 3. Ensure healthy lives and promote well-being for all at all ages'*. A recent Editorial in the British Medical Journal (BMJ) by Professors Graham Thornicroft and Vikram Patel, of King's College London and London School of Hygiene and Tropical Medicine respectively, calls upon colleagues worldwide to include within this Health Goal the following specific mental illness target: **'The provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health.'** They also propose that this is directly supported by **2 indicators** related to the WHO Mental Health Action Plan 2013-2020, adding that it is very difficult to achieve results without specific measurements: **(1) 'To ensure that service coverage for people with severe mental disorders in each country will have increased to at least 20% by 2020 (including a community orientated package of interventions for people with psychosis; bipolar affective disorder; or moderate-severe depression).'** **(2) 'To increase the amount invested in mental health (as a % of total health budget) by 100% by 2020 in each low and middle income country'**	CEO and Medical Director: Saul M. Levin, MD, MPA Chief of Membership and RFM-ECP • International Affairs

Agenda Item #	**Title/Action**	**Responsible Office/Component**
EX.1.1	***The American Journal of Psychiatry* Editorial Board** The Board of Trustees approved the appointment of Joan L. Luby, M.D., to *The American Journal of Psychiatry* Editorial Board for a four-year term to begin January 1, 2015, and expire December 31, 2018. **[cc]**	Chief Operating Officer • Publishing • Association Governance
EX.1.2	***The American Journal of Psychiatry* Editorial Board** The Board of Trustees approved the appointment of Helen S. Mayberg, M.D., F.R.C.P.C., to *The American Journal of Psychiatry* Editorial Board to a four-year term to begin January 1, 2015, and expire December 31, 2018. **[cc]**	Chief Operating Officer • Publishing • Association Governance
EX.1.3	***The American Journal of Psychiatry* Editorial Board** The Board of Trustees approved the appointment of Terrie E. Moffitt, Ph.D., to *The American Journal of Psychiatry* Editorial Board to a four-year term to begin January 1, 2015, and expire December 31, 2018. **[cc]**	Chief Operating Officer • Publishing • Association Governance
EX.1.4	***The American Journal of Psychiatry* Editorial Board** The Board of Trustees approved the appointment of Katherine L. Wisner, M.D., M.S., to *The American Journal of Psychiatry* Editorial Board for a four-year term to begin January 1, 2015, and expire December 31, 2018. **[cc]**	Chief Operating Officer • Publishing • Association Governance
EX.1.5	***The American Journal of Psychiatry* Editorial Board** The Board of Trustees approved the appointment of Xin Yu, M.D., to *The American Journal of Psychiatry* Editorial Board for a four-year term to begin January 1, 2015, and expire December 31, 2018. **[cc]**	Chief Operating Officer • Publishing • Association Governance

Item 2014A2 4.A
Assembly
November 7-9, 2014

Report of the Speaker-Elect
Glenn Martin, M.D.

I want to thank the Assembly for making me the Speaker-Elect. From my perspective the two most important changes that come with the position is a seat on the APA's Board of Trustees and becoming the Vice-Chair of the Joint Reference Committee.

Moving onto the Board is an interesting experience. As Speaker-Elect, the perspective is usually that of promoting and representing the Assembly. On the Board, as mandated by APA bylaws and the governing laws of the District of Columbia, one has a fiduciary responsibility to deliberate and vote on behalf of the entire membership and the organization, and cannot simply and cleanly advocate for an Assembly position. Luckily for me the Assembly in its collective wisdom almost always promotes ideas and positions that are not parochial, but meet the fiduciary mandate. Nevertheless the tension inherent in the dual positions is worth noting.

Since my tenure has begun:

- I have been appointed to serve on a Board Ad Hoc Workgroup on Healthcare Reform, chaired by Dr. Anita Everett. The workgroup will have met by phone twice before this November's meeting of the Assembly and for now we are assembling and reviewing APA HCR-ACA activity as reported by staff and the Councils.
- I have participated in President Summergrad's strategic planning initiative and have been asked to join the related workgroup. At the moment, we are focused on the strategic options survey, communications strategy and preliminary strategic themes. I am sure you will hear more about this at our Assembly meeting in November.
- I am part of a small group consisting of Drs. Binder, Boyer and Young tasked with a review of the referendum process. This was formed in response to action papers forwarded from the Assembly. Our options are significantly constrained by DC corporate law, but I am optimistic we will have recommendations to present to the Board in December that will address the fundamental concern that the voice of the membership will be heard in our organization.

I am also pleased to report that good things are happening at the JRC. Council reports are including much more detailed updates on their progress evaluating and/or implementing action papers. When that is not the case, our Chair and President-Elect Dr. Binder, as well as the other members of the JRC have clearly expressed our expectations for prompt reviews and thorough responses. Where necessary, reminders that the Councils are expected to function year round and not just at the May and Septembers meetings are re-iterated. Dr. Anzia's Recorder's report will have more details about the specific actions and reports pertaining to the action papers.

The JRC membership and APA Administration recognize the need for continuing improvement in communication and cooperation between the Councils, the Assembly, the JRC and the APA administration. To that end, specific suggestions about the review of action papers before Assembly consideration, and the increasing involvement of Councils and Administration before and during our meetings are forthcoming.

In short, I find that the importance of the Assembly is recognized by the Board, the JRC and APA administration. There is a sincere effort to better integrate the functioning and the work products of the Assembly into the APA, and to assist the Assembly in fulfilling its responsibilities within the governance structure of our APA.

Report of the Joint Reference Committee To the Assembly November 7 – 9, 2014

The Joint Reference Committee (JRC) refers the following actions to the Assembly for consideration. The summary of actions from the May 2014 JRC meetings may be found as attachment #3.

ACTION ITEMS

Item 4.A.1 Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist (JRCOCT128.A.1; ASMMAY134.B.1) [Please see attachment #1]

Will the Assembly approve the Position Statement: *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist* and if approved, forward it to the Board of Trustees for consideration?

The proposed position statement was developed by the Council on Addiction Psychiatry

The Council developed a Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist. It was approved by the Joint Reference Committee and submitted to the Assembly for review and approval. Assembly reviewers noted several areas of suggested improvement and returned the statement to the Council for revision. The statement was subsequently modified and is again submitted for JRC, Assembly, and Board approval. The Council wishes to emphasize that the position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.

Item 4.A.2 Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services (JRCMAY148.J.1) [Please see attachment #2]

Will the Assembly approve the Position Statement: *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services* and if approved, forward it to the Board of Trustees for consideration?

The position statement was developed by the Council on Psychiatry and Law.

Title: Residency Training Needs in Addiction Psychiatry for the General Psychiatrist

Issue: Substance use disorders (SUDs) are a major cause of morbidity and mortality among patients with mental illness and a major risk factor in dangerousness to self and others. Despite the availability of effective treatments, most patients with these disorders are not being treated. Providing appropriate training in screening, brief intervention, and treatment for the general psychiatrist could help close this treatment gap and improve outcomes for patients with co-occurring mental illness and SUDs. This position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.

APA Position: General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing screening, brief intervention, referral to treatment (SBIRT); management of psychoactive substance intoxication and withdrawal; evidence-based pharmacotherapy for substance use disorders; management of co-occurring substance use and other psychiatric disorders; and should have exposure to evidence-based psychotherapy and other psychosocial interventions for substance use disorders such as motivational interviewing, cognitive-behavioral therapy, twelve-step programs, among others."

Authors: Karen Drexler, M.D.; Michael Ketteringham, M.D., M.P.H.; Keith Hermanstyne, M.D., M.P.H.

Adoption Date: TBD

Background Information:

This background information is provided as a resource for program directors, faculty, and trainees to assist in developing content for general psychiatry training in assessment, diagnosis and treatment of substance use disorders and related conditions in accordance with ACGME program requirements.

The evidence supporting detailed recommendations is constantly evolving. Program directors are advised to use this along with critical reviews, clinical practice guidelines and other resources to provide the latest, evidence-based training for psychiatry residents.

The Rationale for Addiction Psychiatry Training for General Psychiatrists

Substance Use Disorders (SUDs) are highly prevalent in the United States. In 2010, of people aged 12 and older, an estimated 9% or approximately 22.6 million used illicit drugs, 7% or 17.9 million could be classified as having alcohol dependence, and 27% or 69.6 million people used tobacco. (SAMSHA 2011) Substance abuse treatment modalities have been shown to be effective in treating these populations. One study showed that medications used to treat persons with SUDs can be as effective in terms of relapse rates and adherence as medications used to treat chronic medical illnesses such as DM, asthma, and hypertension. (McLellan 2000) However, despite the efficacy of available treatments, approximately 90% of Americans with treatable SUDS are not in active treatment. (SAMSHA 2011)

A proportion of this under treatment can be attributed to the under surveillance and treatment of patients who are already in active treatment for a non-substance use related mental disorder. Indeed, greater than half of those with a lifetime SUD have a mental illness. (Regier 1990, NIDA 2011) However, despite the fact that many persons with SUDs are already in psychiatric care settings, they are not being screened, diagnosed, and treated**.** (Ewing 1999, Fleming 1991) One survey found that psychiatrists reported alcohol and drug abuse patients to constitute only 10% of their caseloads. (Dorwart 1992) Many general psychiatrists report they do not feel they have the adequate core competency skills to treat SUDs. (Ewan 1982) This may explain why the treatment gap for alcohol abuse is estimated at 78% as compared to other mental disorders like schizophrenia that has an estimated treatment gap of 32%. (Kohn 2004)

The under treatment of SUDs has major implications for the morbidity and mortality of mentally ill individuals. Failure to treat an SUD in the comorbid patient leads to worse outcomes in terms of the severity and longitudinal course of the other treated mental illness. (Hser 2007) Medical comorbidities that are highly prevalent in patients with serious mental illness also have worse outcomes in those patients with a comorbid SUD. (Viron 2010, Batki 2009) Consider the under treatment of tobacco use in persons with mental illness who are twice as likely to smoke as persons without a mental illness. (Lasser 2000) Tobacco use alone accounts for one in five deaths each year in the U.S. (CDC 2008)

The under-treatment of SUDs also increases the likelihood of the mentally ill to harm themselves or others. Mental illness is associated with increased rates of violence towards others, but this association is largely explained by the increased rates of substance abuse by the mentally ill. (Swanson 1990, Cuffel 1994) Mentally disordered individuals with substance abuse comorbidity are significantly more likely to be violent than those with mental disorder alone. (Swanson 1994) Furthermore, across the spectrum of affective and psychotic illness,

comorbid substance abuse significantly increases the risk of suicide compared to people with mental disorders that do not abuse substances. (Cornelius et al 1995, Dassori 1990, McIntyre et al 2008, Oquendo 2010, Sublette 2009) Alcohol dependency alone increases suicide risk six fold compared to those who do not abuse alcohol, leading to arguments that drinking habits must be considered in any suicide risk prevention effort. (Schneider 2009, Pompili 2010, Vijayakumar 2011)

Therefore, general psychiatrists who are competent in substance abuse diagnosis, prevention, and treatment would be able to increase the proportion of persons with an SUD receiving treatment and improve the morbidity and mortality while reducing the dangerousness of their comorbid patients. Proper treatment of SUDs can also reduce recidivism, emergency room visits, inpatient days, and psychiatric and substance use relapses, while improving medication adherence and treatment retention. To meet this end, more attention must be paid to training the psychiatry resident in outpatient treatment of patients with SUDs. A survey conducted in 2008 showed that the total number of curricular hours over the 4 years of training has increased since the 1990s. However, more than 80% of resident encounters with patients with SUDs occur in the psychiatric ER, CL service, and inpatient units. Furthermore, in a majority of outpatient training clinics, only 20% of patients have an SUD as their chief complaint. This is far below the expected 50% co-occurrence of SUDs with mental disorders and is explained partly by under surveillance and diagnosis. However, the study also revealed that 70% of residency clinics refer SUD patients out to substance abuse programs. More exposure to and supervision in the treatment of outpatients with SUDs would improve general psychiatrist confidence and competence in treating these disorders. (Fleming 1994, Shorter 2008)

Recommendations:

General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing the following interventions:

1. **Screening, brief intervention, referral to treatment (SBIRT)**

Rationale: Since the 1970s, evidence has accumulated that brief advice from a physician is an effective strategy to reduce harmful psychoactive substance use. (Whitlock, Polen et al. 2004; Kaner, Beyer et al. 2007; Schonfeld, Lawrence et al. 2010) Screening and brief intervention (SBI) for high-risk alcohol use has been shown to be a cost-effective strategy with similar positive health impact as colorectal cancer screening and influenza and pneumococcal vaccinations. (Solberg, Maciosek et al. 2008; Estee, Sharon et al. 2010) SBIRT for alcohol and other drug use improves mental and physical health and prevents other negative consequences such as absenteeism and legal problems. (Madras, Bertha et al. 2009; Quanbeck, Lang et al. 2010)

Despite strong evidence of effectiveness, health systems and individual providers have been slow to adopt these practices. (Davoudi and Rawson 2010). Persons with mental illness have a higher risk of tobacco, alcohol and other psychoactive substance use. (Farrell, Howes et al. 2003; Grant, Hasin et al. 2004; Kessler, Chiu et al. 2005) Persons with serious mental illness are at increased risk for medical consequences of smoking.(Dixon, Medoff et al. 2007) Yet despite the high prevalence of tobacco smoking in persons with mental illness, interest in reducing or quitting smoking is also significant.(Lasser, Boyd et al. 2000; Moeller-Saxone 2008) Brief interventions are more effective when provided by someone who has an ongoing relationship with the patient. Thus, psychiatrists are in a prime position to make a profound

impact on their patients' mental and physical health by screening for and providing brief counseling for psychoactive substance use.
Key Recommendation: Every psychiatry residency training program should include formal didactic training and clinical experience in providing SBIRT for alcohol and tobacco use in patients with mental illness.

Resources:

For SBIRT for at-risk alcohol use, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has published the *Clinician's Guide for Helping Patients who Drink Too Much*. (Willenbring, Massey et al. 2009) In addition to the paper version, there are Powerpoint slide sets and a video tutorial available at http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx.

For tobacco cessation, the US Public Health Service has published an evidence-based clinical practice guideline that includes information on brief interventions for smoking cessation as well as guidelines for medications and specific recommendations for special populations including the mentally ill. (Anderson, Jorenby et al. 2002) These are available on-line as well at http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

For alcohol, tobacco and other psychoactive substances, the National Institute on Drug Abuse (NIDA) hosts a website with a variety of clinical and teaching tools for healthcare professionals. NM Assist is a web-based tool for screening for substance use disorders, there are other training tools including an objective structured clinical examination (OSCE), web-based interactive trainings and PowerPoint slide sets. These are available on-line at http://www.drugabuse.gov/medical-health-professionals.

2. Management of psychoactive substance intoxication and withdrawal

Rationale: The common co-occurrence of substance use disorders among the mentally ill means that psychiatrists are often responsible for discerning whether acute psychiatric symptoms are induced by psychoactive substance intoxication or withdrawal and for managing these states during psychiatric stabilization in emergency departments and inpatient settings. Textbooks and clinical practice guidelines provide guidance on diagnosis and management of intoxication and withdrawal from psychoactive substances. (American Psychiatric Association 2000; American Psychiatric Association 2006; Galanter and Kleber 2008; Ries 2009; Ruiz, Strain et al. 2011)

Key recommendations:

a. General psychiatry training must include recognition of common signs and symptoms of intoxication and withdrawal for the major categories of psychoactive substances. (American Psychiatric Association 2000; Galanter and Kleber 2008)
b. Psychiatrists should have basic knowledge of major medical complications of psychoactive substance intoxication such as cardiac arrhythmias, acute myocardial infarction, hyperthermia (for stimulants, inhalants and hallucinogens) and respiratory depression (for opioids, alcohol and sedatives). (Ries 2009)
c. Psychiatrists should have a basic knowledge of laboratory testing for psychoactive substance use and of laboratory signs of heavy alcohol use. Examples include liver

function tests, complete blood count, drug screening, ethyl glucuronide and common causes of false positive and false negative tests. (Ruiz, Strain et al. 2011)

d. Psychiatrists should be able to manage alcohol and sedative-hypnotic withdrawal to provide comfort, to facilitate entry into comprehensive addiction treatment, and to prevent severe medical complications such as seizures and delirium. Components of this include:
    a. Using vital signs and standard scales for quantifying withdrawal symptoms such as the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-A). (Sullivan, Sykora et al. 1989)
    b. Assessing whether a patient is in need of hospitalization to manage alcohol withdrawal. (Mee-Lee and American Society of Addiction Medicine. 2001)
    c. Managing alcohol withdrawal using benzodiazepines and other evidence-based medications for management of alcohol withdrawal. (Mayo-Smith 1997; Mayo-Smith, Beecher et al. 2004)
e. Management of opioid withdrawal includes use of opioid agonists, partial agonists, and non-opioid medications for management of individual symptoms of opioid withdrawal. Components of this include:
    a. Quantifying withdrawal severity with scales such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute Narcotic Assessment (CINA). (Wesson and Ling 2003; Tompkins, Bigelow et al. 2009)
    b. Weighing risks and benefits of using long-acting pure mu-opioid agonists versus partial agonists versus non-opioids for managing opioid withdrawal. Long-acting pure mu-opioid agonists such as methadone carry an inherent risk of overdose by accumulation if repeated doses of medication are administered before the peak onset of action is achieved. Partial mu-opioid agonists such as buprenorphine provide a substantially lower risk of overdose, but a risk of precipitated withdrawal, if the patient is not already in withdrawal at the time of the first buprenorphine dose. (Amass, Ling et al. 2004; Ang-Lee, Oreskovich et al. 2006) Psychiatrists should be trained in induction of buprenorphine for both maintenance and management of withdrawal.
f. Management of nicotine withdrawal using the major evidence-based approaches for nicotine dependence including nicotine replacement therapies, bupropion, and varenicline. (Fiore, Jaen et al. 2008)

3. Evidence-based pharmacotherapy for substance use disorders

Rationale: Psychoactive substance use is associated with violence, medical morbidity and mortality, and poor psychiatric outcomes in persons with mental illness. Pharmacotherapy to treat tobacco, alcohol, and opioid use disorders is effective and could be mastered during residency training. The data below is reference from a review by Ross and Peselow. (Ross 2009)

Key Recommendation: General psychiatrists should be proficient in managing FDA-approved medications for the major categories of mental disorders, including psychoactive substance use disorders.

NICOTINE

Nicotine replacement therapy and treatment with bupropion have both been shown to double the chance of abstinence and diminish cravings at 6 months. Varenicline increased the odds of abstinence by a factor of 4 and a factor of 2 when compared to placebo and bupropion respectively. Furthermore, varenicline was 2.5 times more effective than placebo at maintaining abstinence at one year. There may be some hesitancy to prescribe varenicline due to it carrying a black-box warning for depression, suicidal thoughts and actions. However, the medication has been shown to be effective and proper training during residency should lead the general psychiatrist to be effective in its use. Several recent well-designed research studies have shown that varenicline has no increased risk in patients with stable depression and other mental disorders compared to placebo or other FDA-approved therapies.

Key Recommendation: Psychiatry residents receive didactic and clinical supervision in managing tobacco cessation using brief counseling and FDA approved medications including nicotine replacement, bupropion and varenicline.

Resources:
Fiore, M. C., C. R. Jaen, et al. (2008). "Treating Tobacco Use and Dependence- 2008 Update." Agency for Health Care Policy and Research Retrieved Jan 3, 2010, 2010, from http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hsahcpr&part=A28163.

CDC. (2008). "National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Department of Health and Human Services. Smoking and Tobacco Use—Fact Sheet: Health Effects of Cigarette Smoking." from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm.

ALCOHOL

There are 3 FDA approved medications for alcohol dependence. Disulfiram is safe and well tolerated, and when compliance is maintained, it is effective in promoting abstinence. Naltrexone (both oral and long-acting injectable) compared with placebo reduces drinking frequency and relapse to heavy drinking. European studies have shown acamprosate to be superior to placebo in rates of total abstinence, cumulative abstinence duration, and time to first drink in recently detoxified patients.

There are areas that are not FDA approved but show some promise in recent studies. Baclofen studies show it to have a positive effect in relapse prevention, abstinence maintenance, and craving in patients who have recently been detoxified from alcohol. Topiramate was better than placebo in two double-blind placebo-controlled studies in reducing heavy drinking and increasing percentage of abstinent days.

Key Recommendation: Psychiatrists receive didactic training and clinical supervision in management of FDA approved medications and brief counseling for alcohol dependence.

Resources:

National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Clinician's Guide for Helping Patients Who Drink Too Much*. (Willenbring, Massey et al. 2009) PowerPoint slide sets and a video tutorial available at www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx.

OPIOIDS

Appropriately dosed buprenorphine is superior to placebo in diminishing illicit opiate use and treatment retention.

Key Recommendation: All psychiatry residents should receive appropriate didactic training to obtain the DATA 2000 waiver to prescribe buprenorphine and sufficient clinical supervision to assure competency in managing patients on buprenorphine maintenance.

Resources:
APA Resident-Fellow Members have free access to the APA's 8-hour on-line training for buprenorphine.

4. Evidence-based psychotherapy and other psychosocial interventions for substance use disorders

Several behavioral and psychotherapeutic strategies have shown efficacy in treating substance use disorders and can be applied in varied settings (individual, group, or family therapy), mutual help groups, and substance abuse classes. Behavioral strategies can have many benefits including increasing a patient's motivation, exploring their ambivalence in reducing his drug use, identifying situations that might trigger relapse, developing alternatives to substance use, and improving compliance to pharmacotherapy and treatment structure. Research has supported the importance of actively instructing clinicians in evidence-based behavioral strategies (Carroll 2006). Psychiatry residents should receive training in these specific modalities and how they can be applied to patients with substance use disorders.

Key Recommendation: Psychiatrists should develop expertise in evidence-based psychotherapy techniques that they will use frequently (such as motivational interviewing) and familiarity with basic principles of other evidence-based psychotherapies so that they can work collaboratively with their patients and with other providers who may be using evidence-based psychotherapies.

Motivational Interviewing

Motivational interviewing uses empathy and reflective listening in order to enhance a patient's recognition of discrepancy between their stated goals and current behaviors. Using this technique often involves "rolling with the resistance" and examining both sides of a patient's ambivalence in changing his substance use behavior, which can lead to a patient's perceived sense of self-efficacy and increase their motivation to reduce or abstain from substance use. In addition, clinicians can use motivational techniques in targeted, brief interventions in order to promote their tendency to change in a non-confrontational manner. While there has been strong evidence supporting the use of motivational interviewing for patients with alcohol-related disorders, there is also evidence that it can be effective for opioid, stimulant, and polysubtance users.

Contingency Management

Contingency management follows a model that provides incentives to promote abstinence or reduced drug use, with the philosophy that reinforcement (both positive and negative) can improve a patient's success in repeatedly avoiding drug use behaviors. Incentives in previous studies have included vouchers redeemable for specific goods, chances to enter lotteries, or treatment-related benefits (ex. increased methadone doses or ability to take methadone doses home) and research has shown efficacy across different substances including cocaine, opiates, and marijuana. Cost is often cited as a significant barrier to implement technique, but recent research has shown benefits in variable-reinforcement schedules or using lower-cost alternative incentives.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) can be an effective modality that provides both effective skills training to promote abstinence while also helping the patient examine the functional components that influence his drug use such as triggers and potential consequences. CBT can have many benefits including helping the patient examine behavioral patterns, increase their self-monitoring of thoughts and behaviors that can occur prior, during, or after drug use episodes, recognizing cognitive patterns that reinforce drug use, and enhancing problem-solving skills that can improve both drug use outcomes and general life conflicts. Research has shown wide-ranging efficacy in alcohol, opioid, nicotine, and cocaine use disorders and have shown durable benefit after ending treatment.

Twelve Step Facilitation and Mutual Help Participation

Participation in Alcoholics Anonymous is associated with better abstinence rates and reduced substance-related problems (Kaskutas 2009). Treatment programs that encourage 12-step participation are associated with improved abstinence and decreased healthcare costs compared to those that are primarily cognitive-behavioral therapy based (Humphreys and Moos, 2007). Alcoholics Anonymous and other 12-step groups promote development of social networks that reinforce abstinence more effectively than family support (Kaskutas 2009). Twelve-step facilitation is an evidence-based, manually-driven individual therapy that encourages active involvement in Alcoholics Anonymous and other 12-step programs (Nowinski et al 1995) and is available through the NIAAA (http://pubs.niaaa.nih.gov/publications/match.htm). A succinct summary of Twelve-step Facilitation for general psychiatrists is available in the APP Textbook of Substance Abuse Treatment (Galanter and Kleber 2008).

Additional Comments

Substance use disorders occur in the context of personal and family dynamics; several strategies such as interpersonal therapy, family behavioral therapy, and multidimensional family therapy have shown benefit in treating substance use disorders. Familial involvement can be especially helpful in adolescent populations. Given the efficacy of various techniques, researchers are also examining whether combining "ingredients" from different modalities can further optimize treatment efficacy.

5. Management of co-occurring substance use disorders and severe mental illness

Residents should be trained to recognize the importance of comorbid substance use and how it can affect treatment. Although comorbid substance use may lead to diagnostic ambiguity when a present initially presents to a mental health provider, patients with severe psychiatric symptoms may need prompt treatment with antidepressant or antipsychotic medication despite this uncertainty. Therefore, concurrent treatment of both psychiatric illness and substance use disorder is important for optimum treatment efficacy. Residents should also recognize the multiple benefits of specific pharmacotherapy (ex. the use of bupropion for both depression and nicotine cessation) and how certain behavioral strategies can be effective for patients with specific comorbid disorders (ex. use of integrated group therapy for patients with bipolar disorder or PTSD and substance use disorders). Exposure to assertive community treatment, which often involves integrative treatment for patients with both severe mental illness and substance use disorders, can also improve residency training in how to manage patients whose comorbid substance use and severe mental illness lead to significant treatment complexity.
Key Recommendation: Psychiatry residents should receive didactic training and clinical supervision in evidence-based management of co-occurring substance use disorders and severe mental illness.

Resources:
Review of co-occurring depression and SUDs:
Nunes, E. V. and F. R. Levin (2006). "Treating depression in substance abusers." Current Psychiatry Reports **8**(5): 363-70.

Review of psychotic disorders and SUDs:
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DRAFT June 11, 2014

Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

The American Psychiatric Association recognizes the critical public health need for action to promote safe communities and reduce morbidity and mortality due to firearm-related violence. Specifically, the APA supports the following principles and positions:

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory measures. Recognizing that the vast majority of gun violence is not attributable to mental illness, the APA views the broader problem of firearm-related injury as a public health issue and supports interventions that reduce the risk of such harm. Actions to minimize firearm injuries and violence should include:

    a. Requiring background checks and waiting periods on all gun sales or transactions;

    b. Requiring safe storage of all firearms in the home, office or other places of daily assembly;

    c. Regulating the characteristics of firearms to promote safe use for lawful purposes and to reduce the likelihood that they can be fired by anyone other than the owner without the owner's consent;

    d. Limiting access to semi-automatic firearms, high capacity magazines and high velocity ammunition to law enforcement and security personnel as required by their duties;

    e. Banning possession of firearms on the grounds of colleges, hospitals, and similar institutions by anyone other than law enforcement and security personnel; and

    f. Assuring that physicians and other health care professionals are free to make clinically appropriate inquiries of patients and others about possession of and access to firearms and take necessary steps to reduce the risk of loss of life by suicide, homicide, and accidental injury.

2. Research and training on the causes of firearm violence and its effective control, including risk assessment and management, should be a national priority.

    a. Administrative, regulatory and/or legislative barriers to federal support for violence research, including research on firearms violence and deaths, should be removed.

b. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of individuals at heightened risk of committing violence against themselves or others with firearms.

c. The federal government should develop and fund a national database of firearm injuries. This database should include information about all homicides, suicides, and unintentional deaths and injuries, categorized by specific weapon type, as well as information about the individuals involved (absent personal identifiers), geographic location, circumstances, point of purchase, date and other policy-relevant information.

d. Funding for research on firearm injuries and deaths should draw on a broad range of public and private resources and support, such as the Centers for Disease Control, the National Institutes of Health, and the National Science Foundation.

e. All physicians and other health professionals should continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal, state, and local resources should be allocated for training of these professionals. Resources should be increased for safety education programs related to responsible use and storage of firearms.

3. Reasonable restrictions on gun access are appropriate, but such restrictions should not be based solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of symptoms, impairments, and disabilities found in affected individuals. Even within a given diagnosis, there is considerable heterogeneity of symptoms and impairments. Only a small proportion of individuals with a mental disorder pose a risk of harm to themselves or others. The APA supports banning access to guns for persons whose conduct indicates that they present a heightened risk of violence to themselves or others, whether or not they have been diagnosed with a mental disorder.

4. Given that the right to purchase or possess firearms is restricted for specific categories of individuals who are disqualified under federal or state law, the criteria for disqualification should be carefully defined, and should provide for equal protection of the rights of those disqualified. There should be a fair and reasonable process for restoration of firearm rights for those disqualified on such grounds.

   When restrictions are based on federal law, disqualifying events related to mental illness, such as civil commitment or a finding of legal incompetence, are reported to the federal background check database (National Instant Criminal Background Check System,

NICS). Some states have expanded the scope of disqualifying events to be reported to NICS to include non-adjudicated events, such as temporary hospital detentions.

a. Non-adjudicated events should not serve as sufficient grounds for a disqualification from gun ownership and should not be reported to the NICS system. The adjudicatory process provides important protections that ensure the accuracy of determinations (such as dangerousness-based civil commitment), including the right to representation and the right to call and cross-examine witnesses.

b. Rational policy with regard to implementation of such restrictions calls for the duration of the restriction to be based on individualized assessment rather than a categorical classification of mental illness or a history of a mental health-related adjudication.

c. Although the restrictions on access to firearms recommended in items 1 and 2 above would decrease the risk of suicide and violence in the population, extending restrictions to individuals who voluntarily seek mental health care and incorporating their names and mental health histories into a national registry is inadvisable because it could dissuade persons from seeking care and further stigmatize persons with mental disorder.

d. A person whose right to purchase or possess firearms has been suspended on grounds related to mental disorder should have a fair opportunity to have his or her rights restored in a process that properly balances the person's rights with the need to protect public safety and the person's own well-being. Accordingly, the process for restoring an individual's right to purchase or possess a firearm following a disqualification relating to mental disorder should be based on adequate clinical assessment, with decision-making responsibility ultimately resting with an administrative authority or court.

5. Improved identification and access to care for persons with mental disorders may reduce the risk of suicide and violence involving firearms for persons with tendencies toward those behaviors. However, because of the small percentage of violence overall attributable to mental disorders (estimated at 3-5% in the U.S., excluding substance use disorders), it will have only a limited impact on overall rates of violence.

a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in national and local agendas, along with other efforts to augment prevention strategies, reduce the stigma of seeking or obtaining mental health treatment, and diminish the consequences of untreated mental disorders.

b. For those people with mental illness who may pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be

removed. Access to care and associated resources to enhance community follow up, which includes care and resources to address mental disorders, including substance use disorders, should be maximized to ensure that patients who may need to transition between service providers or settings, e.g., from an inpatient setting to community-based treatment, continue to obtain treatment and are not lost to care.

c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws designed to limit firearm possession that mandate reporting to law enforcement officials by psychiatrists and other mental health professionals of all patients who raise concerns about danger to themselves or others are likely to be counterproductive and should not be adopted. In contrast to long-standing rules allowing mental health professionals flexibility in acting to protect identifiable potential victims of patient violence, these statutes intrude into the clinical relationship and are unlikely to be effective in reducing rates of violence.

d. The President of the United States should consolidate and coordinate current interests in improving mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

Joint Reference Committee
May 31, 2014
Arlington, VA

DRAFT SUMMARY OF ACTIONS
As of July 15, 2014

N.B: *When a **LEAD** Component is designated in a referral it means that all other entities to which that item is referred will report back to the **LEAD** component to ensure that the LEAD component can submit its report as requested in the JRC summary of actions*.

JRC Members Present:

Renée Binder, MD: JRC Chairperson; APA President-Elect (stipend); all salary through UCSF – Associate Dean of Faculty Affairs, Department of Psychiatry/ Psychiatry & Law Program and consultant on an in-patient unit.

Daniel Anzia, MD: 80% employed at Advocate Health and Hospitals/Advocate Lutheran Hospitals; Academic Chairperson for the Medical School; Spouse and father of Advanced Practice Nurses.

Jeffrey Akaka, MD: Area 7 Trustee; receives 80% of income from Diamond Head Community Mental Health Center in Hawaii; 20% of income from disability reviews from Social Security; serves on APA*PAC* Board;

Saul Levin, MD, MPA: Chief Executive Officer and Medical Director; receives income from the APA

Glenn A. Martin, MD: Private practice; City of New York; Medical Director for a Health Information Exchange in Queens, NY; Icahn School of Medicine; Associate Dean Mount Sinai; IT director for two hospitals.

Melinda Young, MD: past speaker; self-employed private practice; Board of Trustees member, Assembly Executive Cmte member; Examiner for ABPN; AACAP Member Benefits Committee

Jeffrey A. Lieberman, MD: Excused

JRC Staff:
Margaret Cawley Dewar – Director of Association Governance
Laurie McQueen – Associate Director, Association Governance

Other Attendees:
Annelle Primm, MD – Deputy Medical Director
Jon Fanning – Chief RFM and ECP Officer
Kristin Kroeger – Chief, Allied and External Partnerships
Shaun Snyder, JD – Chief Operating Officer
Yoshie Davison, MSW – Deputy Director, Leadership and Advocacy Initiatives

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
2	Review and Approval of the Summary of Actions from the January 2014 Joint Reference Committee Meeting Will the Joint Reference Committee approve the draft summary of actions from the January 2014 meeting?	The Joint Reference Committee approved the draft summary of actions from the January 2014 meeting.	Laurie McQueen	Association Governance
4	CEO/Medical Director's Office Report **Updates on Referrals**			
4.1	Mental Health Parity Act Compliance & Insurance Accreditation Organizations [ASMNOV1212.C]	Update: Currently, the APA is now in discussion with NCQA on issues surrounding integrated care, and as we move forward with strategies around parity in partnership with our allied groups, we will begin to discuss standards that demonstrate compliance with the Mental Health Parity and Addictions Equity Act.		This action is ongoing.
4.2	APA to Liaison with ABPN Regarding MOC Exam Timing [ASMMAY1312.F]	Update: ABPN has reaffirmed that it will not expand upon ten-year certification dates since it is no longer allowed under the ABMS MOC Standards for 2015.		This action is closed.
4.3	MOC Certification Language [ASMNOV1212.M]	Update: Members of APA senior staff and ABPN senior staff met in February. ABPN staff recently confirmed that Lifetime Certificate Holders will be labeled as "not required to participate in MOC." As APA meets with ABPN annually, we will continue conversations about how systems will not stigmatize lifetime certificate holders.		This action is ongoing.
4.4	Surveying Recently Graduated Psychiatrists & their Residency Training Programs to Assess Preparedness in the Workforce & Identify Potential Areas for Improvement in Training [ASMNOV1212.N]	Update: The American Association of Directors of Psychiatric Residency Training and the Association of Directors of Medical Student Education in Psychiatry are already assessing education around integrated care, and both organizations have agreed to collect relevant data across the U.S. in both psychiatric residencies and medical schools.		This action is ongoing.

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
4.5	The Development of a Resource Document on Rape [ASMNOV1212.U]	Update: A search of APP inventory does not indicate publishing has any active titles directly related to this topic. The most relevant title is the *Clinical Manual for the Management of PTSD*, which has a chapter on Sexual Assault. This excerpt was sent to the Council on Minority Health and Health Disparities work group chairperson (Ludmila de Faria, MD), who is in charge of developing the resource document.	Kristen Kroeger Alison Bondurant	The portion of this action referred to the Office of the Chief Executive Officer has been completed.
4.6	Revitalizing the Public Perception of the APA and the Psychiatric Profession [ASMMAY1312.1]	Update: The CEO informed the Assembly of the Porter-Novelli Communications Audit in addition to the associated Action Paper, and outlined three major steps for APA to improve its communications function: The first step, hiring of the Chief Communications Officer, Jason Young is completed. The second step is to establish an infrastructure, and the third step is to develop and implement a strategic communications plane, which includes participation from the Assembly, AEC, DBs and Members.	CEO and Medical Director (for information)	This action is ongoing.
4.7	Use of New CPT Codes in Health Insurance Exchanges [ASMMAY1312.S]	Update: APA will continue to monitor what is happening in the exchange plans through the OHSF's APA Practice Management line. Exchange insurance plans have been operational only a few months, and more time is needed to have a clearer picture of how the exchange plans are fully operating as detailed information has been unobtainable.	Kristen Kroeger Sam Muszynski, JD	This action is ongoing.
4.8	Council on Children, Adolescents and Their Families-HEMA Funding [JRCOCT138.C]	Update: The APA is currently unable to fund the Caucus of College Mental Health's request at this time as it may set precedent for other Councils to request funds for conferences and travel to non-APA events.	CEO and Medical Director	This action is closed.

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
4.9	Council Communication to Members [JRCOCT138.F.1]	Update: Currently, the Office of the CEO and Medical Director is exploring other avenues to publicize Council Reports more readily to members, as Psych News Alerts cannot fully summarize Council Reports effectively. Once the Chief Communications Officer starts on July 1, 2014, he will be charged with exploring timely avenues of communication for Council Reports that align with strategic communications plan outlined in the Porter-Novelli Report.	Jason Young Shaun Snyder, JD	This action is ongoing.
4.10	Cultural Psychiatry Filter on Annual Meeting App [JRCOCT138.H.2]	Update: The Office of the CEO and Medical Director presented updates on the Cultural Psychiatry Filter on the Annual Meeting App to the Board of Trustees in March 2014. The app, featuring the parameters outlined in the Assembly action paper, was successfully implemented during the 2014 Annual Meeting with 35,967 views on the courses that were listed under the filter. Additionally, the app was downloaded by 8,212 devices, which surpassed the 5,928 downloads for the 2013 Annual Meeting app.		This action is closed.
4.11	Internet Access in Council Meetings During APA Annual Meetings [JRCOCT138.H.3]	Update: The Office of the CEO and Medical Director with the assistance of Meetings and Conventions Department and the IT department researched providing wireless hotspots and having hotel properties provide wireless access, and it was too cost prohibitive for the respective Council and Assembly budgets. Additionally, providing wireless hot spots was not deemed cost effective and due to weak signals may prove to be of unacceptable quality.		This action is closed.
6	Assembly Report			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.1	<u>Multiple Co-payments Charged for Single Prescriptions</u> (ASMMAY1412.A) [Please see item 6, attachment 1] The action paper asks that the APA research the reasons for and legality of the practice of charging two co-payments for a single prescription when pharmacies dispense medications in divided increments because of supply limitations. That the APA advocate for patients not paying more than one co-payment for a one-month supply of a medication, even if dispensed in multiple allotments. That the APA draft policy opposing the charging multiple co-payments for one prescription and communicate its concerns to relevant stakeholders (State Commissioners of Insurance, pharmacy benefit management companies, state Medicaid directors, etc.). That this draft policy be sent to the APA AMA Delegation for submission to the AMA House of Delegates. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.A: *Multiple Co-payments Charged for Single Prescriptions* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to determine if this practice is illegal. If the practice is found to be illegal, the JRC asked that the action paper be forwarded to the Office of the CEO and Medical Director for assignment to the Department of Government Affairs for advocacy on behalf of members and patients. If the practice is found to be legal, the Council on Healthcare Systems and Financing is asked to draft a policy on this issue, obtaining input from the Council on Advocacy and Government Relations. A report to the Joint Reference Committee is expected at the October 2014 meeting.	Kristin Kroeger Becky Yowell Kristin Kroeger	Council on Healthcare Systems and Financing (LEAD) Council on Advocacy and Government Relations Office of the CEO and Medical Director for referral to: Department of Government Affairs **Report to the Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.2	<u>Elimination of Tobacco Products Sold by National Retailers</u> (ASMMAY1412.B) [Please see item 6, attachment 2] The action paper asks that the American Psychiatric Association publicly support all national pharmacies or retailers that discontinue the sale of tobacco products to support health and wellness instead of contributing to disease and death caused by tobacco use, and be it further resolved That this action paper is referred to the American Psychiatric Association's delegates to the American Medical Association House of Delegates for review. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.B: *Elimination of Tobacco Products Sold by National Retailers* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee recommended that the action paper be referred to the Board of Trustees for referral to the APA AMA Delegation.	Shaun Snyder Margaret Dewar Ardell Lockerman Becky Yowell	**Board of Trustees July 2014** APA AMA Delegation

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.3	Maintaining Community Treatment Standards in Federal Correctional Facilities (ASMMAY1412.C) [Please see item 6, attachment 3] Action paper 2014A1 12.C asks • That the APA lobby the Bureau of Prisons to ensure any policies and procedures for the delivery of mental health services do no less than comply with existing federal regulations and community standards of evidenced-based treatment, and be it further, • That the APA ~~publicly~~ oppose any treatment guidelines that minimize the necessity of ~~biological treatment for~~ medical evaluation and treatment of prisoners with ~~of~~ severe mental health disorders ~~and its management by a medical provider be it further,~~ • That the APA lobby the Bureau of Prisons to increase the number of employed psychiatrists by increasing compensation packages for BOP employed psychiatrists on par with other federally employed psychiatrists and community psychiatrists. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.C: *Maintaining Community Treatment Standards in Federal Correctional Facilities* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee revised portions of the action paper as noted. The action paper was referred to the Council on Psychiatry and Law with a request to make recommendations on what steps should be taken in addition to what their Work Group on Persons with Mental Illness in the Criminal Justice System is already doing. The Joint Reference Committee also referred the action paper to the Council on Advocacy and Government Relations to ascertain what the Bureau of Prisons is doing on the issue. A report to the Joint Reference Committee is expected at the October 2014 meeting.	Kristin Kroeger Lori Klinedinst Christopher Whaley	Council on Psychiatry and Law (LEAD) Council on Advocacy and Government Relations **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14] Update to the Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.4	HIPAA and State Restrictions on Duty to Warn (ASMMAY1412.D) [Please see item 6, attachment 4] The action paper asks that the APA continue to work at the federal and state level to review and if appropriate, advocate for change to regulations and laws, such as HIPAA, in order to maximize the ability to hold psychiatrists harmless, who in good faith and in their best reasonable clinical judgment want to warn or report serious threat as a means to protect the public and our patients. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.D: *HIPAA and State Restrictions on Duty to Warn* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law and asked them to weigh both sides of this issue and provide the Joint Reference Committee with recommendations for action. A report to the Joint Reference Committee is expected for the January 2015 meeting.	Kristen Kroeger Lori Klinedinst	Council on Psychiatry and Law **Report to Joint Reference Committee January 2015**
6.5	Psychiatric Education with Respect to Patients at Risk of Violent Behavior (ASMMAY1412.E) [Please see item 6, attachment 5] The action asks that the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist. That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.E: *Psychiatric Education with Respect to Patients at Risk of Violent Behavior* to the appropriate Component(s) for input or follow?	The Joint Reference Committee noted that this issue is included within a proposed Practice Guideline on the Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation. The Joint Reference Committee referred this item to the Council on Medical Education and Lifelong Learning to consider including this within residency training education. The action paper was also referred to the Scientific Program Committee asking them to consider including courses on this topic at the Annual Meeting.	Kristen Kroeger Nancy Delanoche Joy Raether	Council on Medical Education and Lifelong Learning (LEAD) Scientific Program Committee **Report to Joint Reference Committee January 2015**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.6	Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger (ASMMAY1412.F) [Please see item 6, attachment 6] The action paper asks that the APA promote expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.F: *Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to review the issue and provide recommendations on action back to the Joint Reference Committee.	Kristen Kroeger Becky Yowell	Council on Healthcare Systems and Financing (LEAD) **Update to Joint Reference Committee January 2015**
6.7	Increasing Buprenorphine Prescribing Limits (ASMMAY1412.G) [Please see item 6, attachment 7] The action paper asks that the JRC refer the issue of increasing buprenorphine prescribing to the needed population to the Council on Addiction Psychiatry for further consideration such as increasing the limits on the prescriber and the number of prescribers and request a report back to the Assembly in November 2014. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.G: *Increasing Buprenorphine Prescribing Limits* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Addiction Psychiatry and was informed that the Council on Addiction Psychiatry had already formed a work group to address increasing buprenorphine prescribing limits.	Kristen Kroeger Beatrice Eld	Council on Addiction Psychiatry **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.8	<u>No Punishment for Choosing Not to Adopt Electronic Medical Records</u> (ASMMAY1412.H) [Please see item 6, attachment 8] The action paper asks that: 1. The APA will adopt as a general policy, and begin advocating for, the elimination of penalties of any kind for physicians who choose not to use EMRs. 2. The APA will begin immediate discussions with CMS and any other relevant governmental or private agencies regarding this policy. Will the Joint Reference Committee refer the Assembly action paper 2014A1 12.H: *No Punishment for Choosing Not to Adopt Electronic Medical Records* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Advocacy and Government Relations and requested that the Council weigh the pros and cons of the APA lobbying for no punishment for not adopting electronic medical records and making a recommendation to the Joint Reference Committee along with a rationale for the October 2014 meeting.	Kristin Kroeger Christopher Whaley	Council on Advocacy and Government Relations **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
6.9	<u>Patient Satisfaction Surveys and Physician Pay</u> (ASMMAY1412.J) [Please see item 6, attachment 9] The action paper asks that APA shall advocate that patient satisfaction surveys should not be used as a basis for determining physician remuneration. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.J: *Patient Satisfaction Surveys and Physician Pay* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee did not refer this action paper to a component. This issue is embedded within current APA practices and policies.		Closed

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.10	Remove Black Box Warning from Antidepressants (ASMMAY1412.K) [Please see item 6, attachment 10] The action paper asks that APA shall in view of recent research findings, urge the FDA to revisit the inappropriateness of the Black Box warning about suicidality with antidepressants. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.K: *Remove Black Box Warning from Antidepressants* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Research and requested that the council provide the pros and cons for removing the black box warning from antidepressants along with a recommendation, with rationale, to the Joint Reference Committee for its meeting in January 2015.	Kristen Kroeger Emily Kuhl Samantha Shugarman Christopher Whaley	Council on Research (LEAD) Council on Quality Care Council on Advocacy and Government Relations **Report to Joint Reference Committee January 2015**
6.11	American Psychiatric Association and Primary Care Organizations Collaboration in the Affordable Care Act Implementation (ASMMAY1412.L) [Please see item 6, attachment 11] The action paper asks that the APA will develop educational & policy collaborations on primary care and behavioral health integration with relevant primary care educators and primary care organizations regarding the Affordable Care Act Be it further resolved, that these collaborations will be reviewed and reported annually by the Board of Trustees and the Assembly to the APA membership. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.L: *American Psychiatric Association and Primary Care Organizations Collaboration in the Affordable Care Act Implementation* to the appropriate Component(s) for input or follow-up?	Dr. Levin, CEO and Medical Director, informed the Joint Reference Committee that efforts to engage and collaborate with primary care educators and organizations regarding the Affordable Care Act are already underway.		Closed

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.12	Addressing the Shortage of Psychiatrists with Sources of Funding (ASMMAY1412.M) [Please see item 6, attachment 12] The action paper asks: • That the Assembly and the Board of Trustees create a task force, or designate an APA component to create such a task force, to investigate the feasibility of the establishment of scholarship funds or other means of reducing debt for qualified students who will commit themselves to completing a psychiatry residency and who might, for example, agree to practice as a psychiatrist for a defined number of years in an underserved area. • The task force will report its findings to the Assembly and the Board of Trustees at the 2015 Annual Meeting. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.M: *Addressing the Shortage of Psychiatrists with Sources of Funding* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Medical Education and Lifelong Learning and requested that they discuss the pros and cons of the action paper and present the Joint Reference Committee with recommendations for action (with rationale) for the Joint Reference Committee meeting in January 2015. The Council was asked to confer with the American Psychiatric Foundation about the potential for obtaining outside funding.	Kristen Kroeger Nancy Delanoche Deana McCrae Paul Burke	Council on Medical Education and Lifelong Learning Department of Government Affairs American Psychiatric Foundation **Report to Joint Reference Committee January 2015**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.13	<u>Area RFM Representative Modality and Opportunity for APA Updates and Education</u> (ASMMAY1412.N) [Please see item 6, attachment 13] The action paper asks that the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established. That the slide set contains the following information: • APA goals and mission statement, • RFM membership benefits (i.e. discounts from APPI, etc.), • basic structure of the leadership hierarchy within the APA, • information about the PAC, • RFM key leaders with contact information, • RFM leadership opportunities within the APA, • RFM informational guides and/or handbook link, • a brief description of the APA Assembly and it's role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently). That this slide set be used as a template for RFM leaders to add further information specific to his/her area. That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the RFM Representative. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.N*: Area RFM Representative Modality and Opportunity for APA Updates and Education* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer and Medical Director. It was noted that these requests are being addressed by APA staff. The CEO will report to the Joint Reference Committee in October 2014 regarding progress on these endeavors.	Dr. Saul Levin Jon Fanning	Office of the Chief Executive Officer and Medical Director **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.14	ABPN 2015 Exam Expectations (ASMMAY1412.P) [Please see item 6, attachment 14] The action paper asks that the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.P: *APBN 2015 Exam Expectations* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer and Medical Director for discussion during the APA's ongoing meetings with ABPN. It was noted that ABPN has stated that this goal is not obtainable for 2015 but potentially for 2017.	Dr. Saul Levin Kristin Kroeger	Office of the Chief Executive Officer and Medical Director
6.15	APA Referendum Voting Procedure (ASMMAY1412.S) [Please see item 6, attachment 15 and 15a] The action paper asks: 1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing. 2. That it is the will and intent of the Assembly that this action paper, now reaffirmed, be passed on by the JRC to the Board of Trustees. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1421.S: *APA Referendum Voting Procedure* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee forwarded this action paper to the Board of Trustees with a request that the Board have further discussions and weigh a variety of options.	Shaun Snyder Margaret Dewar Ardell Lockerman	Board of Trustees **July 2014**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.16	<u>Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting</u> (ASMMAY1412.U) [Please see item 6, attachment 16] The action paper asks that: 1. APA institute and publicize a President's Award for the District Branch with the highest voting rate (highest percentage) in the election, and for the Area with the same criteria. 2. These awards (a trophy or plaque along with a certificate), be presented at the Annual meeting immediately following the election each year. 3. The awards and the presentation will be duly publicized in Psychiatric News and in other appropriate avenues. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.U: *Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Assembly Executive Committee for their review and requested that they consider having this become an Assembly Award to be given to one District Branch and one Area each year.	Shaun Snyder Margaret Dewar Allison Moraske	Assembly Executive Committee **July 2014** FYI – Elections Committee

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.17	Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System (ASMMAY1412.V) [Please see item 6, attachment 17] The action paper asks that: The Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will resume being the proactive and dynamic voice of the APA to advocate for the efforts to provide for and improve the care and treatment of persons with mental illness in the criminal justice system, and to provide deliverables such as a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, and nationally - to organizations such as NAMI, The National Association of State Mental Health Program Directors - and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council. The Committee on Persons with Mental Illness in the Criminal Justice System would report to the Council on Psychiatry and Law and would provisionally have the following charge: 1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the criminal justice system. 2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system. 3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment. 4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons; 5. Revise and update the Position Statement of 1988. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.V: *Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law and requested that they confer with the Work Group on Persons with Mental Illness in the Criminal Justice System and discuss potential recommendations to upgrade the Work Group into a Committee under the Council.	Kristin Kroeger Lori Klinedinst	Council on Psychiatry and Law **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.18	Patient Safety and Veterans Affair Medical Center Participation in State Prescription Monitoring Programs (ASMMAY1412.X) [Please see item 6, attachment 18] The action paper asks: That the APA will request the Council on Advocacy and Government Relations to explore federal legislation and regulatory opportunities for the APA to advocate for the Veterans Health Administration to create a program that would allow licensed prescribers universal access to state PMPs, and That APA's resources, including the Offices of the APA CEO/Medical Director, the Council on Advocacy and Government Relations and the Council on Addiction become engaged in this endeavor. The APA will advocate for more open access to state PMPs, initially by VA health care providers not licensed in that given state. Will the Joint Reference Committee refer the Assembly action paper ASMMAY1412.X: *Patient Safety and Veterans Affair Medical Center Participation in State Prescription Monitoring Programs* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Advocacy and Government Relations and requested a report back to the Joint Reference Committee for its October 2014 meeting.	Kristin Kroeger Christopher Whaley	Council on Advocacy and Government Relations **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.19	Position Statement on the Psychiatric Implication of HIV/HCV Co-infection (JRCJAN148.L.3; ASMMAY144.B.3) [Please see item 6, attachment 19] The Assembly voted to refer the Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection back to the Joint Reference Committee. The Assembly felt that, in addition to being more of a guideline rather than a position statement, the web pages listed throughout the document were out of date, and confusing. Additionally, there were concerns that insurance providers may not pay for up to date treatments for patients with these conditions. Will the Joint Reference Committee refer the Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the action paper to the Council on Quality Care and the Department of HIV Psychiatry for revision per the Assembly's comments. The Joint Reference Committee requested a report back to the January 2015 Joint Reference Committee.	Kristen Kroeger Emily Kuhl Carol Svoboda	Council on Research Office of HIV Psychiatry **Report to Joint Reference Committee January 2015**
8.A	Council on Addiction Psychiatry	The Joint Reference Committee thanked Dr. Levin and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.A.1	Referral Update/Action Item Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist (JRCOCT128.A.1; ASMMAY134.B.1) [Please see item 8.A, attachment #1] Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve the Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist? The Council developed a Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist. It was approved by the Joint Reference Committee and submitted to the Assembly for review and approval. Assembly reviewers noted several areas of suggested improvement and returned the statement to the Council for revision. The statement was subsequently modified and is again submitted for JRC, Assembly, and Board approval. The Council wishes to emphasize that the position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.	The Joint Reference Committee recommended that the proposed position statement be forwarded to the Assembly for consideration and if approved, sent to the Board of Trustees.	Shaun Snyder Margaret Dewar Allison Moraske Ardell Lockerman	Assembly **November 2014** Board of Trustees **December 2014**
8.B	Council on Advocacy and Government Relations Dr Perlman provided the Joint Reference Committee with a brief update on the activities of the Council, detailing the recent bill passed in Illinois regarding psychologist prescribing; the Murphy Bill, and other items.	The Joint Reference Committee thanked Dr. Perlman and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.C	Council on Children, Adolescents and Their Families Dr. Kraus provided the Joint Reference Committee with a brief update on the activities of the Council including a collaborative effort with AACAP to develop a medical algorithm for the treatment of autism. It was noted that practice parameters for autism were approved by AACAP earlier this year. The Joint Reference Committee asked the Council to meet via conference call between its in-person meetings in September and May.	The Joint Reference Committee thanked Dr. Kraus and the Council for their report and updates.		
	Referral Update: JRCOCT128.C.5; ASMMAY134.B.4: Revised Position Statement on Child Abuse and Neglect by Adults Revisions to the position statement were made to address the Assembly's recommendation that the position statement cover in more detail the overall impact of poor treatment on children. However, the Council was unable to review the document at its May 5 meeting due to time constraints. The Council will take this up at its September meeting when it will also review a draft supporting resource document, which is currently in progress.	The Joint Reference Committee thanked the Council for this update.		
8.D	Council on Communications Dr. DePaulo provided the Joint Reference Committee with a brief update on the activities of the Council including their input and work on the APA Website and discussing what the APA's role in social media should be.	The Joint Reference Committee thanked Dr. DePaulo and the Council for their report and updates.		
8.E	Council on Geriatric Psychiatry	The Joint Reference Committee thanked Dr. Roca and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.E.1	<u>Resident Fellow Position on Council</u> Will the Joint Reference Committee recommend that the Board of Trustee approve designating one member position on the Council to a Resident Fellow? A Resident Fellow position would parallel the member positions on the council designated for an ECP and an Assembly member. There is no additional cost to this change as the Resident Fellow member position would allocate an existing member position on the council to an RFM.	The Joint Reference Committee referred the action to the Office of the Chief Executive Officer and Medical Director and requested a report on the financial implications of this action, were it to be implemented across all the Councils.	Dr. Saul Levin Shaun Snyder Margaret Dewar Laurie McQueen	Office of the Chief Executive Officer and Medical Director Department of Association Governance **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
8.G	Council on Healthcare Systems and Financing	The Joint Reference Committee thanked Dr. Trivedi and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.1	Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform [Please see item 8.G, pp 8-9 and attachment 2] a) Will the Joint Reference Committee ask the relevant APA Councils to review the recommendations of the Ad Hoc Work Group on the Role of Psychiatry in Health Reform and create an inventory of the work already underway at the APA? b) Will the Joint Reference Committee review these inventories and recommend a lead Council for important and actionable recommendations and state appropriate areas of the APA to include for each recommendation? Financial Implications: The initial inventory would require member and staff time; possibly an additional conference call. The costs could likely come from existing budgets. Note that there is currently a staff-led association-wide work group that meets regularly to discuss issues related to integrated care (one element of this work). Once the inventory is complete an assessment (including financial implications) and prioritization of the current activities along with the gaps will need to occur. Background: As part of a discussion on psychiatry and health reform, the CHSF reviewed some of the recommendations from the APA BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform (Paul Summergrad, MD, chair). Members of the Council wondered what had happened with the recommendations and if there had been an implementation plan and/or group. A suggestion was made to do an inventory of the work currently underway that relates to the recommendations in the report as a first step in developing an action plan. The Council suggests there be coordination across the APA to cluster together around meaningful items.	The Joint Reference Committee supported the action and recommended that the request be referred to all Councils and that the results of their review be forwarded to the Council on Healthcare Systems and Financing. The Joint Reference Committee also asked Dr. Saul Levin to forward this information to appropriate APA divisions and departments.	Staff Liaisons to the Councils Dr. Saul Levin Ian Hedges	All Councils Council on Healthcare Systems and Financing (LEAD) **Progress report to Joint Reference Committee October 2014** [Report deadline 9/24/14]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.2	Fall Component Meetings Plenary: Recommendations of the BOT Ad Hoc Work Group on the role of Psychiatry in Health Reform Will the Joint Reference Committee recommend to the appropriate APA body that a plenary session be held at the Fall Meetings (2014) focusing on psychiatry and health reform and the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report? Financial Implications**:** Recognizing that not all Councils are meeting on the same days, the plenary should be scheduled during the group meal function with the maximum anticipated attendance (in an effort to reach the maximum number of attendees possible). The cost would be the audio/visual needs (microphone, power point setup, etc.). The presentation(s) would be done by individuals already in attendance. Background: The discussion noted above was followed by a suggestion to provide a plenary for all Councils at the fall meetings on the report (including the recommendations) from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform. The plenary would provide a mechanism to provide the context for moving forward with specific recommendations and could inform discussion within and amongst Councils at the fall meetings.	The Joint Reference Committee supported the idea of educating council chairpersons regarding health reform and the recommendations of the AHWG on the Role of Psychiatry in Health Reform. The Joint Reference Committee referred this request to the Office of the Chief Executive Officer and Medical Director and requested that innovative ways to get this information to the councils be developed and disseminated to the Councils prior to the Fall Components Meetings.	Dr. Saul Levin Ian Hedges	Dr. Paul Summergrad, APA President Office of the Chief Executive Officer and Medical Director

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.3	Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project [Please see item 8.G, 10-11] Will the Joint Reference Committee support the request of the CHSF to establish a qualified ad-hoc work group to collaborate with appropriate APA staff to advocate APA's position with regard to the Excellence in MH Act? Financial Implications: This would require member and staff time including 1 to 3 conference calls. The costs could likely come from existing budgets. Background: The Council discussed this legislation which creates a pathway for CMHCs to become CCBHCs (Certified Community Behavioral Health Centers) in eight states. These CCBHCs would provide "intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services" among other requirements. CCBHC services then become federally eligible for Medicaid matching reimbursement. There are $25 million dollars in planning grants available to states looking to apply to serve as a demonstration state. The deadline for HHS to issue regulations on the criteria for eligible 'CCBHCs,' including staffing requirements, is September 1st, 2015. Feedback from multiple members of the Council on Healthcare Systems and Financing was that APA should be actively engaged and involved, as much as is permissible, in the rule writing process. This is an important activity and one that APA must take the lead on. Members were concerned that should APA fail to become engaged in the process that the organization would have missed an important opportunity to shape something psychiatrists will have to be actively involved in. It is critical to make sure psychiatrists in these new CCBHCs have responsibility for the overall quality of clinical services. Members expressed concern that this will not happen if other non-physician led organizations do this without our involvement.	The Joint Reference Committee was informed by Kristin Kroeger that a small work group has been formed to address the issues of the Excellence in Mental Health Act. The work group is comprised of individuals with backgrounds in substance use, healthcare systems and financing and government relations. The work group is chaired by Dr. Lori Raney. The Joint Reference Committee thanked Ms. Kroeger for this update and considered the action implemented and requested a progress report for the October 2014 meeting.	Kristin Kroeger Becky Yowell	**Report to the Joint Reference Committee October 2014** [Report deadline 9/24/14]
8.H	Council on Medical Education and Lifelong Learning	The Joint Reference Committee thanked Dr. Summers and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.1	Joint Symposia at APA Annual Meetings Will the Joint Reference Committee recommend that the Board of Trustees approve supporting formal and continued joint symposium with allied organizations at APA Annual Meetings? AADPRT is formally requesting that a joint symposium continue for future APA Annual Meetings. The Council is in support of this and will formally ask the JRC to support regular joint symposia with allied psychiatric organizations to include subspecialty and education organizations. There is no additional cost to the APA as the symposia are already part of the Annual Meeting. Some of the symposia spots will be reserved for allied organizations. The symposium will need to be peer-reviewed by the SPC.	The Joint Reference Committee supports ongoing joint symposia with allied organizations at the APA Annual Meeting. All submitted symposia will be reviewed by the Scientific Program Committee.	Kristen Kroeger Joy Raether	Scientific Program Committee FYI – Board of Trustees
8.H.2	Support for PsychSIGN Will the Joint Reference Committee recommend that the Board of Trustees affirm its continued financial support for PsychSIGN? The PsychSIGN leaders are requesting continued APA support of its programs and activities. The Council is in support of this and will forward this request to the JRC. The APA supports PsychSIGN for $40,000 annually. However, the budget was reduced to $35,000 for 2014. We request that the budget recommence at $40,000 for 2015.	The Joint Reference Committee recommends that the Board of Trustees support PsychSIGN in the amount of $40,000 for 2015.	Shaun Snyder Margaret Dewar Ardell Lockerman	Board of Trustees **July 2014**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.3	Request for a New Component: American Psychiatric Leadership Fellowship [Please see item 8.H, attachment #1] Will the Joint Reference Committee recommend that the Board of Trustees approve reinstatement of the American Psychiatric Leadership Fellowship Selection Committee to select and mentor the American Psychiatric Leadership fellows? When the American Psychiatric Leadership Fellowship lost its industry funding, the selection committee was sunsetted. The Fellowship is now funded by the American Psychiatric Foundation and the former members of the sunsetted selection committee have continued to select and mentor fellows. They now request that the APA President formally appoint members to this now active selection committee. There will be no additional cost to the APA. The minimal cost of a Selection Committee will come from the Fellowship grant funding.	The Joint Reference Committee recommended that the Board of Trustees approve the establishment of the American Psychiatric Leadership Fellowship Selection Committee.	Shaun Snyder Margaret Dewar Ardell Lockerman Paul Burke (for information)	Board of Trustees **July 2014**

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.4	<u>Waive Copyright Restriction for DSM 5 Criteria</u> Will the Joint Reference Committee recommend that the Board of Trustees approve waiving the DSM 5 copyright restrictions for allied, non-profit education organizations for use in non-commoditized teaching/educational resources specifically for medical student education? ADMSEP has created on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5. These modules are provided free on the ADMSEP website, and are also published on MedEdPortal for use by clerkship directors and medical students for general educational purposes and, in some cases, to meet LCME standards ED-2 and ED-8. For example, a module can provide the opportunity for a student unable to see a key condition in a clinical setting to learn about the condition and, therefore, meet clerkship requirements. The modules reference DSM 5. However, the fee that APA requires for use of DSM criteria is not affordable for ADMSEP (a non-profit allied education organization). There is no monetary gain to anyone from these modules. There is not charge for their use and they were developed with the sole goal of improving psychiatric medical student education. There are no additional costs to the APA to waive copyright restriction for the DSM 5 criteria.	The Joint Reference Committee referred this action to the Office of the Chief Executive Officer and Medical Director for a full cost and impact analysis. The Joint Reference Committee expects a detailed report including recommendations, with rationale, for their meeting in October 2014.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director **Report to Joint Reference Committee October 2014** [Report deadline 9/24/14]
8.I	Council on Minority Mental Health and Health Disparities	The Joint Reference Committee thanked Dr. Walker and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.I.1	Search Process for the Directory of the APA Division of Diversity and Health Equity Will the Joint Reference Committee forward to the Board Executive Committee and the CEO/Medical Director the Council's urgent action item concerning the search process for the Director of the APA Division of Diversity and Health Equity, presented in item 8.I, attachment 1, p. 6?	The Joint Reference Committee considered input on this issue from various sources and concluded that the hiring of staff is properly within the purview of the CEO/Medical Director. The Joint Reference Committee recommends that Dr. Levin continue to seek input from the interested stakeholders without sharing confidential candidate information or changing the interview or hiring processes used for other APA director-level positions.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director
8.I.2	APA Website Navigation Will Joint Reference Committee recommend to the Chief Operating Officer that the main page of the APA website contain Diversity as navigation item as illustrated in item 8.I, attachment 2, p. 8?	The Joint Reference Committee referred this item to the Office of the Chief Executive Officer and Medical Director for potential implementation in the ongoing enhancements to the APA website.	Dr. Saul Levin Shaun Snyder	Office of the Chief Executive Officer and Medical Director
	Referral Updates: ASMMAY1312.Q: Development of a resource document on human trafficking A draft of the document is currently in review by work group members. Feedback from interested persons on the Council on Children, Adolescents, and Their Families and Council on Psychiatry and Law, as well as other content experts is being sought at this time. The final document is expected to be submitted to Council by September. Ludmila De Faria, MD, is the chairperson of the work groups which are working on these projects	The Joint Reference Committee thanked the Council for this update.		
	Referral Updates: ASMNOV1212.U: The Development of a Resource Document on Rape – In progress. The work group is currently being reconstituted. Ludmila De Faria, MD, is the chairperson of the work groups which are working on these projects.	The Joint Reference Committee thanked the Council for this update.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J	Council on Psychiatry and Law	The Joint Reference Committee thanked Dr. Hoge and the Council for their report and updates.		
8.J.1	Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services [Please see item 8.J, attachment #3] Will the Joint Reference Committee recommend that the Assembly approve Proposed Position Statement on Firearms Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services, and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the proposed position statement to the Assembly for consideration and if approved by the Assembly, forwarded on to the Board of Trustees. The Joint Reference Committee rearranged the order of the paragraphs in the position statement but did not alter the content of the position statement.	Shaun Snyder Margaret Dewar Allison Moraske Ardell Lockerman	Assembly **November 2014** Board of Trustees **December 2014**
8.J.2	Proposed APA Resource Document on Access to Firearms by People with Mental Disorders [Please see item 8.J, attachment #4] Will the Joint Reference Committee approve the Proposed Resource Document on Access to Firearms by People with Mental Disorders?	The Joint Reference Committee approved the resource document on Access to Firearms by People with Mental Disorders. The document will be sent to the Library and Archives for posting on the APA website.	Jon Fanning Gary McMillan	Library and Archives FYI – Board of Trustees
8.K	Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry) Dr. Gitlin provided the Joint Reference Committee with a brief update on the issues before the Council. Subspecialty training in psychosomatic medicine is becoming more critical and consultation/liaison psychiatry is an important area for providing care. Recruiting more psychiatrists into this area as integrated care expands will be necessary. The Joint Reference Committee noted that psychosomatic medicine fits well with integrated care and psychiatry can be supportive to primary care doctors as the primary healthcare provider for medicine, including mental health care. The Joint Reference Committee noted the issue of how subspecialty groups view the APA.	The Joint Reference Committee thanked Dr. Gitlin and the Council for their report and updates.		N/A

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L	Council on Quality Care	The Joint Reference Committee thanked Dr. Yager and the Council for their report and updates.		
8.L.1	Revision to APA's *Choosing Wisely® campaign* [Please see item 8.L, attachments #1 and #2] Will the Joint Reference Committee recommend updated language to item number five of the APA's *Choosing Wisely® campaign* list, which identifies targeted, evidence-based recommendations that can prompt conversations between patients and physicians about what care is really necessary?	The Joint Reference Committee recommended that the Board of Trustees approve the revisions to the *Choosing Wisely® campaign*.	Shaun Snyder Margaret Dewar Ardell Lockerman	Board of Trustees **July 2014**
8.L.2	Review of APA's Conflict of Interest Policy [Please see item 8.L, attachments #3 and #4 (page 6 of attachment #4)] Will the Joint Reference Committee recommend to the Board of Trustees that the APA COI policy be reviewed and aligned with policies for guideline development groups recommended by the Institute of Medicine (IOM) and the Council of Medical Specialty Societies (CMSS) now being adopted by most other medical specialties?	The Joint Reference Committee referred this action to the Board of Trustees for referral to the Conflict of Interest Committee for their review and development of recommendations for potential revision of the APA's Disclosure of Interests and Affiliations policy.	Laurie McQueen Colleen Coyle	Board of Trustees **July 2014** Conflict of Interest Committee
	Referral Updates: ASMNOV1312.D: Protecting Privacy and Confidentiality in the Age of the Electronic Medical Records Committee on Mental Health Information Technology (CMHIT) has discussed this and thinks some minor changes in wording of the position statement would be appropriate in terms of the security of the record. A discussion with the Council on Psychiatry and the Law and with Council on Healthcare Systems & Financing will occur in June, and final language will be developed and forwarded to JRC on completion	The Joint Reference Committee thanked the Council for this update.		N/A

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
	Referral Updates ASMNOV1212.B: Management of Sensitive Information within Health Information Exchanges (HIEs) • This area has been evolving quickly over the past 18 months, so the committee has waited for some new technical capabilities to be piloted and shown to be acceptable. CMHIT believes that now that this technology for improving the confidentiality of sensitive information has been proven, a useful position statement can be crafted. • CMHIT members, along with Glenn Martin, are preparing a draft paper for review and comment by Council on Healthcare Systems & Financing, Council on Advocacy & Government Relations, and Council on Psychiatry & the Law. A final draft is expected in July.	The Joint Reference Committee thanked the Council for this update.		N/A
8.M	Council on Research Dr. Evans provided the Joint Reference Committee with a brief update on the activities of the Council including the progress of the Council's various work groups. The patient registry work group recommended that the APA develop a pilot registry as this would be important to ACO's as well as individual practitioners. The Joint Reference Committee was informed of the Diagnostic Markers in Treatment Work Group under the aegis of the Council. The council is deferring work on its charge until the report of the BOT's Research Review Committee.	The Joint Reference Committee thanked Dr. Evans and the Council for their report and updates.		N/A

ADDENDUM
Report of the Joint Reference Committee
To the
Assembly
November 7 – 9, 2014

The Joint Reference Committee (JRC) refers the following actions to the Assembly for consideration. All may be considered for placement on the consent calendar

ACTION ITEMS

4.B.3 Retain Position Statement: Relationship Between Treatment and Self-Help
[JRCOCT148.A.1] [Please see attachment #4]

Will the Assembly retain the Position Statement *Relationship between Treatment and Self Help* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Addiction Psychiatry states that the statement is current, relevant and should be retained.

4.B.4 Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions
[JRCOCT148.A.3] [Please see attachment #5]

Will the Assembly retire the Position Statement *Mental Health & Substance Abuse and Aging: Three Resolutions* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Addiction Psychiatry states that the statement was not authored by the APA, and it is not known if updates to resolutions authored by another organization can be made.

4.B.5 Retain Position Statement Elder Abuse, Neglect and Exploitation
[JRCOCT148.E.2] [Please see attachment #6]

Will the Assembly retain the Position Statement *Elder Abuse, Neglect and Exploitation* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.

4.B.6 Retain Position Statement: Discriminatory Disability Insurance Coverage
[JRCOCT148.G.2] [Please see attachment #7]

Will the Assembly retain the Position Statement *Discriminatory Disability Insurance Coverage* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.

4.B.7 Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations
[JRCOCT148.G.4] [Please see attachment #8]

Will the Assembly retain the Position Statement *Psychiatrists Practicing in Managed Care: Rights and Regulations* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.

4.B.8 Retain Position Statement: State Mental Health Services
[JRCOCT148.G.5] [Please see attachment #9]

Will the Assembly retain the Position Statement *State Mental Health Services* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.

4.B.9 Retain Position Statement: Universal Access
[JRCOCT148.G.6] [Please see attachment #10]

Will the Assembly retain the Position Statement *Universal Access* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.

4.B.10 Retain Position Statement: Federal Exemption from the IMD Exclusion
[JRCOCT148.G.7] [Please see attachment #11]

Will the Assembly retain the Position Statement *Federal Exemption from the Institution for Mental Disease (IMD) Exclusion* and if retained, forward it to the Board of Trustees for consideration?

The JRC requested that the Council spell out all the acronyms within the Position Statement.

Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.

4.B.11 Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment
[JRCOCT148.G.11] [Please see attachment #12]

Will the Assembly retire the Position Statement 2002 *Access to Comprehensive Psychiatric Assessment and Integrated Treatment* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement as it is an earlier iteration of the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

4.B.12 Retire Position Statement: Psychotherapy and Managed Care
[JRCOCT148.G.12] [Please see attachment #13]

Will the Assembly retire the Position Statement *Psychotherapy and Managed Care* and if retired, forward to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. The key elements of this statement are captured in the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

4.B.13 Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks
[JRCOCT148.G.13] [Please see attachment #14]

Will the Assembly retire the Position Statement *Guidelines for Handling the Transfer of Provider Networks* and if retired, forward to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. There have been changes in healthcare delivery methods or in the healthcare system which make the current position no longer relevant. Elements of this are covered in the 2009 position statement "Access to Comprehensive Psychiatric Assessment and Integrated Treatment."

4.B.14 Retire Position Statement: Active Treatment
[JRCOCT148.G.14] [Please see attachment #15]

Will the Assembly retire the Position Statement *Active Treatment* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position. The points made in this position statement are covered in other, more current, statements.

4.B.15 Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter
[JRCOCT148.G.15] [Please see attachment #16]

Will the Assembly retire Position Statement *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position statement. This charter was originally developed by leaders in the ABIM Foundation, ACP-ASIM Foundation and the European Federation of Internal Medicine. The key points made in this position statement are covered in other, more current, statements.

4.B.16 Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded
[JRCOCT148.G.16] [Please see attachment #17]

Will the Assembly retire Position Statement *Desegregation of Hospitals for the Mentally Ill and Retarded* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Healthcare Systems and Financing recommends retiring this position. There have been changes in healthcare delivery methods or in the healthcare system which make the subject and current position no longer relevant.

4.B.17 Retain Position Statement: Abortion & Women's Reproductive Health Care Rights
[JRCOCT148.I.1] [Please see attachment #18]

Will the Assembly retain the Position Statement *Abortion & Women's Reproductive Health Care Rights* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Minority Mental Health and Health Disparities believed that the statement sufficiently made the point and given that the statement was fairly new, recommends that it be retained.

4.B.18 Retain Position Statement: Xenophobia, Immigration and Mental Health
[JRCOCT148.I.2] [Please see attachment #19]

Will the Assembly retain the Position Statement *Xenophobia, Immigration and Mental Health* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Minority Mental Health and Health Disparities believed that the statement sufficiently made the point and given that the statement was fairly new, recommends that it be retained.

4.B.19 Retire Position Statement: Juvenile Death Sentences
[JRCOCT148.J.5] [Please see attachment #20]

Will the Assembly retire the Position Statement on *Juvenile Death Sentences* and if retired, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retired as written as it is no longer relevant in light of recent case law.

4.B.20 Retain Position Statement: Peer Review of Expert Testimony
[JRCOCT148.J.6] [Please see attachment #21]

Will the Assembly retain the Position Statement *Peer Review of Expert Testimony* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as it is still relevant for current practice.

4.B.21 Retain Position Statement: Joint Resolution Against Torture
[JRCOCT148.J.7] [Please see attachment #22]

Will the Assembly retain the Position Statement *Joint Resolution Against Torture* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.22 Retain Position Statement: Moratorium on Capital Punishment in the United States
[JRCOCT148.J.8] [Please see attachment #23]

Will the Assembly retain the Position Statement *Moratorium on Capital Punishment in the United States* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.23 Retain Position Statement: Discrimination Against Persons with Previous Psychiatric Treatment
[JRCOCT148.J.9] [Please see attachment #24]

Will the Assembly retain the Position Statement *Discrimination against Persons with Previous Psychiatry Treatment* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice

4.B.24 Retain Position Statement: Insanity Defense
[JRCOCT148.J.910] [Please see attachment #25]

Will the Assembly retain the Position Statement *Insanity Defense* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.25 Retain Position Statement: Psychiatric Participation in Interrogation of Detainees
[JRCOCT148.J.11] [Please see attachment #26]

Will the Assembly retain the Position Statement *Psychiatric Participation in Interrogation of Detainees* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.26 Retain Position Statement: Death Sentences for Persons with Dementia of Traumatic Brain Injury
[JRCOCT148.J.12] [Please see attachment #27]

Will the Assembly retain the Position Statement *Death Sentences for Persons with Dementia or Traumatic Brain Injury* and if retained, forward it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.27 Retain Position Statement: Mentally Ill Prisoners and Death Row
[JRCOCT148.J.13] [Please see attachment #28]

Will the Assembly retain the Position Statement *Mentally Ill Prisoners and Death Row* and if retained, forward to it to the Board of Trustees for consideration?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.28 Retain Position Statement: Diminished Responsibility in Capital Sentencing
[JRCOCT148.J.14] [Please see attachment #29]

Will the Assembly retain the Position Statement *Diminished Responsibility in Capital Sentencing*?

Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.

4.B.29 Retain Position Statement: Endorsement of the Patient-Physician Covenant
[JRCOCT148.L.5] [Please see attachment #30]

Will the Assembly retain the 2007 Position Statement *Endorsement of the Patient-Physician Covenant* and if retained, forward it to the Board of Trustees for consideration?

Rational: The Council on Quality Care agreed to retain the statement until a better one came along or until they choose to revise the statement.

4.B.30 Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents [JRCOCT148.L.6] [Please see attachment #31]

Will the Assembly retain the 2009 Position Statement *Provision of Psychotherapy for Psychiatric Residents* and if retained, forward it to the Board of Trustees for consideration?

Rational: The Council on Quality Care agreed to retain the statement but thought that the statement should be broadened to all training programs, not just psychiatry.

APA Official Actions

Joint Public Policy Statement on Relationship Between Treatment and Self Help

Board of Trustees, December 1997
Joint Reference Committee, October 1997
Council on Addiction Psychiatry, September 1997
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Background

For many years, physicians and other treatment professionals have recognized the value of self-help groups as a valuable resource to patients in addiction treatment and their family members. (See, for example, American Society of Addiction Medicine's 1979 resolution on self help groups; the *ASAM Patient Placement Criteria* (2nd edition), and the American Psychiatric Association's *Practice Guidelines for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, and Opioids*). Addiction professionals and programs routinely recommend such groups to their patients and help them understand and accept the value of becoming an active participant.

It is important to distinguish between professional treatment and self help. Treatment involves at minimum, the following elements:

a. A qualified professional is in charge of, and shares professional responsibility for, the overall care of the patient;
b. A thorough evaluation is performed, including diagnosis, determination of the stage and severity of illness and an assessment of accompanying medical, psychiatric, interpersonal and social problems;
c. A treatment plan is developed, based on both the initial assessment and response to treatment over time. Such treatment is guided by professionally accepted practice guidelines and patient placement criteria;
d. The professional or program responsible and accountable for treatment is also responsible for offering or referring the patient for additional services that may be required as a supplement to addiction treatment;
e. The professional or program currently treating the patient continues therapeutic contact, whenever possible, until stable recovery has been attained.

Self-help groups, although helpful at every stage of treatment and as long-term social and spiritual aid to recovery, do not meet the above criteria and should not be confused with or substituted for professional treatment.
In some instances, utilization review and medical necessity guidelines used by insurers and other managed care entities have sought to substitute self-help attendance for professional treatment in patients who have not reached stable remission from their alcohol or other drug dependence.

Position

The American Psychiatric Association, American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine recommend that:

1. Patients in need of treatment for alcohol or other drug-related disorders should be treated by qualified professionals in a manner consonant with professionally accepted practice guidelines and patient placement criteria;
2. Self-help groups should be recognized as valuable community resources for many patients in addiction treatment and their families. Addiction treatment professionals and programs should develop cooperative relationships with self-help groups;
3. Insurers, managed care organizations, and others should be aware of the difference between self-help groups and treatment;
4. Self-help should not be substituted for professional treatment, but should be considered a complement to treatment directed by professionals. Professional treatment should not be denied to patients or families in need of care.

Approved by:
AAAP Board of Directors, October 1997
ASAM Board of Directors, October 1997

APA Official Actions

Position Statement on Mental Health & Substance Abuse and Aging: Three Resolutions

Approved by the Board of Trustees, December 2004
Approved by the Assembly, November 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

These resolutions were prepared by the National Coalition on Mental Health and the Aging.

RESOLUTION ON MENTAL HEALTH & SUBSTANCE ABUSE SERVICES AND INTERVENTIONS

WHEREAS the 1999 Surgeon General's Report on Mental Health found that disability due to mental disorders, substance use or cognitive impairments in individuals aged 65 and over will become a major public health problem in the near future due to changing demographics; and

WHEREAS the 2003 President's New Freedom Commission on Mental Health identified as barriers to care:

- A fragmented service delivery system;
- Out of date Medicare policies;
- Stigma due to mental illness and advanced age;
- A mismatch between services that are covered and those preferred by older persons; and
- A lack of adequate preventive interventions and programs that aid early identification of geriatric mental illness; and

WHEREAS the U.S. Supreme Court in the 1999 *Olmstead v. L.C.* decision ruled that institutionalization of persons with disabilities who, given appropriate supports, could live in the community is a form of discrimination that violates the Americans with Disabilities Act; and

WHEREAS almost 20% of persons age 55 and over experience specific mental and cognitive disorders that are not part of the "normal" aging process including a prevalence rate of 11.4% for anxiety disorders (Department of Health and Human Services, 1999); and

WHEREAS as many as 20% of older adults in the community and up to 37% in primary care settings experience symptoms of depression (Department of Health and Human Services, 1999); and

WHEREAS the Surgeon General's Report observed that as many as half of all people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives and 15% of older men and 12% of older women treated in primary care clinics regularly drink in excess of limits recommended by the National Institute on Alcohol Abuse and Alcoholism (Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS older persons who are dually eligible for Medicare and Medicaid may lose access to medications that they had under their state Medicaid plan when the prescription drug benefit of the Medicare Prescription Drug Improvement and Modernization Act of 2003 takes effect on January 1, 2006; and

WHEREAS comorbidity of mental illness and substance abuse exacerbates symptoms and often leads to treatment noncompliance, more frequent hospitalization, greater depression and likelihood of suicide, incarceration, family friction, and higher service use and cost (Department of Health and Human Services, 1999); and

WHEREAS it is estimated that 17% of older adults misuse and abuse alcohol and medications and although the majority (87%) of older adults see a physician regularly about 40 % of those who are at risk do not self-identify or seek services for substance abuse problems and are unlikely to be identified by their physicians (Barry, et al., 2001; Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS older adults have the highest suicide rate of any age group with persons 85 years of age and older having a rate almost double (21 per 100,000), and older white men having a rate almost six times (65 per 100,000) the suicide rate of the general population (10.6 per 100,000) (Conwell, et al., 2002; US Public Health Service, 1999); and

WHEREAS there are effective interventions for most mental and substance abuse disorders experienced by older persons (Bartels, et al., 2003; Department of Health and Human Services, 1999, Gatz, et al., 1998); and

WHEREAS older Americans can accrue overall health benefits from successful treatment of their mental health and/or substance abuse disorder (Administration on Aging, 2001; Department of Health and Human Services, 1999); and

WHEREAS older adults and aging baby boomers present a growing and widely diverse ethnic and cultural population that will present major challenges to the nation's public and private mental health, primary care, and substance abuse systems (Administration on Aging, 2004; Whitfield, 2004);

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to support policies that:

Assure access to an affordable and comprehensive range of quality mental health and substance abuse services including:

- outreach
- home and community based care
- prevention
- intervention
- acute care
- long-term care;

Assure that these services are age appropriate, culturally competent, and consumer driven;

Amend statutes that address public and private health and long-term care insurance plans to:

- guarantee parity in coverage and reimbursement for mental health, physical health, and substance abuse disorders
- eliminate exclusions based on pre-existing conditions
- ensure that benefits packages provide full access to a comprehensive range of coordinated and quality services
- ensure that older persons who are eligible for Medicare have access to a full range of medications;

Improve and effectively coordinate benefits, at all government levels, for those individuals who are dually eligible for Medicare and Medicaid coverage;

Promote the development and implementation of home and community-based care as an alternative to institutionalization through a variety of public and private funding mechanisms;

Promote older adult mental health and substance abuse services research, and coordinate and finance the movement of evidence-based and emerging best practices between research and service delivery;

Support the integration of older adult mental health and substance abuse services into primary health care, long term care and community-based service systems;

Promote screening for co-occurring mental and substance use disorders by primary health care, mental health, and substance abuse providers and encourage the development of integrated treatment strategies; and

Increase collaboration among aging, health, mental health, and substance abuse consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant government agencies to promote more effective use of resources and to reduce fragmentation of services.

RESOLUTION ON THE EDUCATION AND DEVELOPMENT OF THE PROFESSIONAL MENTAL HEALTH WORKFORCE

WHEREAS mental health, behavioral health and substance abuse professionals are not sufficiently trained in geriatrics, geriatric practitioners are inadequately trained in mental health, and health, social services and general practitioners are inadequately trained in either mental health or geriatrics (Alliance for Aging Research, 2002; Gatz & Finkel, 1995); and

WHEREAS major national studies, including the 2003 President's New Freedom Commission on Mental Health, recognize that there is a severe shortage of practitioners in the mental health, behavioral health, and aging workforce to treat the mental disorders and substance abuse of older adults due to stigma and economic disincentives (Qualls, et al., 2002; Halpain, et al., 1999; Gatz & Finkel, 1995); and

WHEREAS as the diverse baby boom generation ages, there will be increased demand for culturally competent geriatric mental and behavioral health practitioners (Administration on Aging, 2004; Whitfield, 2004); and

WHEREAS there are evidence-based and emerging best practices for successful treatment of mental and behavioral health disorders (Bartels, et al., 2003; Pinquart & Soerensen, 2001; Department of Health and Human Services, 1999; Gatz, et al., 1998); and

WHEREAS undetected or inappropriately treated mental and behavioral health disorders lead to extraordinarily high rates of suicide among older adults and substantially increased risks of mortality from other diseases (Pearson & Brown, 2000; Department of Health and Human Services, 1999); and

WHEREAS interdisciplinary care has been shown to be the most effective approach for successful treatment of mid-life and older adults (Heinemann & Zeiss, 2002); and

WHEREAS it is imperative that graduate and continuing education programs train more health professionals in effective evidence-based and emerging best practices in geriatric mental health (New Freedom Commission, 2003; Qualls, et al., 2002, Halpain, et al., 1999; Gatz & Finkel, 1995); and

WHEREAS health and mental health professions

often fail to provide basic curricula in geriatric mental health and substance abuse for all students (Alliance for Aging Research, 2002; Gatz & Finkel, 1995); and

WHEREAS the President's New Freedom Commission on Mental Health recognizes that a complex blend of training, professional, organizational, and regulatory issues needs a comprehensive strategic plan to improve workforce recruitment, retention, diversity, and skills training; and,

WHEREAS the President's New Freedom Commission on Mental Health recognizes that without a strategic plan to improve workforce recruitment, retention, diversity, and skills training, it will be difficult to achieve many of the Commission's other recommendations;

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Actively seek to attract new providers in mental health, behavioral health, and substance abuse for older adults by expanding geriatric traineeships for counselors, nurses, psychiatrists, psychologists social workers, and other health professionals such as occupational therapists, physical therapists, pharmacists, and target national financial incentives such as loan forgiveness programs and continuing education funding;

Require that professional mental health and behavioral health education programs that receive federal funding introduce geriatric course work or rotation for all students that includes promotion of evidence based and emerging best practices and skills in treating people with co-occurring mental and addictive disorders;

Require federal programs to promote interdisciplinary training and education;

Encourage states to revise licensing and continuing education requirements so that geriatric mental health, behavioral health, and substance abuse training is required for all licensed health, mental health and social services professionals;

Direct the Department of Health and Human Services to refine its approach to technology transfer in geriatric mental health and behavioral health evidence-based and emerging best practices to ensure that knowledge is translated more rapidly into the content of training curricula, that curricula employ teaching methods of demonstrated effectiveness, and that knowledge about effective education, recruitment, and retention strategies inform all public and private efforts to translate science to services; and

Eliminate disparities in reimbursement between geriatric mental health, behavioral health, and substance abuse practice and other areas of mental health and health care practice.

RESOLUTION ON CONSUMER AND CAREGIVER ISSUES REGARDING MENTAL HEALTH AND SUBSTANCE ABUSE

WHEREAS the number of older adults with mental illness is expected to double to 15 million in the next 30 years (Jeste, et al., 1999); and

WHEREAS almost two thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996); and

WHEREAS studies indicate that 50 – 70% of all primary care medical visits are related to psychological factors such as anxiety, depression, and stress (American Psychological Association, 2004); and

WHEREAS the 1999 Surgeon General's report on Mental Health asserts that stigma surrounding the receipt of mental health treatment affects older people disproportionately and, as a result, older adults and their family members often do not want to be identified with the traditional mental health system therefore making stigma a major barrier to care that results in the underutilization of mental health and substance abuse services; and

WHEREAS as many as 17% of older adults knowingly or unknowingly engage in alcohol or medication misuse and abuse (Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS there is a paucity of research on the extent of mental health and substance abuse problems among older people, effective prevention and treatment strategies (Bartels & Unutzer, 2003; Curry & Jackson, 2003; Department of Health and Human Services, 2001; Katz, 1995); and

WHEREAS older adults have the highest suicide rate of any age group (Hoyert, et al., 1999; US Public Health Service, 1999); and

WHEREAS late-life mental disorders pose difficulties for the burgeoning numbers of family members who assist in caretaking tasks for their loved ones (Light & Lebowitz, 1991);

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging that:

Recommendation 1.1 of the 2003 Presidents New Freedom Commission on Mental Health Final Report, which seeks to advance and implement a national campaign to reduce the stigma associated with mental illness include an emphasis on older adults and seeking care as well as a national strategy for suicide prevention; and

A public/private education campaign be initiated under the Department of Health and Human Services to educate consumers, family members, providers, and the public on healthy aging and mental wellness and the identification and promise of effective treatments

for mental health disorders in older adults incorporating consumer choice/empowerment and involving consumers as educators; and

Older adults be identified as a priority for public mental health and substance abuse program funding; and

Research be conducted to assess the efficacy of prevention and treatment approaches for older adults (including peer support groups); and

Evidence based, emerging best practices, and value based mental health and substance abuse outreach, prevention, and treatment services for older adults be made available, accessible, and affordable and be provided by people trained and experienced working with older adults; and

Providers deliver services that are linguistically, culturally, ethnically, and age appropriate; and

The role of caregivers be recognized and supportive services be provided e.g., support groups, respite care, and counseling.

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APA Official Actions

Position Statement on Elder Abuse, Neglect, and Exploitation

Approved by the Board of Trustees, July 2008
Approved by the Assembly, May 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Issue

Elder abuse, neglect, and exploitation have been identified as major public health problems. All 50 states have adopted either mandatory or voluntary reporting laws. Emotional abuse is often linked with physical abuse, and both types of abuse can result in stress-related disorders. Psychiatric symptoms seen in abused elderly persons include the following: resignation, ambivalence, fear, anger, cognitive impairment, depressed mood, insomnia, substance abuse, delirium, agitation, lethargy and self-neglect.

These psychiatric symptoms are often the result of varied types of emotional and physical abuse, including threats, insults, harassment, lack of safe environment, harsh orders, infantilization, restriction of social and religious activity, and financial exploitation. Caregiver burden should be considered as an important risk factor for abuse, neglect, and exploitation, and appropriate interventions can be developed. This is particularly relevant in addressing APA's vision of ensuring humane care and effective treatment for all persons with mental disorders and its mission to promote the highest quality of psychiatric care.

Position Statement

The American Psychiatric Association (APA) recommends a comprehensive and culturally competent biopsychosocial assessment of victimized elderly persons and their perpetrators be completed in order to facilitate effective interventions, including the utilization of legal, social, and financial resources.

Developed by the American Psychiatric Association Council on Aging, 2007. Revision of the 1994 statement.

See the related resource document.

APA Official Actions

Position Statement on Discriminatory Disability Insurance Coverage

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

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The APA supports coverage for disability for psychiatric disorders the same as for other non-psychiatric medical conditions. The APA is opposed to arbitrary and discriminatory restrictions for mental illness (diagnosis-based contracts) in the coverage of disability.

APA Official Actions

Position Statement on Psychiatrists Practicing in Managed Care: Rights and Regulations

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

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Contract Issues

- Psychiatrists should be allowed to practice to the full extent of their training and licensure and should be permitted to provide services to patients based on medical necessity.
- Medical necessity should be as defined by the AMA, APA, State Legislature or State Regulatory Boards.
- Hold harmless clauses should be eliminated.
- Termination clauses must delineate the specific causes that may lead to termination.

Psychiatrist-Patient Relationships

- The interests of the patients are primary and psychiatrists should be advocates for any treatments believed to be clinically beneficial to the patient.
- No physician should be dropped from a panel for advocating for his patient.

Relationship with managed care organizations

- Economic profiling and pay for performance programs should enhance clinical services.
- Preferred provider status should be explained in all contracts with providers and all subscribing patients. This should be a transparent procedure, explaining the criteria and process used to designate a contracted provider as a "preferred provider." Managed care companies should explain in writing what "preferred provider" status means as related to utilization of services, patient care authorization or denial and impact on referrals.
- Peer review should be based on AMA, APA, State Legislative or State Regulatory Board definitions of medical necessity, and should be performed by peers equal in specialty training and licensed in that state.
- Appeal mechanisms should be transparent and easily accessible and timely, in regards to the criteria used to determine "medical necessity". Mechanisms should be readily available for review by an Independent Review Organization.
- Physicians should not be unfairly terminated after making appropriate complaints to state or federal healthcare agencies.

Managed care organizations should be expected to make every effort to have current listings of network physicians without phantom networks.

- NCQA and URAC policies should be standard expectations
- Reasonable fees and prompt payment should be required.

Developed by the Committee on Managed Care (Paul H. Wick, M.D., Chair, Robert C. Bransfield, M.D. Co-chair, Gregory G. Harris, M.D., George D. Santos, M.D., Jonathan L. Weker, M.D., Barry K. Herman, M.D., Alan A. Axelson, M.D., Anthony L. Pelonero, M.D., Nicolas Abid, M.D., Joel Johnson, M.D.)

APA Official Actions

Position Statement on State Mental Health Services

Approved by the Board of Trustees, December 2008
Approved by the Assembly, November 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

All state mental health authorities for mentally ill, addicted, and developmentally disabled individuals must be under the direction of a qualified psychiatrist or include a qualified psychiatrist at the senior management level.

This statement prepared by the Committee on Public Funding is a revision of an earlier statement prepared by the APA Council on Mental Health Services which was approved by the Executive Committee, September 1970.

APA Official Actions

Position Statement on Universal Access to Health Care

Approved by the Board of Trustees, March 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

It is the policy of the American Psychiatric Association to support universal access to health care, specifically including non-discriminatory coverage of treatment for mental illness, including substance use disorders, for all Americans. The American Psychiatric Association will advocate vigorously for this at local, state and national levels.

Position Statement on Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*

Approved by the Board of Trustees, July 2007
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – APA Operations Manual.

States should be offered the opportunity to receive a Federal exemption from the Institutions for Mental Diseases (IMD) Exclusion for state hospitals and all nonprofits over 16 beds, e.g., private hospitals, community residential programs, dual diagnosis residential treatment. To participate in the exemption a state must demonstrate a maintenance of effort (maintain its mental illness and substance abuse expenditures (excluding medication costs) from all sources, e.g., a state's Department of Mental Health, Department of Public Health, Department of Medical Assistance, Department of Mental Retardation, Department of Corrections, Department of Social Services, Department of Youth Services, other) at a level no less than the state's average expenditure over the preceding five years.

**This position statement has been modified by the Council on Healthcare Systems and Financing (at the request of the Joint Reference Committee) to spell out all the acronyms within the Position Statement.*

APA Official Actions

Position Statement on Access to Comprehensive Psychiatric Assessment and Integrated Treatment

Approved by the Board of Trustees, June 2002
Approved by the Assembly, May 2002

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

When patients are referred for treatment of mental illness, some primary care physicians and managed care organizations (MCOs) initially refer them to a non-medical mental health practitioner. Psychotherapy may then begin without benefit of a comprehensive, biopsychosocial assessment. Referral to a psychiatrist for consultation or medication management may occur only after other therapeutic options have been ineffective. By the time it is decided that a psychiatric referral is needed, the clinical situation may have deteriorated significantly. Such delays can result in more severe symptoms and unnecessarily prolonged suffering.

One justification for delayed psychiatric referral and use of a "split treatment" protocol includes presumed savings derived from not employing a psychiatrist when other healthcare professionals can provide evaluation and therapy services at a lower unit price. Yet there is research showing that patients who receive split treatment may have significantly more outpatient sessions and significantly higher costs. Some MCOs may not have enough in-network psychiatrists available to assure early access and to offer integrated treatment.

MCOs commonly authorize the patient to see the therapist more often and for longer sessions than the prescriber of medication. This format dilutes the development of the doctor-patient relationship and deprives the physician of the fullness and continuity of clinical observation that facilitates diagnostic timeliness and accuracy.

Logistical and financial aspects can diminish the likelihood of patient adherence to a split treatment plan. Having to schedule and attend appointments with two clinicians can be inconvenient, time-consuming, and costly. These factors can increase missed appointments and treatment dropouts.

There may be advantages to split treatment for some patients, for instance those who need specialized therapies. Yet there are some clinical situations in which the prescribing of psychoactive medication is best integrated within a psychotherapy relationship with a psychiatrist, who is the mental health specialist trained in both medical and biopsychosocial science. The judgment about which format would be most effective should be made by a psychiatrist or a clinical team that includes a psychiatrist.

For patients referred for the treatment of mental illness:

- Restricting access to psychiatric assessment and integrated treatment is not cost-effective.
- Delegating treatment to various specialties is a medical, not a procedural or administrative business, decision.
- There are some situations in which split treatment has advantages, many situations in which it is inadvisable, and no situation for which it should be mandated by a health plan.

APA supports screening and referral protocols by which:
Any patient who is referred for mental healthcare can receive a comprehensive psychiatric assessment within a clinically appropriate time.

- Treatment planning is undertaken only after an accurate diagnosis has been formulated by a psychiatrist, who is the clinician equipped with both medical training and a biopsychosocial perspective.
- Patients in need of treatment should not be barred from receiving combined psychotherapy and medication management from psychiatrists who are available and willing to offer it.

In keeping with APA's mission to advocate for patients:

- APA will work to promote adequate access to comprehensive initial psychiatric assessment and integrated treatment for patients.
- APA will work to ensure that any patient requiring a psychiatric assessment will receive one within a clinically appropriate time.

Prepared by the Committee on Managed Care.

APA Official Actions

Position Statement on Psychotherapy and Managed Care

Approved by the Board of Trustees, July 1999
Approved by the Assembly, May 1999

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Managed care organizations (MCOs) limit access to treatment on the basis of cost, not clinical need. This process has been arbitrary, profit-driven, unscientific, clinically uninformed, and dangerous to patients. Furthermore, managed care of mental illness and addictive disorders sanctions treatment restrictions that are not proven to be cost-effective; in fact they run contrary to extensive studies on the cost savings of treatment for mental illness and substance abuse in work productivity, absenteeism, employee turnover, and general medical expenses of the patient and family.

1. Treatment decisions should be based on a differential therapeutic choice reflecting professional standards and guidelines; the patient's clinical presentation, prior treatment history, and preference for treatment; and cost-effectiveness, among other relevant considerations. Psychotherapy is an integral part of the psychiatric practice of medicine. It reflects the interplay of developmental complexity and current stressors that require clarification, understanding, and behavioral change. Psychotherapy may be time- and labor-intensive, and intensive treatment should be available to patients who need it.

2. Cost should be neither the sole nor the primary factor in deciding the indications for and length of treatments. In fact, the relative acute and long-term cost-effectiveness of most treatments (psychotherapeutic and otherwise) is difficult to assess. Managed care has tended to deny access to psychotherapy, and particularly psychotherapy extending beyond a handful of sessions, apparently based on prejudice that such treatment is neither efficacious nor cost-effective. To our knowledge MCOs have conducted and cited no research to substantiate this action. Psychotherapies have demonstrated efficacy for prevalent psychiatric disorders. Comparative cost-effectiveness has not been studied for most medical interventions, but there are suggestions that psychotherapy can be cost effective relative to pharmacotherapy alone, particularly if the family, workplace, and total medical costs are considered over the long term.

3. Psychotherapy must remain an integral part of psychiatric practice. Psychotherapy by psychiatrists has been singled out for adverse treatment by MCOs. This has seriously damaged the practice of integrated, comprehensive biopsychosocial treatment by psychiatrists and diminished the availability of psychotherapy to MCO members (i.e., patients). It has fostered a managed care model of treatment that commonly splits the treatment of patients between a) non-medical professionals conducting restricted amounts of psychotherapy and b) physicians (psychiatrists or primary care physicians) prescribing medication. At worst, patients are denied the psychotherapy altogether.

   In contrast to well organized, collaborative approaches, the current MCO model of split treatment is vulnerable to diffusion of responsibility, inadequate communication of clinical information, inefficiency, and higher cost. The model limits the psychiatrist's flexibility in tailoring the treatment to the patient. It may be confusing to the patient. There is a risk of a diminished psychiatrist-patient relationship and reduced psychotherapeutic work on compliance issues.

   Further, common MCO practices that limit contact with patients by psychiatrists preclude proper evaluation and genuine direction of treatment, including psychotherapy, by a physician. Third-party control of treatment planning and implementation is gross interference in medical decision-making by a MCO employee with usually less training and far less clinical data to support decisions. It is improper direction of treatment by a utilization review agent.

4. This increasingly prevalent model of mental health services has had a deleterious effect on the training and clinical experience of young psychiatrists. It has colored the public image of psychiatry and threatens to change the fundamental professional characteristics and skills of the psychiatrist.

Therefore the APA will work vigorously to end the pattern of managed care exclusion of integrated psychotherapy services by psychiatrists by all available means: through research, education, negotiation when and where feasible with the managed care industry, legislation, and litigation. The Board hereby charges the relevant components to develop specific strategies to end this pattern. Because this is an immediate threat to current psychiatric practice, it must have a very high priority.

APA Official Actions

Position Statement on Proposed Guidelines for Handling the Transfer of Provider Networks

Approved by the Board of Trustees, December 1995

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

The continuity of the patient therapist relationship is a significant factor in benefits derived from psychiatric treatment and therefore should be honored when insurance benefits programs change from indemnity plans to any kind of preferred provider network or from one network to another.

In the current practice of managed care, employers may change from one managed behavioral health care company (MBHCC) to another with a resulting change in the provider network. For mental health care, this can represent a disruption in the continuity of patient care, if patients are engaged with providers who are not included in the new network, and this disruption will have detrimental effects on the patients. These guidelines are articulated to maximize continuity in the event of such changes.

Objectives

To ensure continuity of patient care in the event of transfer of employer-sponsored health care management from one network to another.

Procedures

As soon as the transfer is planned:

- the new MBHCC should review the provider network of the old MBHCC to determine where there is overlap and where there are providers that are not included in the new network;
- the new MBHCC should actively evaluate the possibility of including those provider in their network; and
- the old MBHCC should review the new MBHCC's network so that new patients in the system can be directed to providers who will be able to follow them after the transfer.

Beginning no later than three months prior to the network transfer the current MBHCC should:

- develop a list of patients currently in treatment;
- review treatment plans with their providers to determine if treatment is planned to continue beyond the time of transfer; and
- provide a list of patients who should continue their treatment beyond the time of transfer to the new MBHCC.

For those patients who will be continuing treatment and whose providers are not in the new system, the following areas should be negotiated in the transfer:

- If possible, providers should be brought into the new network.
- If not possible, providers should be given provisional in-network status to continue/complete work with assigned patients (this depends upon the provider's willingness to accept fee schedules and terms of interaction with the new MBHCC).
- Patients requiring treatment beyond the time of transfer should be permitted to remain with the same provider for at least 3 months after the transfer.
- Patients requiring longer term treatment should be evaluated on a case-by-case basis, keeping in mind the value of continuing with the same provider.
- Patients with chronic or complex conditions should have careful treatment planning involving coordinated case management from both of the MBHCCs.

Am J Psychiatry 136:5, May 1979

Position Statement on Active Treatment

This statement was approved by the Assembly at its meeting in October 1978 and by the Board of Trustees at its meeting in December 1978. The statement was originated by the Council on Mental Health Services[1] and revised by a special Assembly task force.[2]

PSYCHIATRIC TREATMENT is a planned effort on behalf of persons defined either by themselves or by their community as mentally ill or emotionally disturbed and in need of treatment. The person directing it must be qualified by specialized education and training to evaluate and understand the totality of the biological, psychological, and social factors that play a part in such an illness. Treatment is provided through medical procedures designed to benefit the ill person.

1. Treatment may begin prior to the establishment of a final diagnosis. The process of evaluation is an act of treatment.

2. The standards used by a community to judge behavior may not always be in agreement with the standards leading to a diagnosis used by a psychiatrist to judge behavior. For example, some people judged by community standards to be "bad" rather than ill may suffer from a diagnosable mental illness. On the other hand, some persons whose behavior is identified as aberrant by a given community may be perceived by the psychiatrist as following an alternative lifestyle and not as suffering from an illness.

3. As in physical illness, an individual's subjective distress may in itself be sufficient justification for treatment.

4. Psychiatric disorders result from the complex interaction of physical, psychological, and social factors and treatment may be directed toward any or all three of these areas.

5. Treatment may include measures to maintain current functioning and prevent further deterioration as well as measures designed to improve or eliminate dysfunction.

6. A variety of professional disciplines may be involved in a treatment program. The extent and kind of participation of any practitioner in a specific treatment program should be determined by the person primarily responsible for providing treatment. The professional qualifications and ethics of the various disciplines are defined by each professional group within society's sanctions. No practitioner should be required to participate in a manner contrary to the ethic of his or her discipline.

7. A formal or informal treatment plan is an integral part of treatment. The plan should include the goals of treatment and problems that may be anticipated and should be revised when appropriate and indicated. Psychiatric treatment should be based on principles that can be explained and communicated during review by one's peers.

8. Providing a human environment for the care of persons in need is not equivalent to providing treatment. However, when the environment is carefully organized to respond in a therapeutic manner to patients' needs and behavior and is staffed and supervised by qualified members of appropriate professional disciplines, it is a form of treatment. Treatment of that kind is usually referred to as a therapeutic environment or milieu therapy.

9. Psychiatric treatment is the sum of the activities of a psychiatrically qualified physician in meeting the therapeutic needs of a patient, a family, or a (community) group. This may include the supervision of others who are providing treatment and for whose activities the psychiatrist accepts professional and legal responsibility.

APA Official Actions

Endorsement of *Medical Professionalism in the New Millennium: A Physician Charter*

Approved by the Board of Trustees, 2002

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

Fundamental Principles

Principle of primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and

through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

Developed by leaders in the ABIM Foundation, the ACP–ASIM Foundation, and the European Federation of Internal Medicine.

Position Statement on Desegregation of Hospitals for the Mentally Ill and Retarded

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This statement, a revision of a statement approved in December 1963, was approved by the Assembly of District Branches at its November 4–5, 1975, meeting and by the Board of Trustees at its December 5–6, 1975, meeting. The revision was recommended by the Council on National Affairs.[1].

THE AMERICAN PSYCHIATRIC ASSOCIATION is in favor of desegregation of all hospitals for the mentally ill and retarded. This statement is offered as contributory to the national will to eliminate legal and social impediments to the extension of all services to all citizens. The acceptance of this principle and its translation into practice would remove the need to duplicate facilities to accommodate segregation. It would release all available resources in support of a wider range of treatment services for the benefit of all mentally ill citizens.

APA Official Actions

Abortion and Women's Reproductive Health Care Rights

On behalf of all APA members who are dedicated to the provision of the best possible mental health care to women patients, the American Psychiatric Association hereby states in its position on Abortion and a Women's Reproductive Health Care Rights that:

The American Psychiatric Association opposes all constitutional amendments, legislation, and regulations curtailing family planning and abortion services to any segment of the population;

The American Psychiatric Association reaffirms its position that abortion is a medical procedure for which physicians should respect the patient's right to freedom of choice—psychiatrists may be called on as consultants to the patient or physician in those cases in which the patient or physician requests such consultation to expand mutual appreciation of motivation and consequences of such a choice; and

The American Psychiatric Association affirms that the freedom to act to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications.

This APA position statement was prepared by the APA Committee on Women (Asha Mishra, M.D. [chair]; Stacey Burpee, D.O.; Jamae Campbell, M.D.; Sharon Jacobson, M.D.; Christina Mangurian, M.D.; Judith Milner, M.D.; Sylvia Olarte, M.D.; Michele Preminger, M.D.; Claudia Reardon, M.D.; Gail Robinson, M.D.; Sudeepta Varma, M.D.; Kathy Vincent, M.D.). It was approved by the Assembly in May 2009 and by the Board of Trustees in September 2009. The chair wishes to acknowledge Nada Stotland, M.D., for her participation in the development of this position statement.

APA Official Actions

Xenophobia, Immigration, and Mental Health

The American Psychiatric Association (APA) takes an official stand against the destructive consequences of ethnic prejudice and xenophobia, both for populations and for individuals. It expresses deep concern over the adverse public health and mental health consequences of these unchecked prejudices. Because of these significant adverse consequences, the APA calls for any national debates (e.g., on policies such as immigration and naturalization, foreign relations, and response to terrorism) involving people of different national ethnic, or racial backgrounds to be based on objective data and rational national interest, and not on prejudices or ideology.

The APA calls on the mass media to show responsibility and sensitivity to the rights of immigrants, refugees, and all foreign-born people, and to refrain from inflaming xenophobia in their programming. The APA advocates for the rights of immigrants, refugees, and asylum seekers to be respected, including rights to safe haven, security, and nurturance of one's own ethnic and cultural beliefs/values, and identity as essential for psychological health. It further calls for national education on cultural competence and diversity, starting in public schools and mental health settings and extending to the mass media. Such education should include discussion about xenophobia and negative prejudice and their destructive consequences, as well as the acceptance and valuation of diversity.

This APA position statement was drafted by the APA Committee of Hispanic Psychiatrists (Andres J. Pumariega, M.D. [chair]; Dan Castellanos, M.D.; Jose De La Gandara, M.D.; Esperanza Diaz, M.D.; Tatiana Falcone, M.D.; Sarah Huertas-Goldman, M.D.; Alex Kopelowicz, M.D.; Luis Fernando Ramirez, M.D.; Carlos Rodriguez, M.D.; Leonardo Rodriguez, M.D.; Amado Suarez, M.D.; Natalie Weder, M.D.). It was approved by the Assembly in May 2009 and by the Board of Trustees in September 2009.

APA Official Actions

Position Statement on Juvenile Death Sentences

Approved by the Board of Trustees, June 2001
Reaffirmed, 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The United States is one of the few countries in the world that executes juveniles, and, since 1990, it has executed 10 persons for crimes committed prior to age 18. Juveniles constitute approximately 2% of total death sentences, and, as of June, 1999, there were 70 persons on death row for crimes committed at age 16 or 17. With the increasing trend of waiving juvenile offenders to the adult court and imposing harsher sentences than in the past, these numbers can be expected to rise. Although the U.S. Supreme Court's decision in Thompson v. Oklahoma (1988) precluded execution of persons who were younger than 16 years of age at the time of their crimes, the Court ruled the following year (in Stanford v. Kentucky) that executing offenders who were 16 or 17 at the time of their crimes did not amount to cruel and unusual punishment under the Eighth Amendment. The United States remains the only country in the world that has not yet ratified the UN Convention, Article 37a, which states that "Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offenses committed by persons below eighteen years of age."

For the following reasons, the harshest punishments, including the death penalty, should be precluded in cases involving offenders whose crimes were committed prior to age 18. Adolescents are cognitively and emotionally less mature than adults. They are less able than adults to consider the consequences of their behavior, they are easily swayed by peers, and they may show poor judgment. That juveniles differ from adults in their decision-making capacities is reflected in our nation's laws regarding voting, driving, access to alcoholic beverages, consent to treatment, contracting, and in the juvenile court itself. We also know that teens who have been victims of abuse or have witnessed violence may show increased levels of emotional arousal and a tendency to overreact to perceived threats. Victims of child abuse and neglect are over represented among incarcerated juveniles, including those on death row. Studies of this population consistently demonstrate a high prevalence of mental disorders, serious brain injuries, substance abuse, and learning disabilities, which may predispose to aggressive or violent behaviors. In many instances, these juveniles have not received adequate diagnostic assessments or interventions. National statistics also indicate that African-American and Hispanic youth are disproportionately diverted into juvenile correctional facilities and waived to the adult criminal court system.

Many psychiatrists oppose use of the death penalty in all cases due to concerns about its discriminatory application (including discrimination against poor offenders who do not have equal access to adequate legal representation) and about what appears to be an unavoidable risk of error. The deterrent value of capital punishment has yet to be demonstrated. However, whatever one may think about the overall deterrent effect of the death penalty, it is particularly unlikely to deter adolescents from crime, as they tend to live in the present, think of themselves as invincible, and have difficulty contemplating the long-term consequences of their behavior.

The traditional philosophy of the juvenile court has been rehabilitation. This goal is now made more attainable than ever by improved assessment tools, new effective community-intervention programs, and treatments for underlying psychiatric disorders. However, such efforts are often undermined by the diversion of scarce dollars into incarceration, long sentences, and carrying out the death penalty rather than into earlier intervention efforts and strengthening the juvenile justice system so that it can effectively respond to dangerous and/or repeat youth offenders to ensure public safety.

Therefore, the American Psychiatric Association strongly opposes the imposition of the death penalty for crimes committed as juveniles.

This policy originated with the American Academy of Child and Adolescent Psychiatry. It was endorsed by APA Council on Children, Adolescents, and Their Families and revised by APA Council on Psychiatry and Law.

APA Official Actions

Position Statement on Peer Review of Expert Testimony

Approved by the Board of Trustees, December 1991
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Peer review of psychiatric expert testimony is a promising mechanism for improving the quality of information that psychiatrists present to the legal system. Preliminary experience suggests that peer review can be of considerable value when it focuses on educating psychiatrists, on a voluntary basis, about potential problems with their testimony. The American Psychiatric Association encourages innovative development of models of peer review of psychiatric expert testimony by APA district branches, departments of psychiatry, and other groups. The APA's resource document on peer review of psychiatric expert testimony may be of assistance to groups that are interested in developing peer review mechanisms. Experience with different approaches should be evaluated systematically to facilitate the development of optimal models for peer review.

APA Official Actions

Joint Resolution Against Torture of the American Psychiatric Association and the American Psychological Association

Approved by the Board of Trustees, December 1985
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Whereas, American psychiatrists are bound by their *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* to "provide competent medical service with compassion and respect for human dignity," and

Whereas, American psychologists are bound by their *Ethical Principles* to "respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights," and

Whereas, the existence of state-sponsored torture and other cruel, inhuman, or degrading treatment has been documented in many nations around the world, and

Whereas, psychological knowledge and techniques may be used to design and carry out torture, and

Whereas, torture victims often suffer from multiple, long-term psychological and physical problems,

Be it resolved, that the American Psychiatric Association and the American Psychological Association condemn torture wherever it occurs, and

Be it further resolved, that the American Psychiatric Association and the American Psychological Association support the *UN Declaration and Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*; and the *UN Principles of Medical Ethics*, as well as the joint Congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984.

APA Official Actions

Position Statement on Moratorium on Capital Punishment in the United States

Approved by the Board of Trustees, October 2000
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Whereas the American Bar Association has concluded that the death penalty is administered in an unfair and arbitrary manner and has recommended a moratorium on executions until proper reforms are implemented; and

Whereas psychiatrists, due to their involvement in and familiarity with the criminal justice system, have become increasingly aware of the weaknesses and deficiencies of the current capital sentencing process including considerations in regard to the mentally ill and developmentally disabled;

The American Psychiatric Association endorses a moratorium on capital punishment in the United States until jurisdictions seeking to reform the death penalty implement policies and procedures to assure that capital punishment, if used at all, is administered fairly and impartially in accord with the basic requirements of due process.

The statement, prepared by the Council on Psychiatry and the Law, was approved as amended, with the proviso that the language is intended neither as an endorsement nor a statement of disapproval of the death penalty.

Position Statement on Discrimination Against Persons With Previous Psychiatric Treatment

Reaffirmed 2007

This position statement was developed by the Council on Psychiatry and Law.[1] It was approved by the APA Assembly in November 1996 and by the Board of Trustees in March 1997.

Many people have suffered discrimination and social disadvantage because they have a psychiatric diagnosis or a history of psychiatric treatment. Information about diagnosis or treatment has been used unfairly to deny immigration, professional or occupational licensure, employment, insurance, housing, and credit and to otherwise reduce opportunities for full participation in the life of society. Stigmatization and discrimination also tend to diminish the well-being of the population as a whole by discouraging people from seeking needed psychiatric evaluation and treatment.

The American Psychiatric Association vigorously opposes discrimination based on mental disorder or a history of psychiatric treatment. Such discrimination is often based on unfounded, irrational misconceptions and fears about mental illness. Moreover, categorical distinctions based on mental disorder are tantamount to class discrimination because they assume that everyone who has received a particular diagnosis or treatment is identical. In fact, individuals with the same diagnosis or receiving the same treatment may manifest different kinds of symptoms; even when the symptoms are the same, they may vary widely in their severity. Nor is there a direct or simple connection between symptom severity and impairments that may be relevant to a particular decision. For example, an individual who suffers from a severe major depression associated with weight loss and anhedonia may be disabled from working or may have no discernible decrement in work capacity.

Because economic and emotional well-being are so often dependent on vocational satisfaction, discrimination in employment is especially harmful. Unfortunately, employers often ask applicants whether they have ever had a mental illness or whether they have ever been under the care of a psychiatrist. Employers argue that questions that screen for a history of psychiatric treatment allow them to delineate a group of applicants for more-searching inquiry. This argument, however, relies on the assumption that the presence or absence of a psychiatric history is an accurate predictor of an individuals's ability to function effectively in the workplace. Research has failed to substantiate such a causal link. Standing alone, a psychiatric diagnosis provides little direct information about whether an individual is able to perform a specific occupational task. As a result, such "screening" questions significantly increase the risk of discrimination while producing little useful information in the great majority of cases. Moreover, to the extent that questionnaires fail to ask about physical or other medical conditions, they serve only to further stigmatize mental illness. Far more helpful in determining an applicant's fitness to perform a specific job are questions that inquire about past behavior in work or school settings—e.g., absences, frequent job changes, or significant drops in grades or work performance.

Some constructive steps have been taken to combat stigmatization and discrimination in the workplace and elsewhere in society. The most recent and far-reaching of these measures is the Americans With Disabilities Act (ADA), 42 U.S.C. §§12101–12213, which was enacted on July 26, 1990. The ADA provides broad antidiscrimination protection for persons with physical or mental impairments. The legislation builds on some prior federal laws, such as the Rehabilitation Act of 1973, 29 U.S.C. §§791–794, and the Fair Housing Act Amendments of 1988, 42 U.S.C. §§3601–3619. The ADA extends the reach of these laws substantially. For example, unlike §504 of the Rehabilitation Act, the ADA's coverage is not limited to employers or public entities that receive federal funds. All but the smallest businesses must comply with the ADA.

Under the ADA, a person with a "disability" is defined as someone who has "a physical or mental impairment that substantially limits one or more of the major life activities of such individuals," as well as individuals who have "a record of such an impairment" or are "regarded as having such an impairment." The ADA prohibits the use of certain medical examinations and inquiries. Prior to offering employment, an employer may only raise questions about the applicant's ability to perform job-related functions and may not ask whether the person has a disability or inquire about the nature or severity of such a disability. The act does not protect an employee who is currently using drugs illegally, who is abusing alcohol, or who poses a "direct threat" to the health or safety of others. The Equal Employment Opportunity Commission is responsible for administrative enforcement of the ADA provisions relating to employers.

One important effect of the ADA has been to encourage employers to develop formal descriptions of the essential functions of various jobs and to redesign job applications and interviews to focus on areas relevant to an applicant's ability to perform these functions. Similarly, professional licensing boards concerned with an applicant's character and fitness to practice have begun to redirect their inquiries to focus on previous *behavior* (not medical history) that might bear on these questions.

The permissible use of medical examinations (including mental health evaluations) remains somewhat controversial. In order to reduce the risk of unwarranted discrimination, the ADA disallows medical examinations before a job offer has been made. (Tests of the applicant's ability to perform specific job-related tasks, such as tests of physical agility, are permitted.) After a job offer has been made, or during the course of employment, a medical evaluation can play an important role in assessing the applicant's (or employee's) ability to perform a job or in designing reasonable accommodations. Again, however, employment decisions must be based on the person's functional capacity, not on the person's diagnosis or disability per se.

The Equal Employment Opportunity Commission has issued enforcement guidance on employment interviews and medical examinations to help employers comply with the ADA. Psychiatrists should become familiar with the basic requirements of the ADA so that they can help their patients avoid discrimination by invoking the act's protections (e.g., declining to disclose personal information or requesting appropriate accommodations).

Although the ADA and other antidiscrimination legislation reflect a growing awareness of the need to combat discrimination, especially in employment, APA strongly supports additional measures designed to end stigmatization and discrimination against people with histories of psychiatric treatment and to facilitate their full participation in society.

[1]The members of the council for 1996–1997 were Steven K. Hoge, M.D. (chairperson), Raymond F. Patterson, M.D. (vice-chairperson), David J. Barry, M.D., Elissa P. Benedek, M.D., Renee Leslie Binder, M.D., Jorge Raul Veliz-Cruz, M.D. (observer-consultant), Richard Bonnie, J.D. (consultant), Carole Cole Kleinman, M.D. (consultant), Jagannathan Srinivasaraghavan, M.D. (consultant), Alan A. Stone, M.D. (consultant), Howard V. Zonana, M.D. (consultant), Michelle Riba, M.D. (Board liaison), Jeffrey L. Metzner, M.D. (Assembly liaison), Harry A. Brandt, M.D. (corresponding member), Alan B. Hertz, M.D. (corresponding member), Jeffrey S. Janofsky, M.D. (corresponding member), Brian J. Ladds, M.D. (corresponding member), Patricia Ryan Recupero, M.D. (corresponding member), and Maria Daehler, M.D. (APA/Glaxo Wellcome Fellow).

APA Official Actions

Position Statement on the Insanity Defense

Approved by the Board of Trustees, December 2007
Approved by the Assembly, November 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The insanity defense[1] is deeply rooted in Anglo-American law. Although the specific standard by which legal insanity is determined has varied over time and across jurisdictions, the insanity defense has always been grounded in the belief that there are defendants whose mental conditions are so impaired at the time of the crime that it would be unfair to punish them for their acts.

Recognizing that the insanity defense plays a critical role in the administration of criminal justice in the United States, the American Psychiatric Association endorses the following positions:

1. Serious mental disorders[2] can substantially impair an individual's capacities to reason rationally and to inhibit behavior that violates the law. The APA strongly supports the insanity defense because it offers our criminal justice system a mechanism for recognizing the unfairness of punishing persons who exhibit substantial impairment of mental function at the time of their actions.
2. The APA does not favor any particular legal standard for the insanity defense over another, so long as the standard is broad enough to allow meaningful consideration of the impact of serious mental disorders on individual culpability.

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[1] By the term "insanity defense," we include verdicts of "not guilty by reason of insanity," "guilty but not criminally responsible," and related formulations.

[2] "Serious mental disorder" is meant to encompass not only major psychiatric disorders, but also developmental disabilities and other causes of impaired mental function (e.g., severe head trauma) that otherwise meet the legal criteria for the insanity defense.

APA Official Actions

Position Statement on Psychiatric Participation in Interrogation* of Detainees

Approved by the Board of Trustees, May 2006
Approved by the Assembly, May 2006

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

1. The American Psychiatric Association reiterates its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action.

2. a) Every person in military or civilian detention, whether in the United States or elsewhere, is entitled to appropriate medical care under domestic and international humanitarian law.
   b) Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities.
   c) Psychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee.
   d) This paragraph is not meant to preclude treating psychiatrists who become aware that the detainee may pose a significant threat of harm to him/herself or to others from ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to other treatment relationships.

3. No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.

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*As used in this statement, "interrogation" refers to a deliberate attempt to elicit information from a detainee for the purposes of incriminating the detainee, identifying other persons who have committed or may be planning to commit acts of violence or other crimes, or otherwise obtaining information that is believed to be of value for criminal justice or national security purposes. It does not include interviews or other interactions with a detainee that have been appropriately authorized by a court or by counsel for the detainee or that are conducted by or on behalf of correctional authorities with a prisoner serving a criminal sentence.

APA Official Actions

Position Statement on Death Sentences for Persons with Dementia or Traumatic Brain Injury

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

The Presidential Council has previously recommended, and the APA has adopted, two position statements on mental illness and the death penalty -- one proposing criteria of diminished responsibility for offenses committed by offenders suffering from severe mental disorder at the time of their offenses, and another pertaining to issues arising after sentencing when prisoners on death row suffer from mental illness. These two statements were developed in close collaboration with the American Bar Association Task Force on Mental Disability and the Death Penalty. The Council has now approved a third position (and final) proposal on this subject developed in collaboration with the ABA Task Force. This statement has a very limited aim -- it is designed simply to urge courts and legislatures to extend the Supreme Court's ruling in Atkins v. Virginia (exempting people with mental retardation from the death penalty) to two other disorders involving equivalent levels of impairment -- dementia and traumatic brain injury. The proposed position statement follows:

"Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury."

APA Official Actions

Position Statement on Mentally Ill Prisoners on Death Row

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

(a) Grounds for Precluding Execution. A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forego or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case. Procedures to be followed in each of these categories of cases are specified in (b) through (d) below.

(b) Procedure in Cases Involving Prisoners Seeking to Forego or Terminate Post-Conviction Proceedings. If a court finds that a prisoner under sentence of death who wishes to forego or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

(c) Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings. If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to a lesser punishment.

(d) Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose. If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to a lesser punishment.

APA Official Actions

Position Statement on Diminished Responsibility in Capital Sentencing

Approved by the Board of Trustees, November 2004
Approved by the Assembly, December 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Defendants shall not be sentenced to death or executed if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to their conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.

APA Official Actions

Endorsement of the Patient-Physician Covenant

Approved by the Board of Trustees, September 1995
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to signifycantly alter the physician's role as healer, carer, helper, and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gateclosers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patients at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

Ralph Crawshaw, M.D.
David E. Rogers, M.D.
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Lonnie R. Bristow, M.D.
Christine K. Cassel, M.D.
Jeremiah A. Barondess, M.D.

JAMA. 1995;273(19):1553-1553.

APA Official Actions

Position Statement on Provision of Psychotherapy for Psychiatric Residents

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The American Psychiatric Association affirms that training programs have a responsibility to advocate to ensure psychiatric residents have access, within the limits of what is available in the community, to affordable, private and confidential psychiatric services, including individual psychotherapy, on a par with all other medical services. If provided within the resident's training program, such therapy should not be carried out by a therapist with a supervisory or evaluative role. Without reducing training or clinical care requirements, residents should have protected time to pursue psychotherapy, while facing no stigmatizing or discriminatory consequences.

Item 2014A2 4.B.1
Assembly
November 7-9, 2014

POSITION STATEMENT

Title: Residency Training Needs in Addiction Psychiatry for the General Psychiatrist

Issue: Substance use disorders (SUDs) are a major cause of morbidity and mortality among patients with mental illness and a major risk factor in dangerousness to self and others. Despite the availability of effective treatments, most patients with these disorders are not being treated. Providing appropriate training in screening, brief intervention, and treatment for the general psychiatrist could help close this treatment gap and improve outcomes for patients with co-occurring mental illness and SUDs. This position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.

APA Position: General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing screening, brief intervention, referral to treatment (SBIRT); management of psychoactive substance intoxication and withdrawal; evidence-based pharmacotherapy for substance use disorders; management of co-occurring substance use and other psychiatric disorders; and should have exposure to evidence-based psychotherapy and other psychosocial interventions for substance use disorders such as motivational interviewing, cognitive-behavioral therapy, twelve-step programs, among others."

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Adoption Date: Assembly Approved November 2014

DRAFT June 11, 2014

APPROVED BY ASSEMBLY NOVEMBER 2014

Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

The American Psychiatric Association recognizes the critical public health need for action to promote safe communities and reduce morbidity and mortality due to firearm-related violence. Specifically, the APA supports the following principles and positions:

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory measures. Recognizing that the vast majority of gun violence is not attributable to mental illness, the APA views the broader problem of firearm-related injury as a public health issue and supports interventions that reduce the risk of such harm. Actions to minimize firearm injuries and violence should include:

    a. Requiring background checks and waiting periods on all gun sales or transactions;

    b. Requiring safe storage of all firearms in the home, office or other places of daily assembly;

    c. Regulating the characteristics of firearms to promote safe use for lawful purposes and to reduce the likelihood that they can be fired by anyone other than the owner without the owner's consent;

    d. Banning possession of firearms on the grounds of colleges, hospitals, and similar institutions by anyone other than law enforcement and security personnel; and

    e. Assuring that physicians and other health care professionals are free to make clinically appropriate inquiries of patients and others about possession of and access to firearms and take necessary steps to reduce the risk of loss of life by suicide, homicide, and accidental injury.

2. Research and training on the causes of firearm violence and its effective control, including risk assessment and management, should be a national priority.

    a. Administrative, regulatory and/or legislative barriers to federal support for violence research, including research on firearms violence and deaths, should be removed.

    b. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of individuals at heightened risk of committing violence against themselves or others with firearms.

c. The federal government should develop and fund a national database of firearm injuries. This database should include information about all homicides, suicides, and unintentional deaths and injuries, categorized by specific weapon type, as well as information about the individuals involved (absent personal identifiers), geographic location, circumstances, point of purchase, date and other policy-relevant information.

d. Funding for research on firearm injuries and deaths should draw on a broad range of public and private resources and support, such as the Centers for Disease Control, the National Institutes of Health, and the National Science Foundation.

e. All physicians and other health professionals should continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal, state, and local resources should be allocated for training of these professionals. Resources should be increased for safety education programs related to responsible use and storage of firearms.

3. Reasonable restrictions on gun access are appropriate, but such restrictions should not be based solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of symptoms, impairments, and disabilities found in affected individuals. Even within a given diagnosis, there is considerable heterogeneity of symptoms and impairments. Only a small proportion of individuals with a mental disorder pose a risk of harm to themselves or others. The APA supports banning access to guns for persons whose conduct indicates that they present a heightened risk of violence to themselves or others, whether or not they have been diagnosed with a mental disorder.

4. Given that the right to purchase or possess firearms is restricted for specific categories of individuals who are disqualified under federal or state law, the criteria for disqualification should be carefully defined, and should provide for equal protection of the rights of those disqualified. There should be a fair and reasonable process for restoration of firearm rights for those disqualified on such grounds.

   When restrictions are based on federal law, disqualifying events related to mental illness, such as civil commitment or a finding of legal incompetence, are reported to the federal background check database (National Instant Criminal Background Check System, NICS). Some states have expanded the scope of disqualifying events to be reported to NICS to include non-adjudicated events, such as temporary hospital detentions.

   a. Non-adjudicated events should not serve as sufficient grounds for a disqualification from gun ownership and should not be reported to the NICS system. The adjudicatory process provides important protections that ensure the accuracy of determinations (such as dangerousness-based civil commitment), including the right to representation and the right to call and cross-examine witnesses.

b. Rational policy with regard to implementation of such restrictions calls for the duration of the restriction to be based on individualized assessment rather than a categorical classification of mental illness or a history of a mental health-related adjudication.

c. Although the restrictions on access to firearms recommended in items 1 and 2 above would decrease the risk of suicide and violence in the population, extending restrictions to individuals who voluntarily seek mental health care and incorporating their names and mental health histories into a national registry is inadvisable because it could dissuade persons from seeking care and further stigmatize persons with mental disorder.

d. A person whose right to purchase or possess firearms has been suspended on grounds related to mental disorder should have a fair opportunity to have his or her rights restored in a process that properly balances the person's rights with the need to protect public safety and the person's own well-being. Accordingly, the process for restoring an individual's right to purchase or possess a firearm following a disqualification relating to mental disorder should be based on adequate clinical assessment, with decision-making responsibility ultimately resting with an administrative authority or court.

5. Improved identification and access to care for persons with mental disorders may reduce the risk of suicide and violence involving firearms for persons with tendencies toward those behaviors. However, because of the small percentage of violence overall attributable to mental disorders (estimated at 3-5% in the U.S., excluding substance use disorders), it will have only a limited impact on overall rates of violence.

a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in national and local agendas, along with other efforts to augment prevention strategies, reduce the stigma of seeking or obtaining mental health treatment, and diminish the consequences of untreated mental disorders.

b. For those people with mental illness who may pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be removed. Access to care and associated resources to enhance community follow up, which includes care and resources to address mental disorders, including substance use disorders, should be maximized to ensure that patients who may need to transition between service providers or settings, e.g., from an inpatient setting to community- based treatment, continue to obtain treatment and are not lost to care.

c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws designed to limit firearm possession that mandate reporting to law enforcement officials by psychiatrists and other mental health professionals of all patients who raise concerns about danger to themselves or others are likely to be counterproductive and should not be adopted. In contrast to long-standing rules allowing mental health professionals flexibility in acting to protect identifiable potential victims of patient violence, these statutes intrude into the clinical relationship and are unlikely to be effective in reducing rates of violence.

d. The President of the United States should consolidate and coordinate current interests in improving mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

APA Official Actions

Joint Public Policy Statement on Relationship Between Treatment and Self Help

Board of Trustees, December 1997
Joint Reference Committee, October 1997
Council on Addiction Psychiatry, September 1997
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Background

For many years, physicians and other treatment professionals have recognized the value of self-help groups as a valuable resource to patients in addiction treatment and their family members. (See, for example, American Society of Addiction Medicine's 1979 resolution on self help groups; the *ASAM Patient Placement Criteria* (2nd edition), and the American Psychiatric Association's *Practice Guidelines for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, and Opioids*). Addiction professionals and programs routinely recommend such groups to their patients and help them understand and accept the value of becoming an active participant.

It is important to distinguish between professional treatment and self help. Treatment involves at minimum, the following elements:

a. A qualified professional is in charge of, and shares professional responsibility for, the overall care of the patient;
b. A thorough evaluation is performed, including diagnosis, determination of the stage and severity of illness and an assessment of accompanying medical, psychiatric, interpersonal and social problems;
c. A treatment plan is developed, based on both the initial assessment and response to treatment over time. Such treatment is guided by professionally accepted practice guidelines and patient placement criteria;
d. The professional or program responsible and accountable for treatment is also responsible for offering or referring the patient for additional services that may be required as a supplement to addiction treatment;
e. The professional or program currently treating the patient continues therapeutic contact, whenever possible, until stable recovery has been attained.

Self-help groups, although helpful at every stage of treatment and as long-term social and spiritual aid to recovery, do not meet the above criteria and should not be confused with or substituted for professional treatment.
In some instances, utilization review and medical necessity guidelines used by insurers and other managed care entities have sought to substitute self-help attendance for professional treatment in patients who have not reached stable remission from their alcohol or other drug dependence.

Position

The American Psychiatric Association, American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine recommend that:

1. Patients in need of treatment for alcohol or other drug-related disorders should be treated by qualified professionals in a manner consonant with professionally accepted practice guidelines and patient placement criteria;
2. Self-help groups should be recognized as valuable community resources for many patients in addiction treatment and their families. Addiction treatment professionals and programs should develop cooperative relationships with self-help groups;
3. Insurers, managed care organizations, and others should be aware of the difference between self-help groups and treatment;
4. Self-help should not be substituted for professional treatment, but should be considered a complement to treatment directed by professionals. Professional treatment should not be denied to patients or families in need of care.

Approved by:
AAAP Board of Directors, October 1997
ASAM Board of Directors, October 1997

APA Official Actions

Position Statement on Mental Health & Substance Abuse and Aging: Three Resolutions

Approved by the Board of Trustees, December 2004
Approved by the Assembly, November 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

These resolutions were prepared by the National Coalition on Mental Health and the Aging.

RESOLUTION ON MENTAL HEALTH & SUBSTANCE ABUSE SERVICES AND INTERVENTIONS

WHEREAS the 1999 Surgeon General's Report on Mental Health found that disability due to mental disorders, substance use or cognitive impairments in individuals aged 65 and over will become a major public health problem in the near future due to changing demographics; and

WHEREAS the 2003 President's New Freedom Commission on Mental Health identified as barriers to care:

- A fragmented service delivery system;
- Out of date Medicare policies;
- Stigma due to mental illness and advanced age;
- A mismatch between services that are covered and those preferred by older persons; and
- A lack of adequate preventive interventions and programs that aid early identification of geriatric mental illness; and

WHEREAS the U.S. Supreme Court in the 1999 *Olmstead v. L.C.* decision ruled that institutionalization of persons with disabilities who, given appropriate supports, could live in the community is a form of discrimination that violates the Americans with Disabilities Act; and

WHEREAS almost 20% of persons age 55 and over experience specific mental and cognitive disorders that are not part of the "normal" aging process including a prevalence rate of 11.4% for anxiety disorders (Department of Health and Human Services, 1999); and

WHEREAS as many as 20% of older adults in the community and up to 37% in primary care settings experience symptoms of depression (Department of Health and Human Services, 1999); and

WHEREAS the Surgeon General's Report observed that as many as half of all people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives and 15% of older men and 12% of older women treated in primary care clinics regularly drink in excess of limits recommended by the National Institute on Alcohol Abuse and Alcoholism (Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS older persons who are dually eligible for Medicare and Medicaid may lose access to medications that they had under their state Medicaid plan when the prescription drug benefit of the Medicare Prescription Drug Improvement and Modernization Act of 2003 takes effect on January 1, 2006; and

WHEREAS comorbidity of mental illness and substance abuse exacerbates symptoms and often leads to treatment noncompliance, more frequent hospitalization, greater depression and likelihood of suicide, incarceration, family friction, and higher service use and cost (Department of Health and Human Services, 1999); and

WHEREAS it is estimated that 17% of older adults misuse and abuse alcohol and medications and although the majority (87%) of older adults see a physician regularly about 40 % of those who are at risk do not self-identify or seek services for substance abuse problems and are unlikely to be identified by their physicians (Barry, et al., 2001; Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS older adults have the highest suicide rate of any age group with persons 85 years of age and older having a rate almost double (21 per 100,000), and older white men having a rate almost six times (65 per 100,000) the suicide rate of the general population (10.6 per 100,000) (Conwell, et al., 2002; US Public Health Service, 1999); and

WHEREAS there are effective interventions for most mental and substance abuse disorders experienced by older persons (Bartels, et al., 2003; Department of Health and Human Services, 1999, Gatz, et al., 1998); and

WHEREAS older Americans can accrue overall health benefits from successful treatment of their mental health and/or substance abuse disorder (Administration on Aging, 2001; Department of Health and Human Services, 1999); and

WHEREAS older adults and aging baby boomers present a growing and widely diverse ethnic and cultural population that will present major challenges to the nation's public and private mental health, primary care, and substance abuse systems (Administration on Aging, 2004; Whitfield, 2004);

THEREFORE, BE IT RESOLVED by the 2005 White House Conference on Aging to support policies that:

Assure access to an affordable and comprehensive range of quality mental health and substance abuse services including:

- outreach
- home and community based care
- prevention
- intervention
- acute care
- long-term care;

Assure that these services are age appropriate, culturally competent, and consumer driven;

Amend statutes that address public and private health and long-term care insurance plans to:

- guarantee parity in coverage and reimbursement for mental health, physical health, and substance abuse disorders
- eliminate exclusions based on pre-existing conditions
- ensure that benefits packages provide full access to a comprehensive range of coordinated and quality services
- ensure that older persons who are eligible for Medicare have access to a full range of medications;

Improve and effectively coordinate benefits, at all government levels, for those individuals who are dually eligible for Medicare and Medicaid coverage;

Promote the development and implementation of home and community-based care as an alternative to institutionalization through a variety of public and private funding mechanisms;

Promote older adult mental health and substance abuse services research, and coordinate and finance the movement of evidence-based and emerging best practices between research and service delivery;

Support the integration of older adult mental health and substance abuse services into primary health care, long term care and community-based service systems;

Promote screening for co-occurring mental and substance use disorders by primary health care, mental health, and substance abuse providers and encourage the development of integrated treatment strategies; and

Increase collaboration among aging, health, mental health, and substance abuse consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant government agencies to promote more effective use of resources and to reduce fragmentation of services.

RESOLUTION ON THE EDUCATION AND DEVELOPMENT OF THE PROFESSIONAL MENTAL HEALTH WORKFORCE

WHEREAS mental health, behavioral health and substance abuse professionals are not sufficiently trained in geriatrics, geriatric practitioners are inadequately trained in mental health, and health, social services and general practitioners are inadequately trained in either mental health or geriatrics (Alliance for Aging Research, 2002; Gatz & Finkel, 1995); and

WHEREAS major national studies, including the 2003 President's New Freedom Commission on Mental Health, recognize that there is a severe shortage of practitioners in the mental health, behavioral health, and aging workforce to treat the mental disorders and substance abuse of older adults due to stigma and economic disincentives (Qualls, et al., 2002; Halpain, et al., 1999; Gatz & Finkel, 1995); and

WHEREAS as the diverse baby boom generation ages, there will be increased demand for culturally competent geriatric mental and behavioral health practitioners (Administration on Aging, 2004; Whitfield, 2004); and

WHEREAS there are evidence-based and emerging best practices for successful treatment of mental and behavioral health disorders (Bartels, et al., 2003; Pinquart & Soerensen, 2001; Department of Health and Human Services, 1999; Gatz, et al., 1998); and

WHEREAS undetected or inappropriately treated mental and behavioral health disorders lead to extraordinarily high rates of suicide among older adults and substantially increased risks of mortality from other diseases (Pearson & Brown, 2000; Department of Health and Human Services, 1999); and

WHEREAS interdisciplinary care has been shown to be the most effective approach for successful treatment of mid-life and older adults (Heinemann & Zeiss, 2002); and

WHEREAS it is imperative that graduate and continuing education programs train more health professionals in effective evidence-based and emerging best practices in geriatric mental health (New Freedom Commission, 2003; Qualls, et al., 2002, Halpain, et al., 1999; Gatz & Finkel, 1995); and

WHEREAS health and mental health professions

often fail to provide basic curricula in geriatric mental health and substance abuse for all students (Alliance for Aging Research, 2002; Gatz & Finkel, 1995); and

WHEREAS the President's New Freedom Commission on Mental Health recognizes that a complex blend of training, professional, organizational, and regulatory issues needs a comprehensive strategic plan to improve workforce recruitment, retention, diversity, and skills training; and,

WHEREAS the President's New Freedom Commission on Mental Health recognizes that without a strategic plan to improve workforce recruitment, retention, diversity, and skills training, it will be difficult to achieve many of the Commission's other recommendations;

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging to:

Actively seek to attract new providers in mental health, behavioral health, and substance abuse for older adults by expanding geriatric traineeships for counselors, nurses, psychiatrists, psychologists social workers, and other health professionals such as occupational therapists, physical therapists, pharmacists, and target national financial incentives such as loan forgiveness programs and continuing education funding;

Require that professional mental health and behavioral health education programs that receive federal funding introduce geriatric course work or rotation for all students that includes promotion of evidence based and emerging best practices and skills in treating people with co-occurring mental and addictive disorders;

Require federal programs to promote interdisciplinary training and education;

Encourage states to revise licensing and continuing education requirements so that geriatric mental health, behavioral health, and substance abuse training is required for all licensed health, mental health and social services professionals;

Direct the Department of Health and Human Services to refine its approach to technology transfer in geriatric mental health and behavioral health evidence-based and emerging best practices to ensure that knowledge is translated more rapidly into the content of training curricula, that curricula employ teaching methods of demonstrated effectiveness, and that knowledge about effective education, recruitment, and retention strategies inform all public and private efforts to translate science to services; and

Eliminate disparities in reimbursement between geriatric mental health, behavioral health, and substance abuse practice and other areas of mental health and health care practice.

RESOLUTION ON CONSUMER AND CAREGIVER ISSUES REGARDING MENTAL HEALTH AND SUBSTANCE ABUSE

WHEREAS the number of older adults with mental illness is expected to double to 15 million in the next 30 years (Jeste, et al., 1999); and

WHEREAS almost two thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996); and

WHEREAS studies indicate that 50 – 70% of all primary care medical visits are related to psychological factors such as anxiety, depression, and stress (American Psychological Association, 2004); and

WHEREAS the 1999 Surgeon General's report on Mental Health asserts that stigma surrounding the receipt of mental health treatment affects older people disproportionately and, as a result, older adults and their family members often do not want to be identified with the traditional mental health system therefore making stigma a major barrier to care that results in the underutilization of mental health and substance abuse services; and

WHEREAS as many as 17% of older adults knowingly or unknowingly engage in alcohol or medication misuse and abuse (Substance Abuse and Mental Health Services Administration, 1998); and

WHEREAS there is a paucity of research on the extent of mental health and substance abuse problems among older people, effective prevention and treatment strategies (Bartels & Unutzer, 2003; Curry & Jackson, 2003; Department of Health and Human Services, 2001; Katz, 1995); and

WHEREAS older adults have the highest suicide rate of any age group (Hoyert, et al., 1999; US Public Health Service, 1999); and

WHEREAS late-life mental disorders pose difficulties for the burgeoning numbers of family members who assist in caretaking tasks for their loved ones (Light & Lebowitz, 1991);

THEREFORE BE IT RESOLVED by the 2005 White House Conference on Aging that:

Recommendation 1.1 of the 2003 Presidents New Freedom Commission on Mental Health Final Report, which seeks to advance and implement a national campaign to reduce the stigma associated with mental illness include an emphasis on older adults and seeking care as well as a national strategy for suicide prevention; and

A public/private education campaign be initiated under the Department of Health and Human Services to educate consumers, family members, providers, and the public on healthy aging and mental wellness and the identification and promise of effective treatments

for mental health disorders in older adults incorporating consumer choice/empowerment and involving consumers as educators; and

Older adults be identified as a priority for public mental health and substance abuse program funding; and

Research be conducted to assess the efficacy of prevention and treatment approaches for older adults (including peer support groups); and

Evidence based, emerging best practices, and value based mental health and substance abuse outreach, prevention, and treatment services for older adults be made available, accessible, and affordable and be provided by people trained and experienced working with older adults; and

Providers deliver services that are linguistically, culturally, ethnically, and age appropriate; and

The role of caregivers be recognized and supportive services be provided e.g., support groups, respite care, and counseling.

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APA Official Actions

Position Statement on Elder Abuse, Neglect, and Exploitation

Approved by the Board of Trustees, July 2008
Approved by the Assembly, May 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Issue

Elder abuse, neglect, and exploitation have been identified as major public health problems. All 50 states have adopted either mandatory or voluntary reporting laws. Emotional abuse is often linked with physical abuse, and both types of abuse can result in stress-related disorders. Psychiatric symptoms seen in abused elderly persons include the following: resignation, ambivalence, fear, anger, cognitive impairment, depressed mood, insomnia, substance abuse, delirium, agitation, lethargy and self-neglect.

These psychiatric symptoms are often the result of varied types of emotional and physical abuse, including threats, insults, harassment, lack of safe environment, harsh orders, infantilization, restriction of social and religious activity, and financial exploitation. Caregiver burden should be considered as an important risk factor for abuse, neglect, and exploitation, and appropriate interventions can be developed. This is particularly relevant in addressing APA's vision of ensuring humane care and effective treatment for all persons with mental disorders and its mission to promote the highest quality of psychiatric care.

Position Statement

The American Psychiatric Association (APA) recommends a comprehensive and culturally competent biopsychosocial assessment of victimized elderly persons and their perpetrators be completed in order to facilitate effective interventions, including the utilization of legal, social, and financial resources.

Developed by the American Psychiatric Association Council on Aging, 2007. Revision of the 1994 statement.

See the related resource document.

APA Official Actions

Position Statement on Discriminatory Disability Insurance Coverage

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The APA supports coverage for disability for psychiatric disorders the same as for other non-psychiatric medical conditions. The APA is opposed to arbitrary and discriminatory restrictions for mental illness (diagnosis-based contracts) in the coverage of disability.

APA Official Actions

Position Statement on Psychiatrists Practicing in Managed Care: Rights and Regulations

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

Contract Issues

- Psychiatrists should be allowed to practice to the full extent of their training and licensure and should be permitted to provide services to patients based on medical necessity.
- Medical necessity should be as defined by the AMA, APA, State Legislature or State Regulatory Boards.
- Hold harmless clauses should be eliminated.
- Termination clauses must delineate the specific causes that may lead to termination.

Psychiatrist-Patient Relationships

- The interests of the patients are primary and psychiatrists should be advocates for any treatments believed to be clinically beneficial to the patient.
- No physician should be dropped from a panel for advocating for his patient.

Relationship with managed care organizations

- Economic profiling and pay for performance programs should enhance clinical services.
- Preferred provider status should be explained in all contracts with providers and all subscribing patients. This should be a transparent procedure, explaining the criteria and process used to designate a contracted provider as a "preferred provider." Managed care companies should explain in writing what "preferred provider" status means as related to utilization of services, patient care authorization or denial and impact on referrals.
- Peer review should be based on AMA, APA, State Legislative or State Regulatory Board definitions of medical necessity, and should be performed by peers equal in specialty training and licensed in that state.
- Appeal mechanisms should be transparent and easily accessible and timely, in regards to the criteria used to determine "medical necessity". Mechanisms should be readily available for review by an Independent Review Organization.
- Physicians should not be unfairly terminated after making appropriate complaints to state or federal healthcare agencies.

Managed care organizations should be expected to make every effort to have current listings of network physicians without phantom networks.

- NCQA and URAC policies should be standard expectations
- Reasonable fees and prompt payment should be required.

Developed by the Committee on Managed Care (Paul H. Wick, M.D., Chair, Robert C. Bransfield, M.D. Co-chair, Gregory G. Harris, M.D., George D. Santos, M.D., Jonathan L. Weker, M.D., Barry K. Herman, M.D., Alan A. Axelson, M.D., Anthony L. Pelonero, M.D., Nicolas Abid, M.D., Joel Johnson, M.D.)

APA Official Actions

Position Statement on State Mental Health Services

Approved by the Board of Trustees, December 2008
Approved by the Assembly, November 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

All state mental health authorities for mentally ill, addicted, and developmentally disabled individuals must be under the direction of a qualified psychiatrist or include a qualified psychiatrist at the senior management level.

This statement prepared by the Committee on Public Funding is a revision of an earlier statement prepared by the APA Council on Mental Health Services which was approved by the Executive Committee, September 1970.

APA Official Actions

Position Statement on Universal Access to Health Care

Approved by the Board of Trustees, March 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

It is the policy of the American Psychiatric Association to support universal access to health care, specifically including non-discriminatory coverage of treatment for mental illness, including substance use disorders, for all Americans. The American Psychiatric Association will advocate vigorously for this at local, state and national levels.

Position Statement on Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*

Approved by the Board of Trustees, July 2007
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – APA Operations Manual.

States should be offered the opportunity to receive a Federal exemption from the Institutions for Mental Diseases (IMD) Exclusion for state hospitals and all nonprofits over 16 beds, e.g., private hospitals, community residential programs, dual diagnosis residential treatment. To participate in the exemption a state must demonstrate a maintenance of effort (maintain its mental illness and substance abuse expenditures (excluding medication costs) from all sources, e.g., a state's Department of Mental Health, Department of Public Health, Department of Medical Assistance, Department of Mental Retardation, Department of Corrections, Department of Social Services, Department of Youth Services, other) at a level no less than the state's average expenditure over the preceding five years.

**This position statement has been modified by the Council on Healthcare Systems and Financing (at the request of the Joint Reference Committee) to spell out all the acronyms within the Position Statement.*

APA Official Actions

Position Statement on Access to Comprehensive Psychiatric Assessment and Integrated Treatment

Approved by the Board of Trustees, June 2002
Approved by the Assembly, May 2002

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual.*

When patients are referred for treatment of mental illness, some primary care physicians and managed care organizations (MCOs) initially refer them to a non-medical mental health practitioner. Psychotherapy may then begin without benefit of a comprehensive, biopsychosocial assessment. Referral to a psychiatrist for consultation or medication management may occur only after other therapeutic options have been ineffective. By the time it is decided that a psychiatric referral is needed, the clinical situation may have deteriorated significantly. Such delays can result in more severe symptoms and unnecessarily prolonged suffering.

One justification for delayed psychiatric referral and use of a "split treatment" protocol includes presumed savings derived from not employing a psychiatrist when other healthcare professionals can provide evaluation and therapy services at a lower unit price. Yet there is research showing that patients who receive split treatment may have significantly more outpatient sessions and significantly higher costs. Some MCOs may not have enough in-network psychiatrists available to assure early access and to offer integrated treatment.

MCOs commonly authorize the patient to see the therapist more often and for longer sessions than the prescriber of medication. This format dilutes the development of the doctor-patient relationship and deprives the physician of the fullness and continuity of clinical observation that facilitates diagnostic timeliness and accuracy.

Logistical and financial aspects can diminish the likelihood of patient adherence to a split treatment plan. Having to schedule and attend appointments with two clinicians can be inconvenient, time-consuming, and costly. These factors can increase missed appointments and treatment dropouts.

There may be advantages to split treatment for some patients, for instance those who need specialized therapies. Yet there are some clinical situations in which the prescribing of psychoactive medication is best integrated within a psychotherapy relationship with a psychiatrist, who is the mental health specialist trained in both medical and biopsychosocial science. The judgment about which format would be most effective should be made by a psychiatrist or a clinical team that includes a psychiatrist.

For patients referred for the treatment of mental illness:

- Restricting access to psychiatric assessment and integrated treatment is not cost-effective.
- Delegating treatment to various specialties is a medical, not a procedural or administrative business, decision.
- There are some situations in which split treatment has advantages, many situations in which it is inadvisable, and no situation for which it should be mandated by a health plan.

APA supports screening and referral protocols by which:
Any patient who is referred for mental healthcare can receive a comprehensive psychiatric assessment within a clinically appropriate time.

- Treatment planning is undertaken only after an accurate diagnosis has been formulated by a psychiatrist, who is the clinician equipped with both medical training and a biopsychosocial perspective.
- Patients in need of treatment should not be barred from receiving combined psychotherapy and medication management from psychiatrists who are available and willing to offer it.

In keeping with APA's mission to advocate for patients:

- APA will work to promote adequate access to comprehensive initial psychiatric assessment and integrated treatment for patients.
- APA will work to ensure that any patient requiring a psychiatric assessment will receive one within a clinically appropriate time.

Prepared by the Committee on Managed Care.

APA Official Actions

Position Statement on Psychotherapy and Managed Care

Approved by the Board of Trustees, July 1999
Approved by the Assembly, May 1999

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

Managed care organizations (MCOs) limit access to treatment on the basis of cost, not clinical need. This process has been arbitrary, profit-driven, unscientific, clinically uninformed, and dangerous to patients. Furthermore, managed care of mental illness and addictive disorders sanctions treatment restrictions that are not proven to be cost-effective; in fact they run contrary to extensive studies on the cost savings of treatment for mental illness and substance abuse in work productivity, absenteeism, employee turnover, and general medical expenses of the patient and family.

1. Treatment decisions should be based on a differential therapeutic choice reflecting professional standards and guidelines; the patient's clinical presentation, prior treatment history, and preference for treatment; and cost-effectiveness, among other relevant considerations. Psychotherapy is an integral part of the psychiatric practice of medicine. It reflects the interplay of developmental complexity and current stressors that require clarification, understanding, and behavioral change. Psychotherapy may be time- and labor-intensive, and intensive treatment should be available to patients who need it.

2. Cost should be neither the sole nor the primary factor in deciding the indications for and length of treatments. In fact, the relative acute and long-term cost-effectiveness of most treatments (psychotherapeutic and otherwise) is difficult to assess. Managed care has tended to deny access to psychotherapy, and particularly psychotherapy extending beyond a handful of sessions, apparently based on prejudice that such treatment is neither efficacious nor cost-effective. To our knowledge MCOs have conducted and cited no research to substantiate this action. Psychotherapies have demonstrated efficacy for prevalent psychiatric disorders. Comparative cost-effectiveness has not been studied for most medical interventions, but there are suggestions that psychotherapy can be cost effective relative to pharmacotherapy alone, particularly if the family, workplace, and total medical costs are considered over the long term.

3. Psychotherapy must remain an integral part of psychiatric practice. Psychotherapy by psychiatrists has been singled out for adverse treatment by MCOs. This has seriously damaged the practice of integrated, comprehensive biopsychosocial treatment by psychiatrists and diminished the availability of psychotherapy to MCO members (i.e., patients). It has fostered a managed care model of treatment that commonly splits the treatment of patients between a) non-medical professionals conducting restricted amounts of psychotherapy and b) physicians (psychiatrists or primary care physicians) prescribing medication. At worst, patients are denied the psychotherapy altogether.

   In contrast to well organized, collaborative approaches, the current MCO model of split treatment is vulnerable to diffusion of responsibility, inadequate communication of clinical information, inefficiency, and higher cost. The model limits the psychiatrist's flexibility in tailoring the treatment to the patient. It may be confusing to the patient. There is a risk of a diminished psychiatrist-patient relationship and reduced psychotherapeutic work on compliance issues.

   Further, common MCO practices that limit contact with patients by psychiatrists preclude proper evaluation and genuine direction of treatment, including psychotherapy, by a physician. Third-party control of treatment planning and implementation is gross interference in medical decision-making by a MCO employee with usually less training and far less clinical data to support decisions. It is improper direction of treatment by a utilization review agent.

4. This increasingly prevalent model of mental health services has had a deleterious effect on the training and clinical experience of young psychiatrists. It has colored the public image of psychiatry and threatens to change the fundamental professional characteristics and skills of the psychiatrist.

Therefore the APA will work vigorously to end the pattern of managed care exclusion of integrated psychotherapy services by psychiatrists by all available means: through research, education, negotiation when and where feasible with the managed care industry, legislation, and litigation. The Board hereby charges the relevant components to develop specific strategies to end this pattern. Because this is an immediate threat to current psychiatric practice, it must have a very high priority.

APA Official Actions

Position Statement on Proposed Guidelines for Handling the Transfer of Provider Networks

Approved by the Board of Trustees, December 1995

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

The continuity of the patient therapist relationship is a significant factor in benefits derived from psychiatric treatment and therefore should be honored when insurance benefits programs change from indemnity plans to any kind of preferred provider network or from one network to another.

In the current practice of managed care, employers may change from one managed behavioral health care company (MBHCC) to another with a resulting change in the provider network. For mental health care, this can represent a disruption in the continuity of patient care, if patients are engaged with providers who are not included in the new network, and this disruption will have detrimental effects on the patients. These guidelines are articulated to maximize continuity in the event of such changes.

Objectives

To ensure continuity of patient care in the event of transfer of employer-sponsored health care management from one network to another.

Procedures

As soon as the transfer is planned:

- the new MBHCC should review the provider network of the old MBHCC to determine where there is overlap and where there are providers that are not included in the new network;
- the new MBHCC should actively evaluate the possibility of including those provider in their network; and
- the old MBHCC should review the new MBHCC's network so that new patients in the system can be directed to providers who will be able to follow them after the transfer.

Beginning no later than three months prior to the network transfer the current MBHCC should:

- develop a list of patients currently in treatment;
- review treatment plans with their providers to determine if treatment is planned to continue beyond the time of transfer; and
- provide a list of patients who should continue their treatment beyond the time of transfer to the new MBHCC.

For those patients who will be continuing treatment and whose providers are not in the new system, the following areas should be negotiated in the transfer:

- If possible, providers should be brought into the new network.
- If not possible, providers should be given provisional in-network status to continue/complete work with assigned patients (this depends upon the provider's willingness to accept fee schedules and terms of interaction with the new MBHCC).
- Patients requiring treatment beyond the time of transfer should be permitted to remain with the same provider for at least 3 months after the transfer.
- Patients requiring longer term treatment should be evaluated on a case-by-case basis, keeping in mind the value of continuing with the same provider.
- Patients with chronic or complex conditions should have careful treatment planning involving coordinated case management from both of the MBHCCs.

Am J Psychiatry 136:5, May 1979

Position Statement on Active Treatment

This statement was approved by the Assembly at its meeting in October 1978 and by the Board of Trustees at its meeting in December 1978. The statement was originated by the Council on Mental Health Services[1] and revised by a special Assembly task force.[2]

PSYCHIATRIC TREATMENT is a planned effort on behalf of persons defined either by themselves or by their community as mentally ill or emotionally disturbed and in need of treatment. The person directing it must be qualified by specialized education and training to evaluate and understand the totality of the biological, psychological, and social factors that play a part in such an illness. Treatment is provided through medical procedures designed to benefit the ill person.

1. Treatment may begin prior to the establishment of a final diagnosis. The process of evaluation is an act of treatment.

2. The standards used by a community to judge behavior may not always be in agreement with the standards leading to a diagnosis used by a psychiatrist to judge behavior. For example, some people judged by community standards to be "bad" rather than ill may suffer from a diagnosable mental illness. On the other hand, some persons whose behavior is identified as aberrant by a given community may be perceived by the psychiatrist as following an alternative lifestyle and not as suffering from an illness.

3. As in physical illness, an individual's subjective distress may in itself be sufficient justification for treatment.

4. Psychiatric disorders result from the complex interaction of physical, psychological, and social factors and treatment may be directed toward any or all three of these areas.

5. Treatment may include measures to maintain current functioning and prevent further deterioration as well as measures designed to improve or eliminate dysfunction.

6. A variety of professional disciplines may be involved in a treatment program. The extent and kind of participation of any practitioner in a specific treatment program should be determined by the person primarily responsible for providing treatment. The professional qualifications and ethics of the various disciplines are defined by each professional group within society's sanctions. No practitioner should be required to participate in a manner contrary to the ethic of his or her discipline.

7. A formal or informal treatment plan is an integral part of treatment. The plan should include the goals of treatment and problems that may be anticipated and should be revised when appropriate and indicated. Psychiatric treatment should be based on principles that can be explained and communicated during review by one's peers.

8. Providing a human environment for the care of persons in need is not equivalent to providing treatment. However, when the environment is carefully organized to respond in a therapeutic manner to patients' needs and behavior and is staffed and supervised by qualified members of appropriate professional disciplines, it is a form of treatment. Treatment of that kind is usually referred to as a therapeutic environment or milieu therapy.

9. Psychiatric treatment is the sum of the activities of a psychiatrically qualified physician in meeting the therapeutic needs of a patient, a family, or a (community) group. This may include the supervision of others who are providing treatment and for whose activities the psychiatrist accepts professional and legal responsibility.

APA Official Actions

Endorsement of *Medical Professionalism in the New Millennium: A Physician Charter*

Approved by the Board of Trustees, 2002

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Preamble

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

Fundamental Principles

Principle of primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A Set of Professional Responsibilities

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and improvement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and

through their professional associations, must take responsibility for assisting in the creation and implementtation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

Summary

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

Developed by leaders in the ABIM Foundation, the ACP–ASIM Foundation, and the European Federation of Internal Medicine.

Position Statement on Desegregation of Hospitals for the Mentally Ill and Retarded

This statement, a revision of a statement approved in December 1963, was approved by the Assembly of District Branches at its November 4–5, 1975, meeting and by the Board of Trustees at its December 5–6, 1975, meeting. The revision was recommended by the Council on National Affairs.[1].

THE AMERICAN PSYCHIATRIC ASSOCIATION is in favor of desegregation of all hospitals for the mentally ill and retarded. This statement is offered as contributory to the national will to eliminate legal and social impediments to the extension of all services to all citizens. The acceptance of this principle and its translation into practice would remove the need to duplicate facilities to accommodate segregation. It would release all available resources in support of a wider range of treatment services for the benefit of all mentally ill citizens.

APA Official Actions

Abortion and Women's Reproductive Health Care Rights

On behalf of all APA members who are dedicated to the provision of the best possible mental health care to women patients, the American Psychiatric Association hereby states in its position on Abortion and a Women's Reproductive Health Care Rights that:

The American Psychiatric Association opposes all constitutional amendments, legislation, and regulations curtailing family planning and abortion services to any segment of the population;

The American Psychiatric Association reaffirms its position that abortion is a medical procedure for which physicians should respect the patient's right to freedom of choice—psychiatrists may be called on as consultants to the patient or physician in those cases in which the patient or physician requests such consultation to expand mutual appreciation of motivation and consequences of such a choice; and

The American Psychiatric Association affirms that the freedom to act to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications.

This APA position statement was prepared by the APA Committee on Women (Asha Mishra, M.D. [chair]; Stacey Burpee, D.O.; Jamae Campbell, M.D.; Sharon Jacobson, M.D.; Christina Mangurian, M.D.; Judith Milner, M.D.; Sylvia Olarte, M.D.; Michele Preminger, M.D.; Claudia Reardon, M.D.; Gail Robinson, M.D.; Sudeepta Varma, M.D.; Kathy Vincent, M.D.). It was approved by the Assembly in May 2009 and by the Board of Trustees in September 2009. The chair wishes to acknowledge Nada Stotland, M.D., for her participation in the development of this position statement.

APA Official Actions

Xenophobia, Immigration, and Mental Health

The American Psychiatric Association (APA) takes an official stand against the destructive consequences of ethnic prejudice and xenophobia, both for populations and for individuals. It expresses deep concern over the adverse public health and mental health consequences of these unchecked prejudices. Because of these significant adverse consequences, the APA calls for any national debates (e.g., on policies such as immigration and naturalization, foreign relations, and response to terrorism) involving people of different national ethnic, or racial backgrounds to be based on objective data and rational national interest, and not on prejudices or ideology.

The APA calls on the mass media to show responsibility and sensitivity to the rights of immigrants, refugees, and all foreign-born people, and to refrain from inflaming xenophobia in their programming. The APA advocates for the rights of immigrants, refugees, and asylum seekers to be respected, including rights to safe haven, security, and nurturance of one's own ethnic and cultural beliefs/values, and identity as essential for psychological health. It further calls for national education on cultural competence and diversity, starting in public schools and mental health settings and extending to the mass media. Such education should include discussion about xenophobia and negative prejudice and their destructive consequences, as well as the acceptance and valuation of diversity.

This APA position statement was drafted by the APA Committee of Hispanic Psychiatrists (Andres J. Pumariega, M.D. [chair]; Dan Castellanos, M.D.; Jose De La Gandara, M.D.; Esperanza Diaz, M.D.; Tatiana Falcone, M.D.; Sarah Huertas-Goldman, M.D.; Alex Kopelowicz, M.D.; Luis Fernando Ramirez, M.D.; Carlos Rodriguez, M.D.; Leonardo Rodriguez, M.D.; Amado Suarez, M.D.; Natalie Weder, M.D.). It was approved by the Assembly in May 2009 and by the Board of Trustees in September 2009.

APA Official Actions

Position Statement on Juvenile Death Sentences

Approved by the Board of Trustees, June 2001
Reaffirmed, 2008

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The United States is one of the few countries in the world that executes juveniles, and, since 1990, it has executed 10 persons for crimes committed prior to age 18. Juveniles constitute approximately 2% of total death sentences, and, as of June, 1999, there were 70 persons on death row for crimes committed at age 16 or 17. With the increasing trend of waiving juvenile offenders to the adult court and imposing harsher sentences than in the past, these numbers can be expected to rise. Although the U.S. Supreme Court's decision in Thompson v. Oklahoma (1988) precluded execution of persons who were younger than 16 years of age at the time of their crimes, the Court ruled the following year (in Stanford v. Kentucky) that executing offenders who were 16 or 17 at the time of their crimes did not amount to cruel and unusual punishment under the Eighth Amendment. The United States remains the only country in the world that has not yet ratified the UN Convention, Article 37a, which states that "Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offenses committed by persons below eighteen years of age."

For the following reasons, the harshest punishments, including the death penalty, should be precluded in cases involving offenders whose crimes were committed prior to age 18. Adolescents are cognitively and emotionally less mature than adults. They are less able than adults to consider the consequences of their behavior, they are easily swayed by peers, and they may show poor judgment. That juveniles differ from adults in their decision-making capacities is reflected in our nation's laws regarding voting, driving, access to alcoholic beverages, consent to treatment, contracting, and in the juvenile court itself. We also know that teens who have been victims of abuse or have witnessed violence may show increased levels of emotional arousal and a tendency to overreact to perceived threats. Victims of child abuse and neglect are over represented among incarcerated juveniles, including those on death row. Studies of this population consistently demonstrate a high prevalence of mental disorders, serious brain injuries, substance abuse, and learning disabilities, which may predispose to aggressive or violent behaviors. In many instances, these juveniles have not received adequate diagnostic assessments or interventions. National statistics also indicate that African-American and Hispanic youth are disproportionately diverted into juvenile correctional facilities and waived to the adult criminal court system.

Many psychiatrists oppose use of the death penalty in all cases due to concerns about its discriminatory application (including discrimination against poor offenders who do not have equal access to adequate legal representation) and about what appears to be an unavoidable risk of error. The deterrent value of capital punishment has yet to be demonstrated. However, whatever one may think about the overall deterrent effect of the death penalty, it is particularly unlikely to deter adolescents from crime, as they tend to live in the present, think of themselves as invincible, and have difficulty contemplating the long-term consequences of their behavior.

The traditional philosophy of the juvenile court has been rehabilitation. This goal is now made more attainable than ever by improved assessment tools, new effective community-intervention programs, and treatments for underlying psychiatric disorders. However, such efforts are often undermined by the diversion of scarce dollars into incarceration, long sentences, and carrying out the death penalty rather than into earlier intervention efforts and strengthening the juvenile justice system so that it can effectively respond to dangerous and/or repeat youth offenders to ensure public safety.

Therefore, the American Psychiatric Association strongly opposes the imposition of the death penalty for crimes committed as juveniles.

This policy originated with the American Academy of Child and Adolescent Psychiatry. It was endorsed by APA Council on Children, Adolescents, and Their Families and revised by APA Council on Psychiatry and Law.

APA Official Actions

Position Statement on Peer Review of Expert Testimony

Approved by the Board of Trustees, December 1991
Reaffirmed, 2007

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Peer review of psychiatric expert testimony is a promising mechanism for improving the quality of information that psychiatrists present to the legal system. Preliminary experience suggests that peer review can be of considerable value when it focuses on educating psychiatrists, on a voluntary basis, about potential problems with their testimony. The American Psychiatric Association encourages innovative development of models of peer review of psychiatric expert testimony by APA district branches, departments of psychiatry, and other groups. The APA's resource document on peer review of psychiatric expert testimony may be of assistance to groups that are interested in developing peer review mechanisms. Experience with different approaches should be evaluated systematically to facilitate the development of optimal models for peer review.

APA Official Actions

Joint Resolution Against Torture of the American Psychiatric Association and the American Psychological Association

Approved by the Board of Trustees, December 1985
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Whereas, American psychiatrists are bound by their *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* to "provide competent medical service with compassion and respect for human dignity," and

Whereas, American psychologists are bound by their *Ethical Principles* to "respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights," and

Whereas, the existence of state-sponsored torture and other cruel, inhuman, or degrading treatment has been documented in many nations around the world, and

Whereas, psychological knowledge and techniques may be used to design and carry out torture, and

Whereas, torture victims often suffer from multiple, long-term psychological and physical problems,

Be it resolved, that the American Psychiatric Association and the American Psychological Association condemn torture wherever it occurs, and

Be it further resolved, that the American Psychiatric Association and the American Psychological Association support the *UN Declaration and Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*; and the *UN Principles of Medical Ethics*, as well as the joint Congressional Resolution opposing torture that was signed into law by President Reagan on October 4, 1984.

APA Official Actions

Position Statement on Moratorium on Capital Punishment in the United States

Approved by the Board of Trustees, October 2000
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Whereas the American Bar Association has concluded that the death penalty is administered in an unfair and arbitrary manner and has recommended a moratorium on executions until proper reforms are implemented; and

Whereas psychiatrists, due to their involvement in and familiarity with the criminal justice system, have become increasingly aware of the weaknesses and deficiencies of the current capital sentencing process including considerations in regard to the mentally ill and developmentally disabled;

The American Psychiatric Association endorses a moratorium on capital punishment in the United States until jurisdictions seeking to reform the death penalty implement policies and procedures to assure that capital punishment, if used at all, is administered fairly and impartially in accord with the basic requirements of due process.

The statement, prepared by the Council on Psychiatry and the Law, was approved as amended, with the proviso that the language is intended neither as an endorsement nor a statement of disapproval of the death penalty.

Position Statement on Discrimination Against Persons With Previous Psychiatric Treatment

Reaffirmed 2007

This position statement was developed by the Council on Psychiatry and Law.[1] It was approved by the APA Assembly in November 1996 and by the Board of Trustees in March 1997.

Many people have suffered discrimination and social disadvantage because they have a psychiatric diagnosis or a history of psychiatric treatment. Information about diagnosis or treatment has been used unfairly to deny immigration, professional or occupational licensure, employment, insurance, housing, and credit and to otherwise reduce opportunities for full participation in the life of society. Stigmatization and discrimination also tend to diminish the well-being of the population as a whole by discouraging people from seeking needed psychiatric evaluation and treatment.

The American Psychiatric Association vigorously opposes discrimination based on mental disorder or a history of psychiatric treatment. Such discrimination is often based on unfounded, irrational misconceptions and fears about mental illness. Moreover, categorical distinctions based on mental disorder are tantamount to class discrimination because they assume that everyone who has received a particular diagnosis or treatment is identical. In fact, individuals with the same diagnosis or receiving the same treatment may manifest different kinds of symptoms; even when the symptoms are the same, they may vary widely in their severity. Nor is there a direct or simple connection between symptom severity and impairments that may be relevant to a particular decision. For example, an individual who suffers from a severe major depression associated with weight loss and anhedonia may be disabled from working or may have no discernible decrement in work capacity.

Because economic and emotional well-being are so often dependent on vocational satisfaction, discrimination in employment is especially harmful. Unfortunately, employers often ask applicants whether they have ever had a mental illness or whether they have ever been under the care of a psychiatrist. Employers argue that questions that screen for a history of psychiatric treatment allow them to delineate a group of applicants for more-searching inquiry. This argument, however, relies on the assumption that the presence or absence of a psychiatric history is an accurate predictor of an individuals's ability to function effectively in the workplace. Research has failed to substantiate such a causal link. Standing alone, a psychiatric diagnosis provides little direct information about whether an individual is able to perform a specific occupational task. As a result, such "screening" questions significantly increase the risk of discrimination while producing little useful information in the great majority of cases. Moreover, to the extent that questionnaires fail to ask about physical or other medical conditions, they serve only to further stigmatize mental illness. Far more helpful in determining an applicant's fitness to perform a specific job are questions that inquire about past behavior in work or school settings—e.g., absences, frequent job changes, or significant drops in grades or work performance.

Some constructive steps have been taken to combat stigmatization and discrimination in the workplace and elsewhere in society. The most recent and far-reaching of these measures is the Americans With Disabilities Act (ADA), 42 U.S.C. §§12101–12213, which was enacted on July 26, 1990. The ADA provides broad antidiscrimination protection for persons with physical or mental impairments. The legislation builds on some prior federal laws, such as the Rehabilitation Act of 1973, 29 U.S.C. §§791–794, and the Fair Housing Act Amendments of 1988, 42 U.S.C. §§3601–3619. The ADA extends the reach of these laws substantially. For example, unlike §504 of the Rehabilitation Act, the ADA's coverage is not limited to employers or public entities that receive federal funds. All but the smallest businesses must comply with the ADA.

Under the ADA, a person with a "disability" is defined as someone who has "a physical or mental impairment that substantially limits one or more of the major life activities of such individuals," as well as individuals who have "a record of such an impairment" or are "regarded as having such an impairment." The ADA prohibits the use of certain medical examinations and inquiries. Prior to offering employment, an employer may only raise questions about the applicant's ability to perform job-related functions and may not ask whether the person has a disability or inquire about the nature or severity of such a disability. The act does not protect an employee who is currently using drugs illegally, who is abusing alcohol, or who poses a "direct threat" to the health or safety of others. The Equal Employment Opportunity Commission is responsible for administrative enforcement of the ADA provisions relating to employers.

One important effect of the ADA has been to encourage employers to develop formal descriptions of the essential functions of various jobs and to redesign job applications and interviews to focus on areas relevant to an applicant's ability to perform these functions. Similarly, professional licensing boards concerned with an applicant's character and fitness to practice have begun to redirect their inquiries to focus on previous *behavior* (not medical history) that might bear on these questions.

The permissible use of medical examinations (including mental health evaluations) remains somewhat controversial. In order to reduce the risk of unwarranted discrimination, the ADA disallows medical examinations before a job offer has been made. (Tests of the applicant's ability to perform specific job-related tasks, such as tests of physical agility, are permitted.) After a job offer has been made, or during the course of employment, a medical evaluation can play an important role in assessing the applicant's (or employee's) ability to perform a job or in designing reasonable accommodations. Again, however, employment decisions must be based on the person's functional capacity, not on the person's diagnosis or disability per se.

The Equal Employment Opportunity Commission has issued enforcement guidance on employment interviews and medical examinations to help employers comply with the ADA. Psychiatrists should become familiar with the basic requirements of the ADA so that they can help their patients avoid discrimination by invoking the act's protections (e.g., declining to disclose personal information or requesting appropriate accommodations).

Although the ADA and other antidiscrimination legislation reflect a growing awareness of the need to combat discrimination, especially in employment, APA strongly supports additional measures designed to end stigmatization and discrimination against people with histories of psychiatric treatment and to facilitate their full participation in society.

[1]The members of the council for 1996–1997 were Steven K. Hoge, M.D. (chairperson), Raymond F. Patterson, M.D. (vice-chairperson), David J. Barry, M.D., Elissa P. Benedek, M.D., Renee Leslie Binder, M.D., Jorge Raul Veliz-Cruz, M.D. (observer-consultant), Richard Bonnie, J.D. (consultant), Carole Cole Kleinman, M.D. (consultant), Jagannathan Srinivasaraghavan, M.D. (consultant), Alan A. Stone, M.D. (consultant), Howard V. Zonana, M.D. (consultant), Michelle Riba, M.D. (Board liaison), Jeffrey L. Metzner, M.D. (Assembly liaison), Harry A. Brandt, M.D. (corresponding member), Alan B. Hertz, M.D. (corresponding member), Jeffrey S. Janofsky, M.D. (corresponding member), Brian J. Ladds, M.D. (corresponding member), Patricia Ryan Recupero, M.D. (corresponding member), and Maria Daehler, M.D. (APA/Glaxo Wellcome Fellow).

APA Official Actions

Position Statement on the Insanity Defense

Approved by the Board of Trustees, December 2007
Approved by the Assembly, November 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The insanity defense[1] is deeply rooted in Anglo-American law. Although the specific standard by which legal insanity is determined has varied over time and across jurisdictions, the insanity defense has always been grounded in the belief that there are defendants whose mental conditions are so impaired at the time of the crime that it would be unfair to punish them for their acts.

Recognizing that the insanity defense plays a critical role in the administration of criminal justice in the United States, the American Psychiatric Association endorses the following positions:

1. Serious mental disorders[2] can substantially impair an individual's capacities to reason rationally and to inhibit behavior that violates the law. The APA strongly supports the insanity defense because it offers our criminal justice system a mechanism for recognizing the unfairness of punishing persons who exhibit substantial impairment of mental function at the time of their actions.
2. The APA does not favor any particular legal standard for the insanity defense over another, so long as the standard is broad enough to allow meaningful consideration of the impact of serious mental disorders on individual culpability.

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[1] By the term "insanity defense," we include verdicts of "not guilty by reason of insanity," "guilty but not criminally responsible," and related formulations.

[2] "Serious mental disorder" is meant to encompass not only major psychiatric disorders, but also developmental disabilities and other causes of impaired mental function (e.g., severe head trauma) that otherwise meet the legal criteria for the insanity defense.

APA Official Actions

Position Statement on Psychiatric Participation in Interrogation* of Detainees

Approved by the Board of Trustees, May 2006
Approved by the Assembly, May 2006

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

1. The American Psychiatric Association reiterates its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action.

2. a) Every person in military or civilian detention, whether in the United States or elsewhere, is entitled to appropriate medical care under domestic and international humanitarian law.
b) Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities.
c) Psychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee.
d) This paragraph is not meant to preclude treating psychiatrists who become aware that the detainee may pose a significant threat of harm to him/herself or to others from ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to other treatment relationships.

3. No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.

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*As used in this statement, "interrogation" refers to a deliberate attempt to elicit information from a detainee for the purposes of incriminating the detainee, identifying other persons who have committed or may be planning to commit acts of violence or other crimes, or otherwise obtaining information that is believed to be of value for criminal justice or national security purposes. It does not include interviews or other interactions with a detainee that have been appropriately authorized by a court or by counsel for the detainee or that are conducted by or on behalf of correctional authorities with a prisoner serving a criminal sentence.

APA Official Actions

Position Statement on Death Sentences for Persons with Dementia or Traumatic Brain Injury

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The Presidential Council has previously recommended, and the APA has adopted, two position statements on mental illness and the death penalty -- one proposing criteria of diminished responsibility for offenses committed by offenders suffering from severe mental disorder at the time of their offenses, and another pertaining to issues arising after sentencing when prisoners on death row suffer from mental illness. These two statements were developed in close collaboration with the American Bar Association Task Force on Mental Disability and the Death Penalty. The Council has now approved a third position (and final) proposal on this subject developed in collaboration with the ABA Task Force. This statement has a very limited aim -- it is designed simply to urge courts and legislatures to extend the Supreme Court's ruling in Atkins v. Virginia (exempting people with mental retardation from the death penalty) to two other disorders involving equivalent levels of impairment -- dementia and traumatic brain injury. The proposed position statement follows:

"Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury."

APA Official Actions

Position Statement on Mentally Ill Prisoners on Death Row

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

(a) Grounds for Precluding Execution. A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forego or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case. Procedures to be followed in each of these categories of cases are specified in (b) through (d) below.

(b) Procedure in Cases Involving Prisoners Seeking to Forego or Terminate Post-Conviction Proceedings. If a court finds that a prisoner under sentence of death who wishes to forego or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

(c) Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings. If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to a lesser punishment.

(d) Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose. If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to a lesser punishment.

APA Official Actions

Position Statement on Diminished Responsibility in Capital Sentencing

Approved by the Board of Trustees, November 2004
Approved by the Assembly, December 2004

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Defendants shall not be sentenced to death or executed if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to their conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.

APA Official Actions

Endorsement of the Patient-Physician Covenant

Approved by the Board of Trustees, September 1995
Reaffirmed, 2007

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, carer, helper, and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gateclosers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patients at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

Ralph Crawshaw, M.D.
David E. Rogers, M.D.
Edmund D. Pellegrino, M.D.
Roger J. Bulger, M.D.
George D. Lundberg, M.D.
Lonnie R. Bristow, M.D.
Christine K. Cassel, M.D.
Jeremiah A. Barondess, M.D.

JAMA. 1995;273(19):1553-1553.

APA Official Actions

Position Statement on Provision of Psychotherapy for Psychiatric Residents

Approved by the Board of Trustees, September 2009
Approved by the Assembly, May 2009

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

The American Psychiatric Association affirms that training programs have a responsibility to advocate to ensure psychiatric residents have access, within the limits of what is available in the community, to affordable, private and confidential psychiatric services, including individual psychotherapy, on a par with all other medical services. If provided within the resident's training program, such therapy should not be carried out by a therapist with a supervisory or evaluative role. Without reducing training or clinical care requirements, residents should have protected time to pursue psychotherapy, while facing no stigmatizing or discriminatory consequences.

Minutes of a Meeting of the Assembly of the American Psychiatric Association New York Marriott Marquis – New York, NY May 2-4, 2014

Welcome and Introductions

Dr. Melinda Young, Speaker of the Assembly, called the 80th meeting of the Assembly of the American Psychiatric Association (APA) to order on May 2nd, 2014, at the New York Marriott Marquis in New York, New York. Dr. Young began the meeting by recognizing the work of former APA staff member Dr. Darrel Regier, MPH, for his work on the development of the DSM-5. Dr. Young and the Assembly formally thanked Dr. Regier for his distinguished and honorable service to the APA and to psychiatry.

1. Remarks of the Board of Trustees

A. President

Committee on Bylaws

Action: Will the Assembly vote to ratify the amendments to the APA Bylaws complying with the "The Non-profit Corporation Act of 2010"?

The Assembly voted to ratify the recommended amendments to the APA Bylaws complying with the "The Non-profit Corporation Act of 2010".

C. Treasurer

Dr. David Fassler, Treasurer, presented his report to the Assembly. APA revenue was $83 million compared to a budget of $62 million and that the positive variance was due to sales of DSM-5. Expenses were below budget by approximately $4 million due to vacancy savings, lower than anticipated postage and mailing costs, and a one-time adjustment related to the APA pension plan.. Dues revenue has been relatively stable over recent years, though the amount of dues paying members has begun a gradual increase. Annual Meeting registration was very positive and has already made budget. Advertising revenue continues its downward trend, although it has been stable since 2013 at around $4 million. DSM-5 sales were impressive and exceeded budget and expectations. However this is not expected to continue at the same remarkable sale rate. The combined organizational reserves are approximately $115 million. Dr. Fassler concluded his report by remarking it was his last presentation to the Assembly as Treasurer. He thanked the Assembly for its unwavering support.

2. Report of the CEO and Medical Director

Dr. Saul Levin, MPA, CEO and Medical Director addressed the Assembly. He emphasized that as CEO and Medical Director, he has two duties: one is to ensure the financial health of the APA

and the other is to look at the clinical aspects of psychiatry. Dr. Levin noted that in the eight months since he became CEO and Medical Director, he has had the opportunity to meet with a number of District Branches and Area Councils. Dr. Levin provided updates on a number of Assembly action papers that had been assigned to the Office of the CEO and Medical Director.

Dr. Levin presented the new APA organizational chart to the Assembly which was developed after a review of the previous APA organizational chart and consultation with APA staff. Dr. Levin noted that, in addition to the Deputy Medical Director, Dr. Annelle Primm, Chief Financial Officer Terri Swetnam, PhD and APA General Counsel, Colleen Coyle, Dr. Levin explained that there are now several new chiefs who work together to ensure that every area of the APA is working as an effective organization. He introduced Shaun Snyder, JD, Chief Operating Officer, Kristin Kroeger, Chief of Policy, Programs and Partnerships and Jon Fanning, Chief of Membership and RFM-ECP. He also announced that two new positions, Chief of Communications and Chief of Government Affairs will be filled shortly.

Dr. Levin noted some areas of recent focus for the APA, including Medicare Part D, partnerships with other organizations including the AACAP and the National Association of Social Workers and increasing membership numbers. He stressed the importance of the conflict of interest policy and process the APA has established. Dr. Levin concluded his remarks by thanking the Assembly and responding to questions from the audience.

3. **Report and Dialogue of the APA President and Assembly Speaker**

Dr. Jeffrey Lieberman, APA President and Dr. Melinda Young, APA Assembly Speaker participated in a dialogue with the APA Assembly. Drs. Lieberman and Young responded to questions posed from members about the recent Board of Trustees meeting and the Board Summary of Actions.

4. **Report and Dialogue of the President-Elect and Speaker-Elect**

Dr. Paul Summergrad, APA President-Elect and Dr. Jenny Boyer, APA Assembly Speaker-Elect participated in a dialogue with members of the Assembly. Drs. Summergrad and Boyer responded to questions about decisions made during the Joint Reference Committee meeting and information contained within the JRC Summary of Actions.

5. Report of the Recorder

Dr. Glenn Martin, Recorder, referred members to his report contained within Section 5 of the backup materials. He asked that the Assembly approve the minutes of the November 8-10, 2013 meeting (5.A).

Action: Will the Assembly vote to approve the minutes of its November 8-10, 2013 Meeting?
The Assembly voted to approve the November 2013 Assembly Minutes.

Dr. Martin sought to determine if a quorum was present by asking if representatives from the following District Branches were in attendance: *Maine Association of Psychiatric Physicians, New Hampshire Psychiatric Society, Ontario District Branch, Rhode Island Psychiatric Society, Psychiatric Society of Delaware*, and the *New Jersey Psychiatric Association*. Of the District Branches called, the following had representation at the meeting: *Maine Association of Psychiatric Physicians, New Hampshire Psychiatric Society, Ontario District Branch, Rhode Island Psychiatric Society, Psychiatric Society of Delaware,* and the *New Jersey Psychiatric Association*.

Dr. Martin declared a quorum of the Assembly.

6. Report of the Rules Committee

Dr. R. Scott Benson, Chair of the Rules Committee, referred the Assembly to the Rules Committee report. Item 6.A included the action assignments to reference committees and other Assembly groups. Dr. Benson presented Item 6.B, the consent calendar, and asked if any member of the Assembly wished to add or remove any item. Items 4.B.3, 8.L.1, 8.L.2, 8.L.3, 8.L.4, 8.L.5, 8.L.6, 8.L.7, 8.L.8, 8.L.9 and 12.K were removed from the consent calendar.

Action: Will the Assembly vote to approve the Consent Calendar with the exception of 4.B.3, 8.L.1, 8.L.2, 8.L.3, 8.L.4, 8.L.5, 8.L.6, 8.L.7, 8.L.8, 8.L.9 and 12.K removed?
The Assembly voted to approve the Consent Calendar as amended.

Dr. Benson presented Item 6.C, *Special Rules of the Assembly*. These are the usual rules governing debate in the Assembly. The Rules Committee moved that the Assembly adopt the *Special Rules of the Assembly* for this meeting.

Action: Will the Assembly vote to adopt the *Special Rules of the Assembly* for this meeting?

The Assembly voted to adopt the *Special Rules of the Assembly* for this meeting.

7. Reports of Assembly Committees

A. Nominating Committee

Dr. Ann Sullivan, Chair of the Assembly Nominating Committee reminded the Assembly of the procedures for Assembly election voting and reviewed the roster of Assembly candidates for 2014-2015. For Speaker-Elect: Dr. James R. Batterson (Area 4) and Dr. Glenn Martin (Area 2). For Recorder: Dr. Daniel Anzia (Area 4), and Dr. Stephen Brown (Area 7). Later in the meeting Dr. Sullivan announced the voting results.

Dr. Glenn Martin was elected as Speaker-Elect
Dr. Daniel Anzia was elected as Recorder.

B. Committee on Procedures

The Committee brought the following items forward to the Assembly for approval.

Action: Will the Assembly vote to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO)?

The Assembly voted to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO).

Action: Will the Assembly vote to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly?

The Assembly voted to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly.

8. Reports of Councils and Components

Written Council Reports may be found in the backup materials.

10. Reports from Special Components

A. APA AMA Delegation Report & Remarks from Jeremy Lazarus, M.D., Past President, AMA

Dr. Carolyn Robinowitz directed the Assembly to her report on the activities of the American Psychiatric Association AMA Delegation and introduced Dr. Jeremy Lazarus, Past President of the American Medical Association and former Speaker of the Assembly.

Dr. Lazarus began by addressing the role out of the Affordable Care Act (ACA) and health exchanges. Around 8 million people are now signed up for the health exchanges and the AMA continues to be very involved in the implementation of the ACA. A number of suggestions made by the AMA early in the exchange process have become part of the official exchanges including having physicians be part of the governing council of the exchanges and making sure the exchanges pay attention to scope of practice laws. The AMA has also been involved in electronic health records, meeting with vendors and reviewing liability issues.

The AMA has been working on repealing the mandatory use of the ICD-10-CM and the flawed Sustainable Growth Rate (SGR). The conversion from ICD-9 to ICD-10 has been delayed another year due to the SGR patch bill that passed recently. The AMA has also partnered with state medical societies to pass 70 legislative initiatives including truth in advertising legislation and improvements in Medicaid. Dr. Lazarus concluded his remarks by outlining some key points of the AMA strategic plan, including improving health outcomes for patients, improving physician satisfaction, and changing how medical students are trained.

B. American Psychiatric Association Political Action Committee (APA*PAC*)

Dr. Russell Denea, Member, APA*PAC* Board of Directors, gave a brief update on the APA*PAC* activities. The PAC has raised $104,000 in the first four months of 2014, the highest amount raised in that time period since 2008. He stressed that PAC donations are an investment in having a voice at the federal level. Dr. Denea completed his report by announcing PAC contributions by Area, giving special recognition to Area 4 which had contributed the most PAC donations of any Area.

American Psychiatric Foundation

Dr. James E. Nininger, a member of the American Psychiatric Foundation Board of Directors, gave an update on recent American Psychiatric Foundation activities. APF is the fundraising and educational arm of the APA and one of its major projects in recent years has been the *Typical or Troubled*™ program which is a school mental health education program aimed at educating teachers, counselors and other school personnel to identify if a teenager's behavior is typical or if warning signs of a mental health issue are present and further action is needed. Another project has been to help state governments and jurisdiction judges to recognize and appropriately treat mental illness within the jail and prison community. Dr. Nininger concluded his remarks by highlighting the APF fundraising events being held at the Annual Meeting and encouraging ALL Assembly members to contribute to the American Psychiatric Foundation.

Presentation of Assembly Awards:

District Branch Best Practice Award

Dr. Ann Sullivan presented the District Branch Best Practice Award to the *Minnesota Psychiatric Society*. An honorable mention for the award also went to the *Psychiatric Society of Virginia*.

Ronald Shellow Award

The Ronald Shellow Award was presented to Dr. William Ulwelling, Representative, Psychiatric Medical Association of New Mexico.

Remarks from The Honorable Tim Murphy, Ph.D. (Republican – Pennsylvania 18th District)
Chairman, House Energy and Commerce Subcommittee on Oversight and Investigation
Co-chair, Congressional Mental Health Caucus

Congressman Murphy spoke to the Assembly about the Helping Families in Mental Health Crisis Act, a bill he introduced in December in response to the Sandy Hook Elementary School shootings. The bill hopes to drive evidenced based care, help with shortages of psychiatric beds, and empower patients and care givers. Additionally, the bill aims to help clarify theHealth Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FFERPA) as to when information can and should be shared. Congressman Murphy also stressed the importance of integrating mental health and primary care. He completed his presentation by asking the members of the Assembly to review the bill and continue dialogues with other Members of Congress on the bill.

A video of Representative Murphy's complete remarks to the Assembly can be found on the APA website at: http://www.psychiatry.org/advocacy--newsroom/advocacy/h-r--3717-helping-families-in-mental-health-crisis-act.

Remarks from Professor Dame Sue Bailey, FRCPsych, President, Royal College of Psychiatrists

Professor Dame Sue Bailey, FRCPsych, President of the Royal College of Psychiatrists addressed the Assembly. Dr. Bailey outlined how the United Kingdom is working towards parity and how it can be used in day-to-day practice and when talking to policy makers, fellow physicians, general practitioners and anyone else who psychiatrists work with to help provide equal access to the most safe and effective care and treatment. She also emphasized holistic care and how the mind and body work together, integrated care, and investment in mental health research. The UK is aiming for person centered coordinated care and treatment by putting patients more in control of their recovery and making sure services, care, and treatment are fully integrated across medicine. The Royal College of Psychiatrists, along with its partners, has presented a report to the government containing approximately 30 recommendations which has been accepted and it is hopeful that these recommendations can be adopted worldwide.

Update on Coding/CPT Changes

Dr. Ronald Burd, Chair of the Committee on RBRVS, Codes and Reimbursements, gave a brief update to the Assembly. All the recommendations and values for psychiatric services have passed in the final rule. CPT is continuing to work on new codes, particularly for group medication management, longer psychotherapy codes, and computer based therapy. Dr. Burd noted the concern from the Office of the Inspector General about the ability to copy and paste in EHRs in that it may create the opportunity for fraud. Dr. Burd concluded his update by highlighting some the educational seminars and workshops on coding taking place during the Annual Meeting.

Report of the Health Care Reform Strategic Action Work Group

Dr. Eliot Sorel gave an update of the Health Care Reform Strategic Action Work Group, the mission of which is to expand upon the work of the previous Board of Trustees work group on health care and amend APA staff capability to develop an optimal strategy to guide the APA and influence the health care reform process as it impacts mental health care. The key products of the work group will be advocacy kits for the district branches and toolkits for APA members and psychiatric practices in integrated care settings on the Affordable Care Act.

11. Area Council Reports

Reports from Area Councils may be found in the backup materials.

12. Action Papers

Please refer to the Summary of Assembly actions.

13. Old Business

Please refer to the Summary of Assembly actions.

14. New Business

Dr. Padraic Carr, President-Elect of the Canadian Psychiatric Association, spoke to the Assembly extending, on behalf of CPA, an invitation and a welcome to Toronto, Ontario for the APA Annual Meeting in 2015.

Farewell to Speaker and Welcome to New Speaker

Dr. Boyer congratulated Dr. Young for her outstanding service as Speaker of the APA Assembly from May 2013 to May 2014.

Dr. Young welcomed Dr. Boyer as Speaker of the Assembly and passed on the Assembly gavel.

13. Adjournment

Respectfully submitted,
Glenn Martin, M.D.
Assembly Recorder

Assembly
May 2-4, 2014
New York, New York

FINAL SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 1.A.1	Ratification of APA Bylaws: Ratification of the Recommended Amendments to the Bylaws Complying with the "The Non-profit Corporation Act of 2010"	The Assembly ratified the recommended amendments to the Bylaws complying with the "The Non-profit Corporation Act of 2010".	FYI – Board of Trustees, July 2014
2014 A1 4.B.1	Proposed Position Statement: Psychotherapy as an Essential Skill of Psychiatrists	The Assembly approved the Proposed Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 4.B.2	Proposed Position Statement: Prior Authorizations for Psychotropic Medications	The Assembly approved the Proposed Position Statement: *Prior Authorizations for Psychotropic Medications* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 4.B.3	Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection	The Assembly voted to refer the Position Statement on the *Psychiatric Implications of HIV/HCV Co-Infection* back to the Joint Reference Committee.	Joint Reference Committee, May 2014
2014 A1 4.B.4	Proposed Position Statement: The Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana	The Assembly approved the Proposed Position Statement: *The Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 5.A	Will the Assembly vote to approve the minutes of the November 8-10, 2013 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 8-10, 2013 meeting.	Chief Operating Officer • Association Governance
2014 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2014A1 4.B.3, 8.L.1, 8.L.2, 8.L.3, 8.L.4, 8.L.5, 8.L.6, 8.L.7, 8.L.8, 8.L.9 and 12.K were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2014 A1 6.C	Will the Assembly vote to approve the Special Rules of the Assembly?	The Assembly voted to approve the Special Rules of the Assembly.	Chief Operating Officer • Association Governance
2014 A1 7.A	2014-2015 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2014 to May 2015: Speaker-Elect: Glenn Martin, M.D. Recorder: Daniel Anzia, M.D.	Chief Operating Officer • Association Governance
2014 A1 7.B.1	Will the Assembly vote to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO)?	The Assembly voted to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO).	Chief Operating Officer • Association Governance
2014 A1 7.B.2	Will the Assembly vote to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly?	The Assembly voted to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly.	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A1 8.L.1	Assessment of Suicide Risk as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Suicide Risk as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.2	Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.3	Substance Use Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Substance Use Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.4	Assessment of Cultural Factors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Cultural Factors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement
2014A1 8.L.5	Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.6	Assessment of Medical Health as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Medical Health as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.7	Involvement of the Patient in Treatment Decision-Making as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Involvement of the Patient in Treatment Decision-Making as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.8	Quantitative Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Quantitative Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.9	Documentation for the Initial Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Documentation for the Initial Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014 A1 9.A	Ethics Annotation: Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"	The Assembly did not approve the Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry."	Chief of Membership & RFM-ECPs • Office of Ethics & DB/SA Relations (For information)

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.A	Multiple Co-payments Charged for Single Prescriptions	The Assembly voted to approve action paper 2014A1 12.A which asks That our APA research the reasons for and legality of the practice of charging two co-payments for a single prescription when pharmacies dispense medications in divided increments because of supply limitations. That our APA advocate for patients not paying more than one co-payment for a one-month supply of a medication, even if dispensed in multiple allotments. That our APA draft policy opposing charging multiple co-payments for one prescription and communicate its concerns to relevant stakeholders (State Commissioners of Insurance, pharmacy benefit management companies, state Medicaid directors, etc.). That this draft policy be sent to the APA AMA Delegation for submission to the AMA House of Delegates.	Joint Reference Committee, May 2014
2014 A1 12.B	Elimination of Tobacco Products Sold by National Retailers	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.B, which asks that the American Psychiatric Association publicly support all national pharmacies or retailers that discontinue the sale of tobacco products to support health and wellness instead of contributing to disease and death caused by tobacco use, and That this action paper is referred to the American Psychiatric Association's delegates to the American Medical Association House of Delegates for review.	Joint Reference Committee, May 2014
2014 A1 12.C	Maintaining Community Treatment Standards in Federal Correctional Facilities	The Assembly voted to approve action paper 2014A1 12.C, which asks • That the APA lobby the Bureau of Prisons to ensure any policies and procedures for the delivery of mental health services do no less than comply with existing federal regulations and community standards of evidenced-based treatment, and be it further, • That the APA publicly oppose any treatment guidelines that minimize the necessity of biological treatment for severe mental health disorders and its management by a medical provider be it further, • That the APA lobby the Bureau of Prisons to increase the number of employed psychiatrists by increasing compensation packages for BOP employed psychiatrists on par with other federally employed psychiatrists and community psychiatrists.	Joint Reference Committee, May 2014
2014 A1 12.D	HIPAA and State Restrictions on Duty to Warn	The Assembly voted to approve action paper 2014A1 12.D, which asks that the APA continue to work at the federal and state level to review and if appropriate, advocate for change to regulations and laws, such as HIPAA, in order to maximize the ability to hold psychiatrists harmless, who in good faith and in their best reasonable clinical judgment want to warn or report serious threat as a means to protect the public and our patients.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.E	Psychiatric Education with Respect to Patients at Risk of Violent Behavior	The Assembly voted to approve action paper 2014A1 12.E, which asks that the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist. That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines.	Joint Reference Committee, May 2014
2014 A1 12.F	Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger	The Assembly voted to approve action paper 2014A1 12.F, which asks that the APA promotes expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others.	Joint Reference Committee, May 2014
2014 A1 12.G	Increasing Buprenorphine Prescribing Limits	The Assembly voted to approve action paper 2014A1 12.G, which asks that the JRC refer the issue of increasing buprenorphine prescribing to the needed population to the Council on Addiction Psychiatry for further consideration such as increasing the limits on the prescriber and the number of prescribers and request a report back to the Assembly in November 2014.	Joint Reference Committee, May 2014
2014 A1 12.H	No Punishment for Choosing Not to Adopt Electronic Medical Records	The Assembly voted to approve action paper 2014A1 12.H, which asks that: 1. The APA will adopt as a general policy, and begin advocating for, the elimination of penalties of any kind for physicians who choose not to use EMRs. 2. The APA will begin immediate discussions with CMS and any other relevant governmental or private agencies regarding this policy.	Joint Reference Committee, May 2014
2014 A1 12.I	Psychiatric Treatment of High Risk Patient-Community Role	The Assembly voted to postpone action paper 2014A1 12.I until its November, 2014 meeting,	Assembly, November 2014
2014 A1 12.J	Patient Satisfaction Surveys and Physician Pay	The Assembly voted to approve action paper 2014A1 12.J, which asks that APA shall advocate that patient satisfaction surveys should not be used as a basis for determining physician remuneration.	Joint Reference Committee, May 2014
2014 A1 12. K	Remove Black Box Warning from Antidepressants	The Assembly voted to approve action paper 2014A1 12.K, which asks that APA shall: In view of recent research findings, urge the FDA to revisit the inappropriateness of the Black Box warning about suicidality with antidepressants.	Joint Reference Committee, May 2014
2014 A1 12.L	American Psychiatric Association and Primary Care Organizations Collaboration in the Affordable Care Act Implementation	The Assembly voted to approve action paper 2014A1 12.L, which asks that the APA will develop educational & policy collaborations on primary care and behavioral health integration with relevant primary care educators and primary care organizations regarding the *Affordable Care Act*. That these collaborations will be reviewed and reported annually by the Board of Trustees and the Assembly to the APA membership.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.M	Addressing the Shortage of Psychiatrists with Sources of Funding	The Assembly voted to approve action paper 2014A1 12.M, which asks: 1. That the Assembly and the Board of Trustees create a task force, or designate an APA component to create such a task force, to investigate the feasibility of the establishment of scholarship funds or other means of reducing debt for qualified students who will commit themselves to completing a psychiatry residency and who might, for example, agree to practice as a psychiatrist for a defined number of years in an underserved area. 2. The task force will report its findings to the Assembly and the Board of Trustees at the 2015 Annual Meeting.	Joint Reference Committee, May 2014
2014 A1 12.N	Area RFM Representative Modality and Opportunity for APA Updates and Education	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.N, which asks that the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established. That the slide set contains the following information: APA goals and mission statement, RFM membership benefits (i.e. discounts from APPI, etc.), basic structure of the leadership hierarchy within the APA, information about the PAC, RFM key leaders with contact information, RFM leadership opportunities within the APA, RFM informational guides and/or handbook link, a brief description of the APA Assembly and it's role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently). That this slide set be used as a template for RFM leaders to add further information specific to his/her area. That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the Area RFM Representative.	Joint Reference Committee, May 2014
2014 A1 12.O	An Electronic Handbook or "Best Practices" Guide for Individual Training Programs	The paper was withdrawn by the author.	N/A
2014 A1 12.P	ABPN 2015 Exam Expectations	The Assembly voted to approve action paper 2014A1 12.P, which asks that the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015.	Joint Reference Committee, May 2014
2014 A1 12.Q	Industry Sponsored (Supported) Symposia	The Assembly did not approve this item by a vote by strength.	N/A
2014 A1 12.R	Allow Deputies to Vote	The Assembly voted to postpone action paper 2014A1 12.R, *Allow Deputies to Vote* until its November 2014 meeting.	Assembly, November 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.S	APA Referendum Voting Procedure	The Assembly vote to approve action paper 2014A1 12.S, which asks: 1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing. 2. That it is the will and intent of the Assembly that this action paper, now reaffirmed, be passed on by the JRC to the Board of Trustees.	Joint Reference Committee, May 2014
2014 A1 12.T	Task Force on DSM-5 Conflict-of-Interest Management Processes	The Assembly did not approve action paper 2014A1 12.T.	N/A
2014 A1 12.U	Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting	The Assembly voted to approve action paper 2014A1 12.U, which asks that 1. APA institute and publicize a President's Award for the District Branch with the highest voting rate (highest percentage) in the election, and for the Area with the same criteria. 2. These awards (a trophy or plaque along with a certificate), be presented at the Annual meeting immediately following the election each year. 3. The awards and the presentation will be duly publicized in Psychiatric News and in other appropriate avenues.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.V	Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.V, which asks that the Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will resume being the proactive and dynamic voice of the APA to advocate for the efforts to provide for and improve the care and treatment of persons with mental illness in the criminal justice system, and to provide deliverables such as a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, and nationally - to organizations such as NAMI, The National Association of State Mental Health Program Directors - and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council. The Committee on Persons with Mental Illness in the Criminal Justice System would report to the Council on Advocacy and Governmental Relations and would provisionally have the following charge: 1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the criminal justice system. 2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system. 3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment. 4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons; 5. Revise and update the Position Statement of 1988.	Joint Reference Committee, May 2014
2014 A1 12.W	A Revision in the Identification of American Psychiatric Association-Affiliate Associations or Societies	The Assembly did not approve action paper 2014A12 12.W.	N/A
2014 A1 12.X	Patient Safety and Veterans Affair Medical Center Participation in State Prescription Monitoring Programs	The Assembly voted to approve action paper 2014A1 12.X, which asks that the APA will request the Council on Advocacy and Government Relations to explore federal legislation and regulatory opportunities for the APA to advocate for the Veterans Health Administration to create a program that would allow licensed prescribers universal access to state PMPs, and That APA's resources, including the Offices of the APA CEO/Medical Director, the Council on Advocacy and Government Relations and the Council on Addiction Psychiatry become engaged in this endeavor. The APA will advocate for more open access to state PMPs, initially by VA health care providers not licensed in that given state.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.Y	An Electronic Orientation Manual and Orientation Conference Call for ACORF	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.Y which asks that the Chief RFM-ECP officer and the Department of Association Governance develop an electronic orientation packet specifically tailored to incoming RFM Deputy-Representatives which focuses on enhancing organizational structure at the level of the Assembly Committee of Resident Fellows (ACORF). That after ACORF elections take place, and before the first committee conference call, the Chief RFM-ECP officer and the newly elected Chair of ACORF facilitate an orientation conference call with newly elected Deputy-Representatives. That the purpose of this handbook is to provide members of ACORF with the guidelines that are needed to work effectively as a team and to disseminate information between the Area Council and the individual training programs. The orientation packet and meeting could help ACORF members to: 1. Understand the committee mission and purpose; specifics of committee membership; officer expectations; meeting expectations; voting procedures; committee responsibilities. This could be facilitated by developing an ACORF constitution. Please see my other action paper for suggestions on developing a constitution. 2. Understand the process of soliciting, writing and submitting action papers. 3. Develop a communication plan for maintaining an accurate contact list and facilitating institutional and area communication. 4. Understand travel responsibility, reimbursement for travel and other necessary facets of committee membership. That this manual be reviewed and updated by the Chief RFM-ECP officer on a pre-determined schedule.	Chief of Membership & RFM-ECPs Chief Operating Officer • Association Governance
2014 A1 12.Z	Facilitating Communication among Psychiatrists and APA Leadership	The Assembly voted to approve action paper 2014A1 12.Z, which asks that the APA make readily available and easily accessible the contact information of all Assembly members on the APA website; This information would be available only to APA members; That this information would be provided in a way which would protect the confidentiality of the all Assembly members That this information be displayed in a way which will require only minimal annual upkeep in order to simplify the required upkeep process.	Chief Operating Officer • Information Systems
2014 A1 12.AA	Creation of a New APA Affiliate Group	The Assembly did not approve action paper 2014A1 12.AA.	N/A

MEMBERS AND INVITED GUESTS
ASSEMBLY
November 7-9, 2014
As of 11-5

ASSEMBLY EXECUTIVE COMMITTEE

Speaker	Jenny L. Boyer, M.D., JD, PhD
Speaker-Elect	Glenn Martin, M.D.
Recorder	Daniel Anzia, M.D.
Immediate Past Speaker	Melinda Young, M.D.
Past Speaker	R. Scott Benson, M.D.
Parliamentarian	Gary Weinstein, M.D.
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Area 1 Deputy Representative	A. Evan Eyler, M.D.
Area 2 Representative	Seeth Vivek, M.D.
Area 2 Deputy Representative	Jeffrey Borenstein, M.D.
Area 3 Representative	Harry A. Brandt, M.D.
Area 3 Deputy Representative	Joseph Napoli, M.D.
Area 4 Representative	James R. Batterson, M.D.
Area 4 Deputy Representative	Bhasker Dave, M.D.
Area 5 Representative	Laurence Miller, M.D.
Area 5 Deputy Representative	Philip Scurria, M.D.
Area 6 Representative	Joseph Mawhinney, M.D.
Area 6 Deputy Representative	Barbara Yates Weissman, M.D.
Area 7 Representative	Craig F. Zarling, M.D.
Area 7 Deputy Representative	Charles Price, M.D.
M/UR Representative	Ludmila De Faria, M.D.
RFM Representative	Edward Thomas Lewis, III, M.D.
ECP Representative	Steve Koh, M.D.
AAOL Representative	David Scasta, M.D.
CEO and Medical Director	Saul Levin, M.D., MPA

DISTRICT BRANCH REPRESENTATIVES AND DEPUTY REPRESENTATIVES

Area 1

Connecticut Psychiatric Society
John M. DeFigueiredo, M.D., Representative
Reena Kapoor, M.D., Representative

Maine Association of Psychiatric Physicians
James Maier, M.D., Representative
Julie Pease, M.D, Deputy Representative

Massachusetts Psychiatric Society
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Marshall Forstein, M.D., Representative
Carlene MacMillan, M.D., Representative
Manuel Pacheco, M.D., Representative

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Robert Feder, M.D., Representative
Isabel Norian, M.D., Deputy Representative

Ontario District Branch
Leslie Kiraly, M.D., Representative
Shery Zener, M.D., Representative

Quebec & Eastern Canada District Branch
Vincenzo Di Nicola, M.D., Representative

Rhode Island Psychiatric Society
Paul Lieberman, M.D., Representative
L. Russell Pet, M.D., Deputy Representative

Vermont Psychiatric Association
Jonathan Weker, M.D., Representative
Lisa Catapano-Friedman, M.D., Deputy Representative

Area 2

New York State
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Adam Chester, D.O., Representative
Russell Denea, M.D., Representative
Frank Dowling, M.D., Representative
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Marvin Koss, M.D., Representative
Robert Neal, M.D., Representative
Norma Panahon, M.D., Representative
Herbert Peyser, M.D., Representative
Aaron Satloff, M.D., Representative
Gabrielle Shapiro, M.D., Representative
Felix Torres, M.D., Representative
Ramaswamy Viswanathan, M.D., DSc, Representative
Henry Weinstein, M.D., Representative

Area 3

Psychiatric Society of Delaware
Ranga Ram, M.D., Representative
Andrew Donohue, D.O., Deputy Representative

Maryland Psychiatric Society, Inc
Steven Daviss, M.D., Representative
Robert Roca, M.D., MPH, Representative

New Jersey Psychiatric Association
William Greenberg, M.D., Representative
Theresa Miskimen, M.D., Representative

Pennsylvania Psychiatric Society
Michael Feinberg, M.D., for Kenneth M. Certa, M.D., Representative
Sheila Judge, M.D., Representative
Melvin Melnick, M.D., Representative
Jyoti Shah, M.D., Representative

Washington Psychiatric Society
Catherine May, M.D., for Elizabeth Morrison, M.D., Representative
Roger Peele, M.D., Representative
Eliot Sorel, M.D., Representative

Area 4

Illinois Psychiatric Society
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Lisa Rone, M.D., Representative
Shastri Swaminathan, M.D., Representative

Indiana Psychiatric Society
Heather Fretwell, M.D., Representative
Brian Hart, M.D., Deputy Representative

Iowa Psychiatric Society
Laura Van Cleve, D.O., Representative

Kansas Psychiatric Society
Chester Day, M.D., Representative
Shayla Sullivant, M.D., Deputy Representative

Michigan Psychiatric Society
William Cardasis, M.D., Representative
William Sanders, M.D., Representative

Minnesota Psychiatric Society
Dionne Hart, M.D., Representative
Michael Koch, M.D., Deputy Representative

Missouri Psychiatric Association
S. Arshad Husain, M.D., Representative
James Fleming, M.D., Deputy Representative

Nebraska Psychiatric Society
Syed Qadri, M.D., Representative
Jane Theobald, M.D., Deputy Representative

North Dakota Psychiatric Society
Ronald Burd, M.D., Representative
Kevin Dahmen, M.D., Deputy Representative

Ohio Psychiatric Physicians Association
Jonathan Dunn, M.D., Representative
Brien W. Dyer, M.D., Representative
Eileen McGee, M.D., Representative

South Dakota Psychiatric Association
Ulises Pesce, M.D., Representative
William Fuller, M.D., Deputy Representative

Wisconsin Psychiatric Association
John Schneider, M.D., for Clarence Chou, M.D., Representative
Angela Janis, M.D., for Jacob Behrens, M.D., Deputy Representative

Area 5

Alabama Psychiatric Society
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Paul O'Leary, M.D., Deputy Representative

Arkansas Psychiatric Society
Molly Gathright, M.D., Representative
Eugene Lee, M.D., Deputy Representative

Florida Psychiatric Society
John Bailey, D.O., Representative
Louise Buhrmann, M.D., Representative
Elias Sarkis, M.D., Representative

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Howard Maziar, M.D., Representative
Joe L. Morgan, M.D., Representative

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Mark Wright, M.D., Representative

Louisiana Psychiatric Medical Association
Mary Fitz-Gerald, M.D., Representative
Mark Townsend, M.D., Deputy Representative

Mississippi Psychiatric Association, Inc
Sudhakar Madakasira, M.D, Representative
Andrew Bishop, M.D., Deputy Representative

North Carolina Psychiatric Association
Debra Bolick, M.D., Representative
Stephen Buie, M.D., Representative

Oklahoma Psychiatric Physicians Association
Shreekumar Vinekar, M.D., Representative
Harold Ginzburg, M.D., Deputy Representative

Puerto Rico Psychiatric Society
Michael Woodbury-Farina, M.D., Representative
Lelis Nazario, M.D., Deputy Representative

South Carolina Psychiatric Association
David Beckert, M.D., Representative

Tennessee Psychiatric Association
James Kyser, M.D., Representative
Valerie Arnold, M.D., Deputy Representative

Area 5 (continued)

Texas Society of Psychiatric Physicians
Debra Atkisson, M.D., Representative
A. David Axelrad, M.D, Representative
J. Clay Sawyer, M.D., Representative

Society of Uniformed Services Psychiatrists
Elspeth Ritchie, M.D., Representative
James West, M.D., Deputy Representative

Psychiatric Society of Virginia, Inc
John Shemo, M.D., Representative
Ramakrishnan Shenoy, M.D., Representative

West Virginia Psychiatric Association
T.O. Dickey, M.D., Representative
Amelia McPeak, D.O., Deputy Representative

AREA 6

California
Robert Cabaj, M.D., Representative
Richard Granese, M.D., Representative
Lawrence Gross, M.D., Representative
Larry Lawrence, M.D., Representative
Adam Nelson, M.D., Representative
Raymond Reyes, M.D., for Randall Solomon, M.D., Representative
Mary Ann Schaepper, M.D., Representative
Shannon Suo, M.D., for Robert McCarron, D.O., Representative
Maria Tiamson-Kassab, M.D., Representative

Area 7

Alaska Psychiatric Association
Alexander von Hafften, M.D., Representative

Arizona Psychiatric Society
Jehangir Bastani, M.D., Representative
Roland Segal, M.D., Deputy Representative

Colorado Psychiatric Society
L. Charolette Lippolis, D.O., MPH, Representative

Hawaii Psychiatric Medical Association
Leslie Gise, M.D., Representative
Iqbal Ahmed, M.D., Deputy Representative

Idaho Psychiatric Association
Nicole Thurston, M.D., Representative
Zachary Morairty, M.D., Deputy Representative

Montana Psychiatric Association
Joan Green, M.D., Representative

Nevada Psychiatric Association
Dodge Slagle, D.O., Representative
Philip Malinas, M.D., Deputy Representative

Psychiatric Medical Association of New Mexico
Brooke Parish, M.D., Representative
Reuben Sutter, M.D., Deputy Representative

Oregon Psychiatric Association
Annette Matthews, M.D., Representative
Amela Blekic, M.D., Deputy Representative

Utah Psychiatric Association
Jason Hunziker, M.D., Representative
Matthew Moench, M.D., Deputy Representative

Washington State Psychiatric Association
Matthew Layton, M.D., PhD, Representative
Brian Waiblinger, M.D., Representative

Western Canada District Branch
Adeyinka Marcus, M.D., Representative
Ian Forbes, M.D., Deputy Representative

Wyoming Association of Psychiatric Physicians
Stephen Brown, M.D., Representative
O'Ann Fredstrom, M.D., Deputy Representative

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Sohrab Zahedi, M.D., Representative
Gwendolyn Lopez-Cohen, M.D., Deputy Representative

Area 2
Jose Vito, M.D., Representative
Anil Thomas, M.D., Deputy Representative

Area 3
Hind Benjelloun, M.D., Representative
TBD, Deputy Representative

Area 4
Justin Schoen, M.D., Representative
Jacob Behrens, M.D., Deputy Representative

Area 5
Justin Hunt, M.D., Representative
Mark Haygood, D.O., Deputy Representative

Area 6
Steve Koh, M.D.,* Representative
Lawrence Malak, M.D., Deputy Representative

Area 7
Joshua Sonkiss, M.D., Representative
Jason Collison, M.D., Deputy Representative

* Also listed with the Assembly Executive Committee

MINORITY/ UNDERREPRESENTED GROUPS

American Indian, Alaska Native and Native Hawaiian Psychiatrists
Linda Nahulu, M.D., Representative
Crystal Bullard, Deputy Representative

Asian-American Psychiatrists
Edmond Pi, M.D., Representative
Francis Sanchez, M.D., Deputy Representative

Black Psychiatrists
Stephen McLeod-Bryant, M.D., Representative
Rahn Bailey, M.D., Deputy Representative

Hispanic Psychiatrists
Jose De La Gandara, M.D., Representative
Oscar Perez, M.D., Deputy Representative

International Medical Graduate Psychiatrists
Nyapati Rao, M.D., Representative
Antony Fernandez, M.D., Deputy Representative

Lesbian, Gay and Bisexual Psychiatrists
Philip Bialer, M.D., Representative
Ubaldo Leli, M.D., Deputy Representative

Women Psychiatrists
Ludmila De Faria, M.D.,* Representative
Maureen Van Niel, M.D., Deputy Representative

* Also listed with the Assembly Executive Committee

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Area 1
Elie G. Aoun, M.D., Representative
Loreen Pirnie, M.D., Deputy Representative

Area 2
Kandace Licciardi, M.D., Representative
Subhash Chandra, M.D., Deputy Representative

Area 3
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Jessica Abellard, M.D., Deputy Representative

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Matthew McDougall, M.D., Representative
Sarit Hovav, M.D., Deputy Representative

Area 5
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Candes Dotson, M.D., Deputy Representative

Area 6
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Alexis Seegan, M.D., Deputy Representative

Area 7
Stamatios Dentino, M.D., Representative
Kelly Jones, M.D., Deputy Representative

* Also listed with the Assembly Executive Committee

ASSEMBLY ALLIED ORGANIZATION LIAISONS

Area 1

Academy of Psychosomatic Medicine
David Gitlin, M.D.

American Association of Community Psychiatrists
Jeffrey Geller, M.D., MPH

American Academy of Psychiatry & Law
Debra Pinals, M.D.

American Academy of Psychoanalysis
Eric Plakun, M.D.

Area 2

American Academy of Child & Adolescent Psychiaty
Warren Ng, M.D.

American Group Psychotherapy Association
C. Deborah Cross, M.D.

Association of Family Psychiatrists
Gregory Miller, M.D.

Area 3

American Academy Addiction Psychiatry
Joseph Liberto, M.D.

American Association of Psychiatric Administrators
Barry Herman, M.D.

American Society for Adolescent Psychiatry
Richard Ratner, M.D.

Association of Gay and Lesbian Psychiatrists
David Scasta, M.D.*

Southern Psychiatric Association
Mark Komrad, M.D.

Area 4

American Acadmy of Clinical Psychiatrists
Donald Black, M.D.

American Psychoanalytic Association
Prudence Gourguechon, M.D.

American Association for Social Psychiatry
C.M. Prasad, M.D., for Beverly Fauman, M.D.

Area 5

Senior Psychiatrists, Inc
Jack Bonner, M.D.

Area 6

American Association for Geriatric Psychiatry
Gary Small, M.D.

Area 7

American Association for Emergency Psychiatry
Kimberly Nordstrom, M.D., JD

* Also listed with the Assembly Executive Committee

PRIVILEGED GUESTS OF THE ASSEMBLY

BOARD OF TRUSTEES OFFICERS

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President-Elect	Renée Binder, M.D.
Secretary	Maria Oquendo, M.D.
Treasurer	Frank Brown, M.D.

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Area 2	Vivian Pender, M.D.
Area 3	Brian Crowley, M.D.
Area 4	Judith Kashtan, M.D.
Area 5	R. Scott Benson, M.D.*
Area 6	Melinda Young, M.D.*
Area 7	Jeffrey Akaka, M.D.

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Trustee	Dilip V. Jeste, M.D.
Trustee	John Oldham, M.D.
Trustee-at-Large	Anita Everett, M.D.
ECP Trustee-at-Large	Molly McVoy, M.D.
RFM Trustee	Lara Cox, M.D.
RFM Trustee-Elect	Ravi Shah, M.D.
M/UR Trustee	Gail Robinson, M.D.

FELLOWS

APA Public Psychiatry Fellow	Christina Arredondo, M.D.
APA/SAMHSA Fellow	Adeniyi O Adelakun, M.D.
APA/Leadership Fellow	Desiree Shapiro, M.D.
Minority Fellow	Alicia Barnes, D.O.

DISTRICT BRANCH PRESIDENTS, PRESIDENTS-ELECT & EXECUTIVES

standing invitation

GUEST PRESENTERS

* Also listed with Assembly Executive Committee

PAST SPEAKERS OF THE ASSEMBLY

Melinda Young, M.D.*	2013-2014
R. Scott Benson, M.D.*	2012-2013
Ann Marie T. Sullivan, M.D.	2011-2012
Bruce A. Hershfield, M.D.	2010-2011
Gary S. Weinstein, M.D.*	2009-2010
Ronald Burd, M.D.	2008-2009
Jeffrey Akaka, M.D.	2007-2008
Michael Blumenfield, M.D.	2006-2007
Joseph Ezra V. Rubin, M.D.	2005-2006
James E. Nininger, M.D.	2004-2005
Prakash N. Desai, M.D.	2003--2004
Albert Gaw, M.D.	2002–2003
Nada Stotland, M.D., MPH	2001–2002
R. Michael Pearce, M.D.	2000–2001
Alfred Herzog, M.D.	1999–2000
Donna Marie Norris, M.D.	1998–1999
Jeremy Allan Lazarus, M.D.	1997–1998
Roger Dale Walker, M.D.	1996–1997
Richard Kent Harding, M.D.	1995–1996
Norman A. Clemens, M.D.	1994–1995
Richard M. Bridburg, M.D.	1993–1994
G. Thomas Pfaehler, M.D.	1991–1992
Edward Hanin, M.D.	1990–1991
Gerald H. Flamm, M.D.	1989–1990
John S. McIntyre, M.D.	1988–1989
Irvin M. Cohen, M.D.	1987–1988
Roger Peele, M.D.	1986–1987
Fred Gottlieb, M.D.	1984–1985
Harvey Bluestone, M.D.	1983–1984
Lawrence Hartmann, M.D.	1981–1982
Melvin M. Lipsett, M.D.	1980–1981
Robert O. Pasnau, M.D.	1979–1980
Robert J. Campbell, III, M.D.	1978–1979
Daniel A. Grabski, M.D.	1977–1978
Irwin N. Perr, M.D.	1976–1977
Miltiades L. Zaphiropoulos, M.D.	1975–1976
Harry H. Brunt, Jr., M.D.	1971–1972
John S. Visher, M.D.	1970–1971
Robert S. Garber, M.D.	1963–1964
Mathew Ross, M.D.	1956–1957

* Also listed with Assembly Executive Committee

Voting Strength by State for the **November 2014 and May 2015** Assembly Meeting

The Assembly shall be composed of Representatives and Deputy Representatives selected by the District Branches/State Associations; a Representative and Deputy Representative from each Minority/Underrepresented Group; a Resident-Fellow Member Representative and Deputy Representative from each Area; an Early Career Psychiatrist Representative and Deputy Representative from each Area; a Representative from each Assembly Allied Organization; and the Assembly Executive Committee.

At its November 2009 meeting, the Assembly approved APA Assembly Reorganization – Proposal 5 as amended by Reference Committee 5. The first element is the downsizing of the Assembly by changing Assembly District Branch representation to representation by state associations (impacting NY, California and Missouri only). Each state will have Assembly Reps according to a formula of one Rep for the first 450 members and one additional Rep for each 400, or fraction thereof, additional members.

The Central Office will use the report that was run on December 31, 2013 to determine the voting strength for the November 2014 and May 2015 meeting.

District Branch Representatives are eligible to be apportioned according to the following formula:

Numbers of Voting Members	Reps	Dep. Reps
450 or less	1	1
451-851	2	0
852-1252	3	0
1253-1653	4	0
1654-2054	5	0
2055-2455	6	0
2456-2856	7	0
2857-3257	8	0
3258-3658	9	0
3659-4059	10	0
4060-4450	11	0

State (alphabetical order)	Voting Strength	# Reps	# Dep Reps
Alabama	249	1	1
Alaska	63	1	1
Arizona	357	1	1
Arkansas	134	1	1
*California	2868	9	0
Colorado	438	1	1
Connecticut	655	2	0
Delaware	102	1	1
Florida	1045	3	0
Georgia	608	2	0
Hawaii	169	1	1
Idaho	46	1	1

State (alphabetical order)	Voting Strength	# Reps	# Dep Reps
Illinois	968	3	0
Indiana	330	1	1
Iowa	194	1	1
Kansas	189	1	1
Kentucky	274	1	1
Louisiana	309	1	1
Maine	171	1	1
Maryland	667	2	0
Massachusetts	1515	4	0
Michigan	687	2	0
Minnesota	420	1	1
Mississippi	150	1	1
Missouri	427	1	1
Montana	50	1	1
Nebraska	144	1	1
Nevada	129	1	1
New Hampshire	121	1	1
New Jersey	812	2	0
New Mexico	138	1	1
**New York	4115	14	0
North Carolina	825	2	0
North Dakota	51	1	1
Ohio	937	3	0
Oklahoma	204	1	1
Ontario	716	2	0
Oregon	385	1	1
Pennsylvania	1517	4	0
Puerto Rico	123	1	1
Quebec & Eastern Canada	372	1	1
Rhode Island	224	1	1
South Carolina	353	1	1
South Dakota	74	1	1
Tennessee	322	1	1
Texas	1101	3	0
Uniformed Services Psychiatrists	317	1	1
Utah	158	1	1
Vermont	118	1	1
Virginia	599	2	0
Washington (DC)	852	3	0
Washington State	496	2	0
West Virginia	169	1	1
Western Canada	480	1	1
Wisconsin	373	1	1
Wyoming	25	1	1

*****For a period of five years, the State of California shall be permitted a delegation based upon voting strength or 9, whichever is greater.

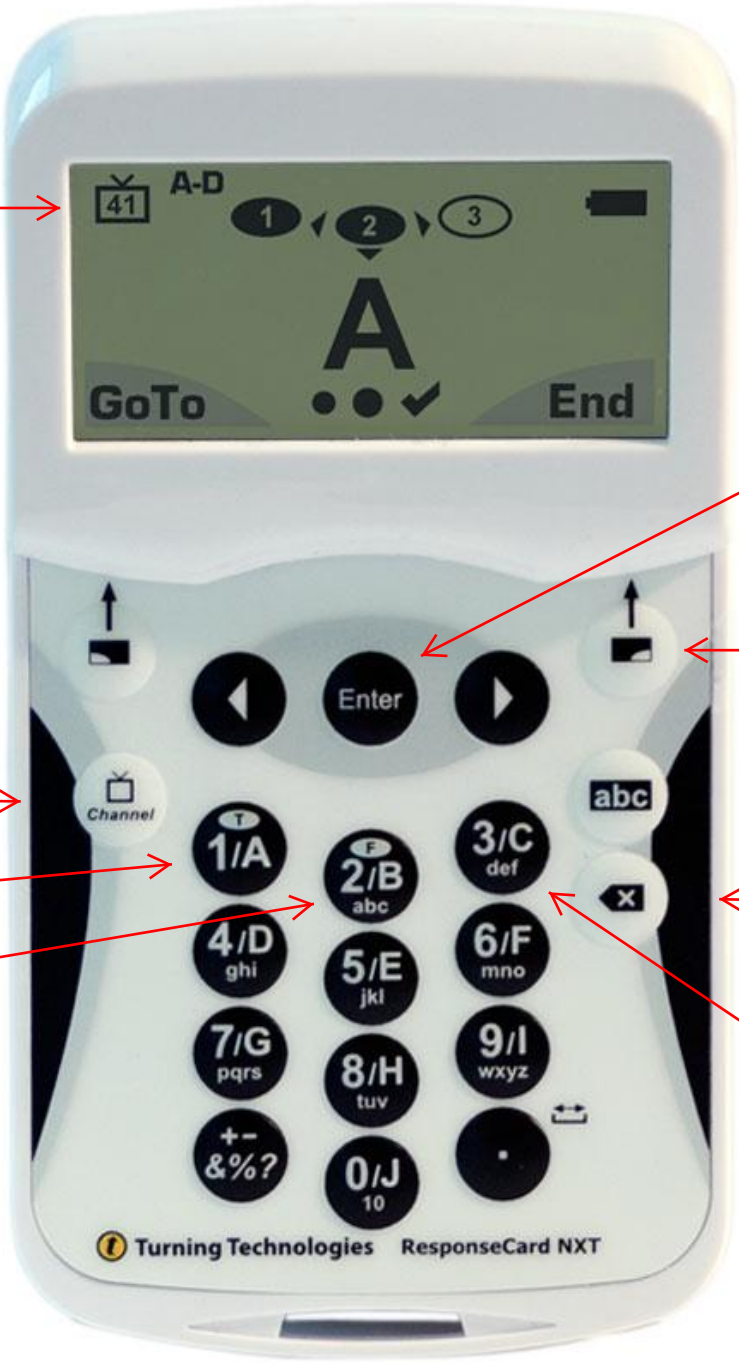
******For a period of five years, the State of New York shall be permitted a total number of Assembly Representatives based upon voting strength or 14, whichever is greater.

Voter Instructions for "Standing Vote" with ARS devices

*Before voting, please make sure that your clicker/response card/ARS device is on "**Channel 41**".*

Please turn on your clicker by pressing "Enter". The Channel should be displayed on the top left corner of the screen.

To change the Channel, please press the "Channel" button, enter the numbers "4" and "1", and then confirm your entry by pressing the button on top right corner (which will be displayed as "OK"). Once the Channel is changed, you should see a checkmark ✓ on the bottom of the screen.



To submit your vote:

- Press "A" for Yes, "B" for No, and "C" for Abstain.
- Press "Enter" button to submit your vote.

<u>Please note</u>: You can enter/submit your vote as many times as you want, but the system will only accept one response per one device. The last response entered/submitted will be recorded as the final vote.

Assembly Executive Committee
Final Report
Friday, May 2, & Monday, May 5, 2014
New York Marriott Marquis, New York

Melinda Young, M.D.,Speaker
Jenny Boyer, M.D., Speaker-Elect
Glenn Martin, M.D., Recorder
Bruce Hershfield, M.D., Parliamentarian
Brian Benton, M.D., Area 1 Rep
A. Evan Eyler, M.D., Area 1 Dep Rep
Seeth Vivek, M.D., Area 2 Rep
Richard Altesman, M.D., Area 2 Dep Rep [**A**]
Harry Brandt, M.D., Area 3 Rep
Joseph Napoli, M.D., Area 3 Dep Rep
Daniel Anzia, M.D., Area 4 Rep
James R. Batterson, M.D., Area 4 Dep Rep
Laurence Miller, M.D., Area 5 Rep
Philip Scurria, M.D., Area 5 Dep Rep
Barton Blinder, M.D., Area 6 Rep
Joseph Mawhinney, M.D., Area 6 Dep Rep
Stephen Brown, M.D., Area 7 Rep
Craig Zarling, M.D., Area 7 Dep Rep
Edmond Pi, M.D.,M/UR Rep
Mark Haygood, D.O., MS, RFM Rep
Steve Koh, M.D., ECP Rep [**A**]
David Scasta, M.D., AAOL Rep
R. Scott Benson, M.D., Immediate Past Speaker
Ann M. Sullivan, M.D., Past Speaker
Saul Levin, M.D., MPA, CEO and Medical Director

Guests (Friday):
Paul Summergrad, M.D., APA President-Elect
Barbara Yates Weissman, M.D., Chair, Reference Committee #1
Robert Roca, M.D., Chair, Reference Committee #2
Shery Zener, M.D., Chair, Reference Committee #3
William Cardasis, M.D., Chair, Reference Committee #4
Stephen McLeod-Bryant, M.D., Chair, Reference Committee #5

Staff:
Margaret C. Dewar, Director of Association Governance
Allison Moraske, Senior Governance Specialist, Assembly
Annelle Primm, M.D., MPH, Deputy Medical Director/Director, Division of Diversity and Health Equity (*Friday*)
Shaun Snyder, Esq., Chief Operating Officer (*Friday*)
Kristin Kroeger, Chief of Policy, Programs & Partnerships (*Friday*)
Jon Fanning, Chief of Membership & RFM/ECP (*Friday*)
Colleen Coyle, JD, APA General Counsel (*Monday*)

Friday, May 2, 2014

1. **Call to Order and Opening Remarks** — *Dr. Young*
   Dr. Young began the meeting by having everyone introduce themselves and disclosure any potential conflicts of interest. Dr. Young also welcomed the Chairs of the Reference Committees. Dr. Young noted that she had visited many district branches and Areas during her term as Speaker. She stressed that the AEC continues to need to work to increase communication between Assembly members and the general APA membership.

2. **Approval of Report of the AEC meeting January 2014**
   MOTION APPROVED: The AEC voted to approve the report of the Assembly Executive Committee from January 2014.

3. **Remarks from Speaker-Elect** — *Dr. Boyer*
   Dr. Boyer referenced the JRC summary of actions in the Assembly packet.

4. **Review of Assembly Agenda** — *Dr. Young*
   The Assembly Executive Committee reviewed the Assembly agenda. Dr. Young explained the protocol

for Representative Murphy's visit to the Assembly on Sunday. The AEC discussed items on the agenda that might provoke additional discussion during the Assembly.

5. **Reports of Assembly Component Chairs**

A. Rules Committee — *Dr. Benson*
Dr. Benson outlined the thorough work of the Rules Committee prior to the Assembly meeting. He also referenced the draft consent calendar for the AEC and requested that the Area Representatives/Deputy Representatives carefully review the consent calendar at the Area Council meetings.

B. **Awards Committee** — *Dr. Sullivan*
Dr. Sullivan announced that the DB Best Practice Award is being awarded to the Minnesota Psychiatric Society and that the Psychiatric Society of Virginia is receiving an Honorable Mention. The Ron Shellow Award will be presented to Dr. William Ulwelling, Representative from the Psychiatric Society of New Mexico.

C. Committee on Procedures — *Dr. Martin*
The Committee on Procedures met prior to the AEC meeting. The Committee has two actions for the Assembly: the approval of the Southern Psychiatric Association as an Assembly Allied Organization (AAO) and the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly. The Committee also discussed modifying the process for reviewing DB Bylaws and the criteria for becoming an AAO. Dr. Martin concluded his report by reminding the AEC that the Assembly had purchased electronic voting devices and that their use would be limited to standing votes. Dr. Martin also noted that he would be conducting a short demonstration of the devices during the first plenary as part of his Recorder report.

D. Assembly Nominating Committee — *Dr. Sullivan*
Dr. Sullivan reviewed the candidates for the upcoming Assembly election:

Candidates for Recorder:
Daniel Anzia, M.D.
Stephen Brown, M.D.

Candidate for Speaker-Elect:
James R. Batterson, M.D.
Glenn Martin, M.D.

6. **New Business/Other Issues**

- **Report of the BOT and ASM Work Group on M/UR Issues**
  At its March, 2014 meeting, the Board of Trustees requested feedback from the Assembly on the report of the BOT and ASM Work Group on M/UR Issues. Dr. Maria Oquendo, Chair of the Work Group and Dr. Young will visit the Area Council meetings on Saturday to discuss the report.

<u>Monday, May 5, 2014</u>

7. Introduction of New Assembly Executive Committee Members
Dr. Gary Weinstein, Parliamentarian (*not present*)
Dr. Jeffrey Borenstein, Deputy Representative, Area 2
Dr. Bhasker Dave, Deputy Representative, Area 4
Dr. Charles Price, Deputy Representative, Area 7
Dr. Ludmila De Faria, M/UR Chair (*not present*)
Dr. Edward Thomas Lewis, III, RFM Chair (*not present*)

8. Follow-up on Passed Assembly Actions — Dr. Young
The AEC reviewed the passed Assembly actions. It was felt that there needs to be a formal process by which action items such as Bylaws amendments and Practice Guidelines are introduced to the Assembly. It was also suggested that those action items requiring a vote by the Assembly be distributed to the District Branch/State Association Executive Staff so that they are discussed at the DB level.

9. Assembly Budget Planning

The AEC reviewed the draft budget proposal developed by the Officers of the Assembly. The AEC approved the following motions based on the draft proposal:

MOTION APPROVED: The Assembly Executive Committee voted that the budget proposal will include the restoration of the Representative status present in New York and California prior to the reorganization in2010. **It was agreed that this motion and all subsequent motions with regard to the Assembly budget will be advisory motions to the Speaker and leadership for the APA Finance and Budget Committee meeting in June.**

MOTION APPROVED: The Assembly Executive Committee voted to revert back to the original formula for Assembly representation prior to the reorganization in 2010:

Numbers of Voting Members	Reps	Dep. Reps
450 or less	1	1
451 900	2	0
901 1350	3	0
1351 1800	4	0
1801 or more	5	0

MOTION APPROVED: The Assembly Executive Committee voted that the budget proposal will include Deputy Representative funding for the November Assembly meeting.

MOTION APPROVED: The Assembly Executive Committee voted that the budget proposal will include M/UR Deputy Representative funding for the November Assembly meeting.

MOTION APPROVED: The Assembly Executive Committee voted that the budget proposal will include funding for Allied Organization Liaisons (AAOLs) to attend the November Assembly meeting.

MOTION APPROVED: The Assembly Executive Committee voted that the block grant model would remain in place. (The discussion after this motion was approved was that while the model would be maintained, additional funding would be requested for those Areas that need it.)

MOTION APPROVED: The Assembly Executive Committee voted that the budget proposal will include innovative grant funds to the Area Councils for special projects.

10. Planning for AEC Summer Meeting — Dr. Boyer

The AEC will be meeting July 25-26 at the Hotel Maya in Long Beach, California. The schedule has been modified to begin at 1:00 PM on Friday afternoon with a working lunch and continue through Saturday with no meeting on Sunday to facilitate travel either Saturday evening or Sunday morning. It was requested that, for planning purposes, the dates for future AEC meetings be finalized and distributed as early as possible. Dr. Boyer requested that members of the AEC send her topics they would like discussed at the meeting.

11. Assembly Work Groups

The Chairs of the MOC, Access to Care, Mentorship Engagement, Communications, and Legislative/Public Affairs gave brief updates on the work group breakout sessions held on Saturday, May 3rd. The AEC will be reviewing the status of current Assembly work groups, including their members and charges at the AEC meeting in July.

12. Closing Remarks — Drs. Boyer and Young

13. Adjournment

UPCOMING AEC MEETINGS

- **July 25-26, 2014, Long Beach, California**
- **Friday, November 7, Washington, D.C.**
- **Sunday, November 9, Washington, D.C.**

American Psychiatric Association
Assembly Executive Meeting
Long Beach, California
July 25-26, 2014
Final Report

Assembly Executive Committee Members:

Jenny L. Boyer, MD, JD, PhD, Speaker
Glenn Martin, MD, Speaker-Elect
Daniel Anzia, MD, Recorder
Gary Weinstein, MD, Parliamentarian
Brian Benton, MD, Area 1 Rep
A. Evan Eyler, MD, Area 1 Dep Rep
Seeth Vivek, MD, Area 2 Rep
Jeffrey Borenstein, MD, Area 2 Dep Rep [**A**]
Harry Brandt, MD, Area 3 Rep
Joseph Napoli, MD, Area 3 Dep Rep
James R. Batterson, MD, Area 4 Rep
Bhasker Dave, MD, Area 4 Dep Rep
Laurence Miller, MD, Area 5 Rep [**A**]
Philip Scurria, MD, Area 5 Dep Rep
Joseph Mawhinney, MD, Area 6 Rep
Barbara Yates-Weissman, MD, Area 6 Dep Rep
Craig Zarling, MD, Area 7 Rep
Charles Price, MD, Area 7 Dep Rep
Ludmila De Faria, MD, M/UR Rep
Edward Thomas Lewis, III, MD, RFM Rep
Steve Koh, MD, ECP Rep
David Scasta, MD, AAOL Rep
Melinda Young, MD, Immediate Past Speaker
R. Scott Benson, MD, Past Speaker
Saul Levin, MD, MPA, CEO and Medical Director

Guest:
Paul Summergrad, MD, APA President

Administration:
Margaret Cawley Dewar, Director of Association Governance
Allison Moraske, Senior Governance Specialist, Assembly
Jessica Hopey, Senior Governance Coordinator
Annelle Primm, MD, MPH, Deputy Medical Director
Kristin Kroeger, Chief of Policy, Programs, and Partnerships
Jon Fanning, Chief of Membership & RFM/ECP
Jason Young, Chief of Communications

Call to Order of the Assembly Executive Committee – *Jenny L. Boyer, MD, JD, PhD*

A. Introductions
Dr. Boyer welcomed the AEC to the meeting and thanked everyone for taking the time to come to the meeting. The AEC members then introduced themselves and disclosed any potential conflicts of interest.

B. Approval of the May, 2014 AEC Report

MOTION APPROVED: The Assembly Executive Committee voted to approve the report of the Assembly Executive Committee from May 2014.

Report from the Speaker – *Jenny L. Boyer, MD*
Dr. Boyer updated the AEC on the recent Board of Trustees meetings and retreat. She noted that the three position statements the Assembly had submitted to the Board were approved at its July meeting. Dr. Boyer attended the Finance and Budget Committee meeting in June and shared the proposed Assembly budget allocations and narrative she presented to the Committee with the AEC. The Finance and Budget Committee will be meeting again in October and the budget will be presented for approval by the Board of Trustees at its December meeting.

Dr. Boyer, along with APA's Division of Research, developed a survey for Assembly members and DB/SA Executive Staff, the goal of which was to prioritize issues raised by psychiatrists in order to focus member services. She gave a brief presentation on the preliminary results, explaining that once the results were finalized, they would be shared with the Assembly Executive Committee.

Report from the Speaker-Elect – *Glenn Martin, MD*
Dr. Martin reviewed the draft summary of actions from the May 2014 Joint Reference Committee meeting. The JRC assigned action paper *12.U: Creation of President's Award for DB & Area with the Highest Percentage of Voting* to the AEC for their review and requested that they consider having this become an Assembly Award.

MOTION APPROVED: The Assembly Executive Committee voted to approve the recommendations outlined in Action Paper 12.U: *Creation of President's Award for DB & Area with the Highest Percentage of Voting* and create an Assembly award for the Area and District Branch with the highest percentage of votes. This action was referred to the Assembly Awards Committee.

Dr. Martin also gave a brief update on the activities of the Assembly Committee on Procedures. The Committee has been reviewing District Branch bylaws. Dr. Martin explained that the Committee reviews the bylaws to assure essential conformity with the APA Bylaws, the Operations Manual and the Procedural Code of the Assembly and noted that every District Branch should have an independent legal review of their DB bylaws to ensure they are compliant with their state laws. A request was made to develop a detailed DB bylaws review schedule. Once reviewed by the committee, it will be shared with all district branches. It was also noted that the committee's role is not to review every element but those core elements which maintain their DB status as a district branch of APA, including, membership categories, elections, etc.

Report from the Recorder – *Daniel Anzia, MD*
Dr. Anzia reviewed the draft summary of actions from the May 2014 Joint Reference Committee meeting. In addition, he discussed the results of the survey of Assembly members concerning the May 2014 Assembly meeting. He noted that a large percentage of members did not know about Assembly mentorship. Dr. Boyer stressed that it is the responsibility of the Area Representative/Deputy Representative to assign mentors to all new Assembly members. It was also noted that mentoring of members at each stage of their career is helpful and encourages active participation in the organization.

Report from the APA CEO and Medical Director – *Saul Levin, MD, MPA*
Dr. Levin began his report by thanking the Assembly Executive Committee and the Assembly for its hard work. Dr. Levin notified the AEC of some recent APA staff changes. He introduced Jason Young, APA's Chief Communications Officer, who joined the APA on July 1st. Mr. Young had previously been Deputy Director of the Office of Communications and Public Affairs from 2003-2007 and most recently, he worked as the Deputy Assistant Secretary for Public Affairs at the U.S. Department of Health & Human Services, helping with the roll out of the *Affordable Care Act*. Dr. Levin noted that Dr. Annelle Primm has transitioned to the full-time, expanded role of Deputy Medical Director. The positions of Director, Division of Research, Director of Education and Director of the Division of Diversity & Health Equity are currently

open and are in the process of being filled. Dr. Levin also re-introduced Kristin Kroeger, Chief of Policy, Programs, and Partnerships and Jon Fanning, Chief of Membership, RFM & ECPs.

Dr. Levin met with Representative Tim Murphy to review the proposed legislation, *H.R. 3717, the Helping Families in Mental Health Crisis Act*. If members have questions about the legislation, they should contact Kristin Kroeger, Chief of Policy, Programs, and Partnerships at kkroeger@psych.org or 703-907-7318.

Dr. Levin also highlighted the *Ensuring Veterans' Resiliency Act, S. 2425* bill, requesting that the AEC reach out to its members in each Area to encourage them to contact their Members of Congress and note strong support for the legislation. [**N.B.:** An email containing draft language for member use was sent to the AEC for distribution to the Area Councils.]

Dr. Levin concluded his report by noting that the recent survey of Assembly members on prioritization of member issues contained a section on diversity. APA celebrated its first Diversity Mental Health Month in July. The APA is also looking to develop more resources and toolkits for the District Branches on diversity.

Report from the APA President – *Paul Summergrad, MD*

Dr. Summergrad outlined a number of new Board work groups that have recently been formed.

- **Ad Hoc Work Group on Education and Training**: The work group will be focused on residency training, medical student education, and some issues related to lifelong learning. Dr. Richard Summers will chair the work group. The charge and its membership are currently being finalized.
- **Ad Hoc Work Group on Healthcare Reform:** This work group is in its third incarnation due to the importance of this issue to psychiatry. The revised charge asks that the Board Work Group : 1) provide guidance to the leadership of the APA, including the Board of Trustees and the administration, 2) continue to develop concrete, specific, actionable products to show members how they will best fit in the changing healthcare environment. Dr. Anita Everett will chair the work group.
- **Ad Hoc Work Group on Real Estate:** The APA has to make an important decision by the end of 2014 as to whether to buy or lease new building space. Dr. Frank Brown, APA Treasurer, will chair the work group.
- **Ad Hoc Work Group on Liability Insurance:** The contract with the APA-endorsed malpractice insurance company, APA Inc., will be expiring in 2015 and the work group will be looking into this issue and make appropriate recommendations back to the Board.

Dr. Summergrad explained that the reports of the Research Advisory Work Group and the Work Group o Minority and Underrepresented Groups are currently being reviewed. Additionally, the DSM-5 Work Group is being reconstituted and will be keeping an eye, along with APA staff, on any emerging issues that t may require APA focus during the next several years.

Dr. Summergrad gave an update on the strategic planning retreat of the Executive Committee of the Board of Trustees. The objectives of the retreat were to:

- Develop a focused set of strategic areas to explore for APA, using input from interviews and the pulse poll survey to reflect on environmental forces, changes in the healthcare landscape, and organizational capabilities
- Discuss next stages of the strategic planning process to best engage the broader community and ensure legitimacy
- Provide input on assumptions and choices to probe in the set of questions to be included in a broader survey to follow the meeting

A number of a people, both members and non-members, were interviewed by the strategic planning consultants who participated in the Retreat. The AEC reviewed and discussed the comments they gathered.

Report on the *Train the Trainers Event on Healthcare Reform* – *Melinda Young, MD*

Dr. Young updated the AEC on the recent *Train the Trainers* event, which took place in Chicago June 21st, the intent of which was to provide training for individuals on healthcare reform which they could then take back to their District Branches. The event was well attended, with approximately 100 District Branch executive staff, leadership and general members. Those who attended the event could earn up to 8.5 hours of CME credit. Dr. Young stated that the training proved to be a learning experience on providing a training program on a complex topic that varies widely from state to state. The topics will be broken down and further developed in order to be posted to the APA website.

Assembly Reorganization

The current composition of the Assembly is set to expire in May, 2015. In May 2014, the AEC passed a number of advisory motions for the Speaker to take to the Finance and Budget Committee. These motions resulted in initial discussion of a potential requested increase of approximately **$223,000** to the 2015 Assembly budget. The Finance and Budget Committee will meet November and the budget the F&B Committee brings forward will be presented for consideration by the Board of Trustees at its December meeting.

MOTION APPROVED: The Assembly Executive Committee voted to approve the reorganization of the Assembly to reflect that the position of Deputy Representative be abolished for the DB/SAs and that each DB/SA will have a minimum of two Representatives each with all rights, responsibilities, and privileges of a Representative. In addition, larger (greater than 450 members) DB/SAs will have two Representatives for the first 450 members and one Representative for each 450 members or portion thereof over the first 450. In states with multiple DBs, each DB will have one Representative with larger DBs in those states using the formula above. *[*two NAY votes*]*

MOTION APPROVED: The Assembly Executive Committee voted to approve that the Assembly Committee on Procedures be charged with the task of looking at inequities that are created or exacerbated by this proposal and shall draft appropriate solutions that may affect votes by strength or the members per Representative ratio and report back to the Assembly Executive Committee.

MOTION APPROVED: The Assembly Executive Committee voted to accept a prioritization of the new budgetary requests in the following order:

1. Maintain the Assembly at approximately its current size and modify the structure of Deputy Representatives as previously passed
2. To fund the Area Councils to support two outside meetings a year, subject to periodic review, in coordination with the APA Meetings & Conventions Department to determine the most cost effective Area Council meeting sites.
3. To support the establishment of an innovation fund
4. To provide funding for M/UR Deputy Representatives separate from the Area Council funding stream
5. To support the strategic initiatives of the APA by supporting travel to the Area Council and Fall Assembly for the Allied Organizations and Sections subject to negotiations between the APA and the Allied Organizations

Dr. Boyer announced that the AEC will be meeting by teleconference prior to the November Assembly to review all these issues. She also requested that the Area Representatives/Deputy Representatives discuss these issues at their upcoming Area Council meetings and that Area 5, which meets in November, have a teleconference to discuss it before the Assembly.

Assembly Long Range Planning – *Melinda Young, MD*

Dr. Young distributed a summary of the work completed by Dr. Ann Sullivan when she chaired the long range planning committee. She requested feedback from the AEC on the next steps of the committee and asked that APA staff also provide feedback from their perspectives. Dr. Young requested that a work group be formed that will work with the long range planning committee on developing tools for increasing communication within, to, and from the Assembly. Drs. Eyler, Zarling, Batterson, De Faria, Koh, Benton, and Lewis volunteered to be on the work group.

Assembly Work Groups

Dr. Boyer requested feedback from the AEC on the current Assembly work groups. Based on this feedback, Dr. Boyer agreed to immediately sunset both the Assembly Work Group on the DSM-5 and the Assembly Work Group on Global Psychiatry. She will be reviewing the remaining work groups, including the Chairs, charges, and membership, and will announce which work groups will be continuing, will be sunset, and those she wants to create, at a later date.

Psychiatric Evaluation Practice Guidelines – *Daniel Anzia, MD*

The AEC was given a memo outlining the main issues that the Steering Committee on Practice Guidelines have considered and changes being made to the guidelines as a result of Assembly feedback. The AEC was also given an executive summary which explained, along with many other things, the background and development process of the guidelines. The Steering Committee will be sending the full text to the Assembly and District Branch/State Association Executive Staff as soon as possible so that the members of the Assembly have a sufficient amount of time to review them well ahead of the November Assembly meeting. [**N.B**.: The link to the Practice Guidelines was posted on August 1, 2014 to the Assembly and District Branch/State Association listservs with a request that all comments be submitted by **September 21st**.]

Preliminary Discussion of the November 7-9, 2014 Assembly

The action paper deadline for the November Assembly meeting is September 18th. The AEC had a number of suggestions for the meeting, including having a portion of the agenda devoted to strategic planning. There was a request to avoid wordsmithing actions or documents from the Assembly floor, and a request that all member edits should submitted to staff ahead of time to help facilitate the review process.

New Business

The AEC discussed its meeting scheduled for January, 2015. It was requested that the AEC return to its original schedule (Friday evening, Saturday, half-day Sunday). The date of January 23-25 was tentatively agreed to. The APA's Meetings and Conventions department will explore location options for those dates.

Adjournment

Upcoming Meetings:

Assembly, November 7-9, 2014, Washington, DC
Assembly Executive Committee, January, 2015, Location TBD
Assembly, May 15-17, 2015, Toronto, Ontario, CANADA

Rules Committee Report

FINAL Action Assignments

Reference Committee Rosters

Reference Committee 1 — Advocating for the Patient

Meets: Friday, November 7, 2014, 3:00 PM-6:00 PM, Longworth Room, Meeting Room Level

Presents: 2nd Plenary, Saturday, November 8, 2014, 10:00 AM- 12:00 PM

Roster:

Lawrence Gross, M.D., Area 6, CHAIR
Manuel Pacheco, M.D., Area 1
Marvin Koss, M.D., Area 2
TBD, Area 3
Eileen McGee, M.D., Area 4
Stephen Buie, M.D., Area 5
Dodge Slagle, D.O., Area 7
Kandace Licciardi, M.D., RFM
Gwendolyn Lopez-Cohen, M.D., ECP
Ludmila De Faria, M.D., M/UR
Debra Pinals, M.D., AAOL

Assignments: 4.B.2, 4.B.29, 4.B.30, 12.A

	2014A2 4.B.2	Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services
cc	**2014A2 4.B.29**	Retain Position Statement: Endorsement of the Patient-Physician Covenant
cc	**2014A2 4.B.30**	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents
	2014A2 12.A	Direct to Consumer Advertising

Reference Committee 2 — Advocating for the Profession

Meets: Friday, November 7, 2014, 3:00 PM-6:00 PM, Dirksen Room, Meeting Room Level

Presents: 2nd Plenary, Saturday, November 8, 2014, 10:00 AM- 12:00 PM

Roster:

Robert Roca, M.D., Area 3, CHAIR
Jonathan Weker, M.D., Area 1
Aaron Satloff, M.D., Area 2
Laura Van Cleve, M.D., Area 4
Sudhakar Madakasira, M.D., Area 5
Richard Granese, M.D., Area 6
Brian Waiblinger, M.D., Area 7
Elie Aoun, M.D., RFM
Anil Thomas, M.D., ECP
Nyapati Rao, MD, M/UR
Richard Ratner, M.D., AAOL

Assignments: 12.B, 12.C, 12.D, 12.E, 12.F

2014A2 12.B	E-prescribing of Controlled Substances
2014A2 12.C	Telepsychiatry
2014A2 12.D	Critical Psychiatrist Shortages at Federal Medical Centers
2014A2 12.E	EHR for Psychiatrists
2014A2 12.F	Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders

Reference Committee 3 — Supporting Education, Training, and Career Development

Meets: Friday, November 7, 2014, 3:00 PM-6:00 PM, State Room, Meeting Room Level
Presents: 3rd Plenary, Saturday, November 8, 2014, 1:00 PM- 3:00 PM

Roster:

Leslie Gise, M.D., Area 7, CHAIR
Shery Zener, M.D., Area 1
Henry Weinstein, M.D., Area 2
Theresa Miskimen, M.D., Area 3
Chester Day, M.D., Area 4
Elspeth Ritchie, M.D., Area 5
Shannon Suo, MD, Area 6
Shalice McKnight, MD, RFM
Lawrence Malak, M.D., ECP
Philip Bialer, M.D., M/UR
Gregory Miller, M.D., AAOL

Assignments: 4.B.1, 12.G, 12.H, 12.I, 12.J, 12.K

2014A2 4.B.1	Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist
2014A2 12.G	Integrating Buprenorphine Maintenance Therapy with Primary Mental Health
2014A2 12.H	Production and Distribution of The APA Mini Reference to Inform Patient Care during Training and Lifelong Practice
2014A2 12.I	Addressing the Educational Specifics and Training Needs of International Medical Graduates
2014A2 12.J	The Impact of the Diminishing Number of IMGs on the Care of the Underserved Populations
2014A2 12.K	Standardization of Psychiatric Nurse Practitioner Training

Reference Committee 4 — Defining and Supporting Professional Values

Meets: Friday, November 7, 2014, 3:00 PM-6:00 PM, Treasury Room, Meeting Room Level
Presents: 3rd Plenary, Saturday, November 8, 2014, 1:00 PM- 3:00 PM

Roster:

John de Figueiredo, M.D., Area 1, CHAIR
Felix Torres, M.D., Area 2
William Greenberg, M.D., Area 3
William Cardasis, M.D., Area 4
Elias Sarkis, M.D., Area 5
Alexis Seegan, M.D., Area 6
J.B. Bastani, M.D., Area 7
Sarit Hovav, M.D., RFM
Sohrab Zahedi, M.D., ECP
Maureen Van Niel, M.D., M/UR
Jack Bonner, M.D., AAOL

Assignments: 8.L.1, 8.L.2, 8.L.3, 8.L.4, 8.L.5, 8.L.6, 8.L.7, 8.L.8, 8.L.9, 13.A

2014A2 8.L.1	Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation
2014A2 8.L.2	Substance Use Assessment
2014A2 8.L.3	Assessment of Suicide Risk
2014A2 8.L.4	Assessment of Risk for Aggressive Behaviors
2014A2 8.L.5	Assessment of Cultural Factors
2014A2 8.L.6	Assessment of Medical Health
2014A2 8.L.7	Quantitative Assessment
2014A2 8.L.8	Involvement of the Patient in Treatment Decision-Making
2014A2 8.L.9	Documentation of the Psychiatric Evaluation
2014A2 13.A	Psychiatric Treatment of High Risk Patient-Community Role

Reference Committee 5 — Enhancing the Scientific Basis of Psychiatric Care/Governance Issues

Meets: Friday, November 7, 2014, 3:00 PM-6:00 PM, Commerce Room, Meeting Room Level
Presents: 3rd Plenary, Saturday, November 8, 2014, 1:00 PM- 3:00 PM
Roster:

Melvin P. Melnick, M.D., Area 3, CHAIR
Paul Lieberman, M.D., Area 1
Ramaswamy Viswanathan, M.D., Area 2
Dionne Hart, M.D., Area 4
Mary Jo Fitz-Gerald, M.D., Area 5
Mary Ann Schaepper, M.D., Area 6
Matthew Layton, M.D., Area 7
TBD, RFM
Joshua Sonkiss, M.D., ECP
Stephen McLeod-Bryant, M.D., M/UR
David Gitlin, M.D., AAOL

Assignments: 12.L, 12.M, 12.N, 12.O, 12.P, 12.Q, 12.R, 12.S, 13.B

cc	2014A2 12.L	Conversion of the Components Directory to an Online-only Format
	2014A2 12.M	Assembly DSM Component
	2014A2 12.N	Exploration: Whether to Add Some Symptoms to the Next DSM
	2014A2 12.O	Medical Term for “Lack of Physical Exercise”
cc	2014A2 12.P	Neurodevelopmental
	2014A2 12.Q	Replacing “Personality Disorder” with “Syndrome”
	2014A2 12.R	District Branch President-Elect Orientation
	2014A2 12.S	Assembly Allied Organization and Sections Liaison (AAOSL) Committee Name Change
	2014A2 13.B	Allow Deputies to Vote

Area Council and Assembly Group Action Assignments

Presents: 4th Plenary, Sunday, November 9, 2014, 8:00 AM - 11:00 AM

Assignments: **4.B.3, 4.B.4, 4.B.5, 4.B.6, 4.B.7, 4.B.8, 4.B.9, 4.B.10, 4.B.11, 4.B.12, 4.B.13, 4.B.14, 4.B.15, 4.B.16, 4.B.17, 4.B.18, 4.B.19, 4.B.20, 4.B.21, 4.B.22, 4.B.23, 4.B.24, 4.B.25 4.B.26, 4.B.27, 4.B.28, 9.A**

cc	**2014A2 4.B.3**	Retain Position Statement: Relationship between Treatment and Self Help All Areas: Primary – Area 2, Secondary – Area 6
cc	**2014A2 4.B.4**	Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions All Areas: Primary – Area 1, Secondary – ECPs
cc	**2014A2 4.B.5**	Retain Position Statement: Elder Abuse, Neglect and Exploitation All Areas: Primary – RFMs, Secondary – Area 4
cc	**2014A2 4.B.6**	Retain Position Statement: Discriminatory Disability Insurance Coverage All Areas: Primary – Area 7, Secondary – M/URs

cc **2014A2 4.B.7** Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations
All Areas: Primary – AAOLs, Secondary – Area 3

cc **2014A2 4.B.8** Retain Position Statement: State Mental Health Services
All Areas: Primary – Area 5, Secondary – ECPs

cc **2014A2 4.B.9** Retain Position Statement: Universal Access to Healthcare
All Areas: Primary – Area 6, Secondary – Area 1

cc **2014A2 4.B.10** Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion
All Areas: Primary – Area 3, Secondary – Area 2

cc **2014A2 4.B.11** Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment
All Areas: Primary – AAOLs, Secondary – Area 5

cc **2014A2 4.B.12** Retire Position Statement: Psychotherapy and Managed Care
All Areas: Primary – ECPs, Secondary – RFMs

cc **2014A2 4.B.13** Retire Position Statement: Proposed Guidelines for Handling the Transfer of Provider Networks
All Areas: Primary – M/URs, Secondary – Area 1

cc **2014A2 4.B.14** Retire Position Statement: Active Treatment
All Areas: Primary – Area 3, Secondary – Area 7

cc **2014A2 4.B.15** Retire Position Statement: Endorsement of *Medical Professionalism in the New Millennium: A Physician Charter*
All Areas: Primary – ECPs, Secondary – Area 2

cc **2014A2 4.B.16** Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded
All Areas: Primary – Area 1, Secondary – RFMs

cc **2014A2 4.B.17** Retain Position Statement: Abortion and Women's Reproductive Health Care Rights
All Areas: Primary – Area 4, Secondary – Area 6

cc **2014A2 4.B.18** Retain Position Statement: Xenophobia, Immigration and Mental Health
All Areas: Primary – RFMs, Secondary – Area 3

cc **2014A2 4.B.19** Retire Position Statement: Juvenile Death Sentences
All Areas: Primary – Area 6, Secondary – AAOLs

cc **2014A2 4.B.20** Retain Position Statement: Peer Review of Expert Testimony
All Areas: Primary – M/URs, Secondary – Area 4

cc **2014A2 4.B.21** Retain Position Statement: Joint Resolution against Torture of the American Psychiatric Association and the American Psychological Association
All Areas: Primary – Area 5, Secondary – ECPs

cc **2014A2 4.B.22** Retain Position Statement: Moratorium on Capital Punishment in the United States
All Areas: Primary – Area 7, Secondary – M/URs

cc **2014A2 4.B.23** Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment
All Areas: Primary – Area 2, Secondary – Area 5

cc **2014A2 4.B.24** Retain Position Statement: Insanity Defense
All Areas: Primary – Area 7, Secondary – Area 6

cc **2014A2 4.B.25** Retain Position Statement: Psychiatric Participation in Interrogation of Detainees
All Areas: Primary – RFMs, Secondary – AAOLs

cc **2014A2 4.B.26** Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury
All Areas: Primary – Area 5, Secondary – Area 1

cc **2014A2 4.B.27** Retain Position Statement: Mentally Ill Prisoners on Death Row
All Areas: Primary – M/URs, Secondary – Area 7

cc **2014A2 4.B.28** Retain Position Statement: Diminished Responsibility in Capital Sentencing
All Areas: Primary – Area 1, Secondary – Area 2

2014A2 9.A Ethics Annotation: Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"
All Areas: Primary – Area 3, Secondary – Area 4

Assembly Rules Committee
Consent Calendar

To provide time for discussion and debate on many issues on the agenda, the Assembly has approved using a Consent Calendar at its meetings. Placement on the Consent Calendar does not imply that an issue is not of prime interest or importance, but rather that it is perceived to be non-controversial, routine, for information (perhaps to another component), or an administrative matter.

When the Consent Calendar if brought to the floor of the Assembly, any member may request removal of any item for debate, for individual action, or for information. Members may have suggestions for additions to the Consent Calendar when it is presented for a vote.

The remaining items are voted on en bloc. Items removed are then taken up in the order in which they appear on the agenda schedule.

A. Does any member of the Assembly wish to add any item to the Consent Calendar?
B. Does any member of the Assembly wish to remove any item from the Consent Calendar?
C. Will the Assembly vote to approve the remaining items on the Consent Calendar?

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cc #1 **2014A2 4.B.3** Retain Position Statement: Relationship between Treatment and Self Help
REMOVED FROM CONSENT CALENDAR
If removed: **All Areas**: Primary – Area 2, Secondary – Area 6

cc#2 **2014A2 4.B.4** Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions
If removed: **All Areas**: Primary – Area 1, Secondary – ECPs

cc#3 **2014A2 4.B.5** Retain Position Statement: Elder Abuse, Neglect and Exploitation
If removed: **All Areas**: Primary – RFMs, Secondary – Area 4

cc#4 **2014A2 4.B.6** Retain Position Statement: Discriminatory Disability Insurance Coverage
If removed: **All Areas**: Primary – Area 7, Secondary – M/URs

cc#5 **2014A2 4.B.7** Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations
If removed: **All Areas**: Primary – AAOLs, Secondary – Area 3

cc#6 **2014A2 4.B.8** Retain Position Statement: State Mental Health Services
If removed: **All Areas**: Primary – Area 5, Secondary – ECPs

cc#7 **2014A2 4.B.9** Retain Position Statement: Universal Access to Health Care
If removed: **All Areas**: Primary – Area 6, Secondary – Area 1

cc#8 **2014A2 4.B.10** Retain Position Statement: Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion
If removed: **All Areas**: Primary – Area 3, Secondary – Area 2

cc#9 **2014A2 4.B.11** Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment
If removed: **All Areas**: Primary – AAOLs, Secondary – Area 5

cc#10 **2014A2 4.B.12** Retire Position Statement: Psychotherapy and Managed Care
If removed: **All Areas**: Primary – ECPs, Secondary – RFMs

cc#11 2014A2 4.B.13 Retire Position Statement: Proposed Guidelines for Handling the Transfer of Provider Networks
If removed: **All Areas**: Primary – M/URs, Secondary – Area 1

cc#12 2014A2 4.B.14 Retire Position Statement: Active Treatment
REMOVED FROM CONSENT CALENDAR
If removed: **All Areas**: Primary – Area 3, Secondary – Area 7

cc#13 2014A2 4.B.15 Retire Position Statement: Endorsement of *Medical Professionalism in the New Millennium: A Physician Charter*
If removed: **All Areas**: Primary – ECPs, Secondary – Area 2

cc#14 2014A2 4.B.16 Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded
If removed: **All Areas**: Primary – Area 1, Secondary – RFMs

cc#15 2014A2 4.B.17 Retain Position Statement: Abortion and Women's Reproductive Health Care Rights
If removed: **All Areas**: Primary – Area 4, Secondary – Area 6

cc#16 2014A2 4.B.18 Retain Position Statement: Xenophobia, Immigration and Mental Health
If removed: **All Areas**: Primary – RFMs, Secondary – Area 3

cc#17 2014A2 4.B.19 Retire Position Statement: Juvenile Death Sentences
If removed: **All Areas**: Primary – Area 6, Secondary – AAOLs

cc#18 2014A2 4.B.20 Retain Position Statement: Peer Review of Expert Testimony
If removed: **All Areas**: Primary – M/URs, Secondary – Area 4

cc#19 2014A2 4.B.21 Retain Position Statement: Joint Resolution against Torture of the American Psychiatric Association and the American Psychological Association
If removed: **All Areas**: Primary – Area 5, Secondary – ECPs

cc#20 2014A2 4.B.22 Retain Position Statement: Moratorium on Capital Punishment in the United States
If removed: **All Areas**: Primary – Area 7, Secondary – M/URs

cc#21 2014A2 4.B.23 Retain Position Statement: Discrimination against Persons with Previous Psychiatric Treatment
If removed: **All Areas**: Primary – Area 2, Secondary – Area 5

cc#22 2014A2 4.B.24 Retain Position Statement: Insanity Defense
If removed: **All Areas**: Primary – Area 7, Secondary – Area 6

cc#23 2014A2 4.B.25 Retain Position Statement: Psychiatric Participation in Interrogation of Detainees
If removed: **All Areas**: Primary – RFMs, Secondary – AAOLs

cc#24 2014A2 4.B.26 Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury
If removed: **All Areas**: Primary – Area 5, Secondary – Area 1

cc#25 2014A2 4.B.27 Retain Position Statement: Mentally Ill Prisoners on Death Row
If removed: **All Areas**: Primary – M/URs, Secondary – Area 7

cc#26 2014A2 4.B.28 Retain Position Statement: Diminished Responsibility in Capital Sentencing
If removed: **All Areas**: Primary – Area 1, Secondary – Area 2

cc#27 2014A2 4.B.29 Retain Position Statement: Endorsement of the Patient-Physician Covenant
If removed: Reference Committee #1

cc#28 2014A2 4.B.30 Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents
If removed: Reference Committee #1

***cc#29 2014A2 12.L** Conversion of the Components Directory to an Online-only Format
REMOVED FROM CONSENT CALENDAR
If removed: Reference Committee #5

***cc#30 2014A2 12.P** Neurodevelopmental
REMOVED FROM CONSENT CALENDAR
If removed: Reference Committee #5

Special Rules of the Assembly

1) There will be a maximum of three minutes for each presentation during debate.

2) The author or presenter has priority in making statements.

3) The Speaker will attempt to solicit a balance of pros and cons.

4) The Speaker will entertain a motion for the question when it is felt that there has been sufficient debate, both positive and negative on the motion.

5) A Reference Committee model is being used as an alternative to Area Council review for some Action Papers. The Rules Committee will select the papers to be processed in this way. The Reference Committee will be selected by the Speaker from nominees submitted by the Area Councils, the ECP Committee, the MIT Committee, the M/UR Committee, and the AAOL Committee, to equalize participation as much as possible. Council Chairs may be appointed as non-voting participants in the Reference Committees. The Reference Committees may modify or combine Action Papers. Their recommended actions will be distributed in time for discussion in the Area Council meetings before being brought to the floor.

6) Presenters of reports should be limited to spelling out clearly the title and identification of the report, giving a short summary of the salient points if necessary, calling for action if indicated, and being available for questions from the floor.

7) New Business should be kept to a minimum, particularly if the issue is already reflected in another Action Paper on the Agenda that was mailed before the meeting.

8) The author will move his or her paper. The Reference Committee, Area Council or Specialty Groups will give a report of recommendations to approve, not approve, amend, or otherwise disapprove of the paper. The discussion will be on that report. If an amended paper fails, or if the reviewing body does not recommend approval, the original paper remains on the floor.

Assembly Committee on Procedures

Executive Summary

1. **Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article I: The Assembly, 9.c. Committee on Procedures* on page 9, which identifies and highlights essential core elements/ requirement for DB/SA Bylaws to serve in the best interest of the APA, and emphasizes that the Committee on Procedures is responsible for the procedural review of the DB/SA bylaws rather than a legal review?**

2. **Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article I: The Assembly, 9.c. Committee on Procedures* on page 9 to eliminate the process for "certification" requirements from the DB/SA?**

3. **Will the Assembly vote to approve the revised language to the Procedural Code in *Article II: The Area Councils, 8.c. Nomination of Trustees* on page 14 to reflect the current APA Operations Manual language hat a member of the APA Nominating Committee cannot accept nomination for a position on the Board of Trustees during their two-year term on the committee?**

4. **Will the Assembly vote to approve the revised language to the Procedural Code in *Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs,* on page 14 to reflect the current APA Bylaws, noting that the procedures for filling vacancies of Area Trustee position are determined by the Board of Trustees?**

5. **Will the Assembly vote to approve the proposed amendment to the Procedural Code in Article I: The Assembly, 8.f. Executive Sessions on page 8 to clarify that legal advice given by the APA General Counsel does not require involving exposure to the membership?**

6. **Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article II: Area Councils, 8. Area Nominating Committee* on page 14 leave it at the discretion of the Area Councils whether or not the Area Trustees have a vote in the Area Council Meeting?**

7. **Will the Assembly vote to approve the set of proposed amendments to the Procedural Code in *Article V: Allied Organizations* on page 19 listing the procedures to become an Assembly Allied Organization, their application requirements, the procedures for exceptions to providing those application requirements, the approval process for application, and the obligations of the liaisons and their organizations to the APA?**

REPORT OF THE ASSEMBLY COMMITTEE ON PROCEDURES

Chairperson: A David Axelrad, MD (Area 5), MD; Members: David Gitlin, MD (Area 1), Jeffrey Borenstein, MD (Area 2), Theresa Miskimen, MD (Area 3), James Robert Batterson, MD (Area 4), Maria Tiamson-Kassab, MD (Area 6), Jason Hunziker, MD (Area 7), Eric Plakun, MD (AAOL), Jose Vito, MD (ECP), Matthew McDougall, MD (RFM), Jose De La Gandara, MD (M/UR); Parliamentarian: Gary Weinstein, MD; Administration: Margaret C. Dewar (Director, Association Governance), Colleen Coyle, JD (APA General Counsel), Chiharu Tobita (Association Governance)

1. Revised DB/SA Bylaws Compliance Review Procedures in the Assembly Procedural Code

a. The Committee on Procedures reviewed a total of 42 DB-SA Bylaws for discussion at their May 2014 Committee Meeting. After an extensive review process of numerous DB/SA Bylaws, the Committee concluded that many DB/SA Bylaws deviated from the *"Model" Bylaws* (Page 22-28 of the Assembly Procedural Code). The "Model" Bylaws include examples of sections which depend on the local/state law. Neither the Committee nor the APA General Counsel can verify whether the DB/SA bylaws are in compliance with their state law.

The Committee developed a Work Group (Chairperson: A David Axelrad, MD; Members: Jason Hunziker, MD, Theresa Miskimen, MD, Eric Plakun, MD, Jose Vito, MD, Glenn Martin, MD and Gary Weinstein, MD; Consultant: Ms. Bonnie Cook, Executive Director, Kentucky Psychiatric Medical Association) with the APA General Counsel, Colleen Coyle, JD, and the Administration (Margaret Dewar, Chiharu Tobita), to identify and highlight essential core elements in the "Model" Bylaws, and incorporate them in the *Procedural Code of the Assembly* as part of the requirement for DB/SA Bylaws. The "Model" Bylaws will remain an example for guidance purposes.

The intent of the new review process is to emphasize that the Committee will be responsible for the procedural review of the DB/SA bylaws rather than a legal review, but also to incorporate essential elements in the DB/SA Bylaws that will be in the best interest of the organization.

The APA will continue to provide DB consultation services, and will work to assure that DB's in need of assistance in updating their bylaws can take advantage of these resources.

I. Proposed amendments in *Article I: The Assembly, 9. Committee and Task Forces, c. Committee on Procedures* on page 9:

c. Committee on Procedures

2) Function. The Committee shall monitor the workings of the Assembly for effectiveness and efficiency; interpret the Procedural Code with regard to specific issues, challenges, or questions; shall receive, study, and initiate proposals for changes in the Procedural Code of the Assembly and the mechanisms of operation of the Assembly. It will also review the Procedural Codes of the Area Councils and the Constitutions and Bylaws of the District Branches to assure **consistency** ~~conformity~~ with the APA Bylaws, the Operations Manual and the Procedural Code of the Assembly. It may serve as liaison with the Board in the preparation and modification of the Operations Manual.

(a) The Committee on Procedures shall arrange for an updated ~~"model"~~ **"sample"** Bylaws or Procedural Code to be **available** ~~distributed~~ to each District Branch and each Area Council ~~at least each three years~~ **within 3 months of when any amendment to the APA Bylaws or Assembly Procedural Code is adopted by the Assembly** . Each updated version shall call attention to substantive changes or modifications in the document. **The Committee will review and the Constitutions and Bylaws of the District Branches on a rotating 3-year basis.**

(b) The following provisions must be included in the DB Bylaws and will be reviewed periodically by the Committee for compliance:

a. Dissolution of DB,

b. Requirements for Membership,

c. Membership Qualifications,
d. Categories of District Branch membership,
e. Voting members,
f. Election to Membership,
g. Transfer and Advancement of membership,
h. Application of Fellows and Nomination of Distinguished Fellows,
i. Inactive Status and Due waiver of membership,
j. Representation to Assembly,
k. Assumption of Office,
l. Recall of Officer or any members of the Council of the DB,
m. Representative to the Assembly,
n. Code of Ethics, and
o. Ethics Complaints.
Other bylaws provisions are included in the Addendum of the Procedural Code as an example of provisions sometimes included in bylaws for the District Branch's reference. Each District Branch is responsible for compliance with state laws governing nonprofit corporations.
~~(b) The chair of the Committee on Procedures shall request from the Secretary of each District Branch and Representative from each Area Council a simple certification that the applicable Bylaws and/or Procedural Code have been reviewed, compared with the "model," and updated the date thereof. Failure to provide such certification within two years after the appropriate reminders constitutes grounds for denial of Assembly voting privileges for that District Branch or that Area Representative and Deputy.~~
~~(c)~~ **(c)** The Assembly's Parliamentarian shall continue to advise on questions from District Branches, Area Councils, or the Assembly Executive Committee, with respect to specific issues, challenges by individual members, or questions of interpretation. If the Assembly does not have a Parliamentarian, the Speaker shall arrange another mechanism for such advice.

ACTION 1: 1. Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article I: The Assembly, 9.c. Committee on Procedures* on page 9, which identifies and highlights essential core elements/ requirement for DB/SA Bylaws to serve in the best interest of the APA, and emphasizes that the Committee on Procedures is responsible for the procedural review of the DB/SA bylaws rather than a legal review?

ACTION 2: 2. Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article I: The Assembly, 9.c. Committee on Procedures* on page 9 to eliminate the process for "certification" requirements from the DB/SA?

b. In the beginning of this year, a concern was raised about the consistency of all APA legal documents.

The Charge of the Work Group is not only to identify and highlight essential core elements in the "Model" Bylaws, and incorporate them in the *Procedural Code of the Assembly* as a part of the requirement of the DB Bylaws review, but to also review the language of the *Assembly & Area Procedural Codes* for consistency with the *APA Bylaws* and *Operations Manual*.

The Work Group made the following suggested amendments to the *Procedural Code* to be consistent with the current *APA Bylaws* and *Operations Manual*.

II. Proposed amendments in *Article II: Area Councils, 8. Area Nominating Committee* on page 14:

Area Nominating Committees

c. Nomination of Trustees. The Area Nominating Committee shall select as candidates for the office of Trustee three voting members of the American Psychiatric Association residing in the Area **who are not members of the APA Nominating Committee .** Two of these candidates shall be designated as nominees and the third as an alternate**.** ~~**in the event that one of the nominees is nominated for another office in the Association.**~~ The names of those selected shall be reported to the Area Council at which time the names of two candidates and an alternate shall be forwarded to the chair of the Nominating Committee of the American Psychiatric Association by September 1.
Area Trustees shall be ex officio members of their respective Area Councils (without vote).
The terms of an Area Trustee being three years, the Areas shall elect their Trustees according to the following rotation: 2005, Areas 2, 5; 2006, Areas 1, 4, 7; 2007, Areas 3,6, and so on.

d. Appointment of an Area Trustee if an in term vacancy occurs:
~~**1)**~~ If the vacancy occurs **during the Area Trustee's term, the vacancy shall be filled in accordance with Section 4.9 of the American Psychiatric Association bylaws.** ~~**in the first two years of the Area Trustee's term, the Area Council will be polled for three nominations; those names will be forwarded to the APA Nominating Committee who will choose two names. Central Office will then send out mail ballots within the Area and will then count the incoming ballots. It is expected that this process will take between three and six months.**~~
~~**2)**~~**1)** ~~**If the vacancy occurs in the third year of the term, the Area Council will nominate and elect a new Trustee to fill the term within three months.**~~
~~**3) Such p**~~**P**artial terms **served by a replacement Trustee** do not count for the maximum of two full terms that a Trustee may serve.

ACTION 3: 3. Will the Assembly vote to approve the revised language to the Procedural Code in *Article II: The Area Councils, 8.c. Nomination of Trustees* on page 14 to reflect the current APA Operations Manual language hat a member of the APA Nominating Committee cannot accept nomination for a position on the Board of Trustees during their two-year term on the committee?

The *APA Operations Manual (OPS Manual*) is currently silent on the procedures of filling vacancies of Area Trustees. An initial recommendation was made that Drs. Jenny Boyer and Glenn Martin as the members of the Board of Trustees, to ask the Board of Trustees to add the discussion of adopting a clear and transparent process or procedures for filling vacancies of Area Trustees in their next meeting agenda.

ACTION 4: Will the Assembly vote to approve the revised language to the Procedural Code in *Article II: Area Councils, 8.d. Appointment of an Area Trustee if an in-term vacancy occurs*, on page 14 to reflect the current APA Bylaws, noting that the procedures for filling vacancies of Area Trustee position are determined by the Board of Trustees?

III. Proposed amendments in *Article I: The Assembly, 8. Executive Committee, f. Executive Sessions* on page 8:

f. Executive Sessions. The Assembly Executive Committee may go into executive session when full and proper discussion of a report or action is likely to involve the exchange of confidential and highly sensitive information and**/or** include legal advice with counsel**.** ~~that may lead to exposure for the membership.~~ In addition, the Committee will go into executive session for consideration of any matter referred to it by the Speaker pursuant to Article I, Section 8 (H). If after initial consideration, the Committee decides that the matter should not be considered in executive session, it will terminate the executive session and refer the matter back to the Speaker and the Assembly.

Discussions of confidential and highly sensitive information can involve all sorts of issues that do not necessarily be exposed to the membership.

ACTION 5: Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article I: The Assembly, 8.f. Executive Sessions* on page 8 to clarify that legal advice given by the APA General Counsel does not require involving exposure to the membership?

c. Additional amendment to the Procedural Code: The Committee proposed an amendment to leave it up to the Areas to decide whether or not the Area Trustees have a vote at the Area Council Meetings.

IV. Proposed amendments in *Article II: Area Councils, 8. Area Nominating Committee* on page 14:

Area Nominating Committees

c. Nomination of Trustees. The Area Nominating Committee shall select as candidates for the office of Trustee three voting members of the American Psychiatric Association residing in the Area **who are not members of the APA Nominating Committee .** Two of these candidates shall be designated as nominees and the third as an alternate**.** ~~**in the event that one of the nominees is nominated for another office in the Association.**~~ The names of those selected shall be reported to the Area Council at which time the names of two candidates and an alternate shall be forwarded to the chair of the Nominating Committee of the American Psychiatric Association by September 1.
Area Trustees shall be ex officio members of their respective Area Councils**.** ~~**(without vote).**~~**; whether or not they have a vote in the Area Council Meeting shall be at the discretion of the Area Council.**
The terms of an Area Trustee being three years, the Areas shall elect their Trustees according to the following rotation: 2005, Areas 2, 5; 2006, Areas 1, 4, 7; 2007, Areas 3,6, and so on.

ACTION 6: 6. Will the Assembly vote to approve the proposed amendment to the Procedural Code in *Article II: Area Councils, 8. Area Nominating Committee* on page 14 leave it at the discretion of the Area Councils whether or not the Area Trustees have a vote in the Area Council Meeting?

d. Future/ Ongoing Projects of the Work Group:

i. Overall review of the Procedural Code
The Work Group will carefully edit and further review the Procedural Code to look for anything out of date that should be removed or implemented. The Work Group will complete this assignment between November 2014 and May 2015.

ii. Consistency of all legal APA documents
The Work Group will review the language of the Assembly and Area Procedural Codes for consistency with the *APA Bylaws* and the *APA Operations Manual*. The Work Group will complete this assignment between November 2014 and May 2015.

iii. Development of DB Bylaws Review Schedule Requested
At the July 2014 AEC meeting, a request was made to develop a detailed DB bylaws review schedule. Once developed by the Procedures Committee, this schedule will be shared with all DBs/SAs. The Work Group will complete this assignment between November 2014 and May 2015.

iv. Membership Category term change: Member-in-Training (MIT) to Resident-Fellow Member (RFM)
The membership category term of Resident-Fellow Member (formerly Member-in-Training) was approved by the Assembly in November 2013 and the Board of Trustees in December 2013. The DBs/SAs will be advised by the Committee on Procedures to reflect this change in the legal documents, especially the DB/SA bylaws.

Ms. Coyle highlighted that this change is not considered a substance change, but merely a name/editorial change. It should not require the District Branches to undergo a formal "bylaws amendment" approval process. APA Administration will notify all DB Executives/POC to ensure this specific change in the DB bylaws.

2. Revised Criteria for Assembly Allied Organization (AAO) in the Assembly Procedural Code

Review of AAO Criteria in the Procedural Code of the Assembly

Since June 2012, APA staff carried out a review of Assembly Allied Organizations by requesting from Assembly Allied Organizations to provide a letter, along with the most updated membership roster, stating that they meet the criteria stated in the *Procedural Code of the Assembly* –

(1) a minimum of 100 members;
(2) at least 80% of those members are psychiatrists; and
(3) two-thirds of those members (psychiatrists) are members of the APA.

According to the current AAO application/ compliance criteria in the *Procedural Code of the Assembly*, the following three (3) AAOs did not meet the criteria:

1. American Academy of Child and Adolescent Psychiatry
2. American Association for Emergency Psychiatry, and
3. American Psychoanalytic Association.

The Committee considered modifying the current AAO compliance/application criteria in the *Procedural Code of the Assembly*. The American Medical Association (AMA) guidelines for admission and representation in the AMA were used as a model for the APA.

A Subcommittee (Chairperson: Dr. Eric Plakun; Members: Drs. Bob Batterson, David Gitlin and Maria Tiamson-Kassab; Administration: Margaret Dewar, Chiharu Tobita) was appointed by the Committee.

The Charge of the Subcommittee is 1) to review and reevaluate the current requirements to become an allied organization of the Assembly (AAO), 2) to examine the review results of the currently incompliant allied organizations, 3) to advise and make recommendations to the Committee on Procedures on amending the Procedural code, by using the American Medical Association (AMA) guidelines for admission and representation in the AMA as a model and guidance for APA criteria, with liberty for innovation, and 4) to review the requirement for membership lists to be provided to support affiliation and see what, if any, exceptions should be permitted.

In his first address to the Assembly, Dr. Levin recognized that the future of the Assembly membership includes involvement of subspecialties, allied organizations and sections; there has been an overall sense of the urgency to bring together as many allied organizations as possible, with APA's role as a central "convening authority" inviting various groups to be Allied Organizations.

The Subcommittee agreed to amend the AAO compliance/application criteria in the Procedural Code to make them more inclusive, especially of the three Allied Organizations (AACAP, American Association for Emergency Psychiatry and American Psychoanalytic Association) that did not meet the current three AAO criteria according to the last AAO compliance review in 2013.

The Subcommittee considered modifying the current AAO criteria by using the American Medical Association (AMA) guidelines for admission and representation in the AMA as a model to be adopted by the APA.

The consensus of the Subcommittee was to develop language that would allow all of the current AAOs to remain in the Assembly, and also to attract additional ones. The Subcommittee agreed to adopt AMA standards and to rewrite the *Article V-Allied organizations of the Procedural Code.*

The final proposal of the Subcommittee on page 19 of the Procedural Code, *Article V: Allied Organizations* is as follows:

ARTICLE V: ALLIED ORGANIZATIONS

1. Professional organizations of psychiatrists with subspecialty skills and interest **that have been in existence for 5 years, have at least one meeting of its membership annually, and** ~~,~~ whose mission and code of ethics are ~~compatible~~ **not in conflict** with those of the American Psychiatric Association, may apply for designation as Assembly Allied Organizations. **If the organization is international, its US branch may apply for designation as an Allied Organization.** Such organizations, not to exceed 25 at any one time, may be ~~so~~ designated **Allied Organizations** if they meet the~~se~~ requirements **below in Section 1 through 3**. ~~Written proof of compliance, to include a membership list, must be submitted with each application.~~

a. The organization has a minimum of 100 **APA** member~~s~~ **psychiatrists**.
b. ~~At least 80% of the members are psychiatrists.~~ **Psychiatrists comprise a majority of voting members of the organization.**
c. ~~Two-thirds of the~~ **At least 40% of the total number of** psychiatrist members are members of the American Psychiatric Association.

~~Submitted membership lists of allied organizations will be kept confidential, used for the sole purpose of determining compliance of stated criteria and will not be used by the APA for any other means or distributed to other individuals or organizations.~~

2. Application for designation as an Assembly Allied Organization shall be made to the Committee on Procedures. **Applications shall include a complete organizational membership list with name, address, professional degree and APA membership status, if known, so that items b and c above may be calculated. If APA member status is not known, the APA will use the membership list to ascertain APA membership status. Submitted membership lists of allied organizations will be kept confidential, used for the sole purpose of determining adherence to stated criteria and will not be used by the APA for any other means or distributed to other individuals or organizations.**

2.1. An organization may request exemption from the requirement for providing a membership list through a letter to the Assembly Speaker explaining why it would be a hardship or risk to the organization or its members to do so. Such organizations shall seek the alternative to 1 a, b and c above of providing the names of 100 APA member psychiatrists to the APA and the total number of psychiatrists and total members in the organization. In no instance shall an organization be approved for exemption from the requirement to provide a membership list if it makes its members' names available to the public or to other non-profit or commercial entities. The Speaker and Assembly Executive Committee shall review such letters and vote on the requested exemption. A majority vote of the Assembly Executive Committee is required to support the exemption, and the decision of the Assembly Executive Committee is final.

2.2. The names of t~~T~~hose **organizations that meet** ~~in compliance with~~ requirements will be forwarded to the Assembly Executive Committee for review and recommendation to the Assembly, where **authority for** final approval **as Assembly Allied Organizations** resides**, based on a majority vote of the Assembly**. The Speaker may solicit applications from appropriate organizations.

2.3. The APA will establish a formal written agreement with each allied organization. The APA will explore the potential for a business arrangement with each allied organization; i.e., member recruitment via joint

dues agreement, lobbying efforts, and other professional management services. **All organizations shall work annually to increase the percentage of their members that are APA members and report these efforts to the APA at periodic reviews. Those organizations with less than 60% APA membership among psychiatrist members shall make such appeals at least twice annually to its members to join the APA.**

3. Each Assembly Allied Organization shall choose or elect one member who is also a member of the American Psychiatric Association to be liaison to the Assembly and an Area Council. ~~All costs of participation to be borne by the Allied Organization.~~ Liaisons will become members of the Assembly, each with voice and one vote, but one vote for each organization in a vote by strength. Liaisons will be assigned by the Speaker to an Area Council and to Committees and Components where their expertise can be utilized at the Speaker's discretion. They will also have membership on the Committee of Allied Organizations Liaisons.

3.1 Liaisons and their organizations shall have the following obligations:
a. The organization shall keep its Assembly liaison informed of policy positions by the organization
b. The liaison shall report to the organization about APA actions.
c. The organization shall provide information about APA actions to its members.
d. The organization shall report about performance of a through c above as part of the periodic review.
e. The liaison will make a yearly report to the APA, via the AAOSL committee, on organizational activities relevant to the APA.

4. Each Assembly Allied Organization shall have its status reviewed **every five years** by the Committee on Procedures for ~~compliance with~~ **adherence to** requirements in Section**s** 1 **through 3** ~~annually~~ or at other intervals determined by the Assembly Executive Committee **if it has reason to believe that adherence to the requirements is in question**. Each Allied Organization shall submit documents proving their continuing ~~compliance with~~ **adherence to** Assembly requirements **as part of the Five Year Review, Such documents will include a current membership list or request for exemption, as above**. An allied organization falling below the established criteria for representation in the Assembly will be allotted ~~one~~ **two** year**s** to achieve ~~compliance~~ **adherence**. Failure to do so may result in non-participation within the Assembly.

ACTION 7: 7. Will the Assembly vote to approve the set of proposed amendments to the Procedural Code in *Article V: Allied Organizations* on page 19 listing the procedures to become an Assembly Allied Organization, their application requirements, the procedures for exceptions to providing those application requirements, the approval process for application, and the obligations of the liaisons and their organizations to the APA?

Item 2014A2 7.E
Assembly
November 7-9, 2014

Report of the Assembly Committee of Early Career Psychiatrists

Members and ASM Appointments

Name	email	Position
SohrabZahedi	sobzi@mac.com	Area 1 Rep (’13-15)
Gwendolyn Lopez	lopezcohenmd@gmail.com	Area 1 dep rep (’13-15)
Jose Vito	josevito@yahoo.com	Area 2 rep (’13-15)
Anil Thomas	Anil.Thomas@nyumc.org	Area 2 dep rep (’13-15)
Hind Benjelloun	hbenjelloun@yahoo.com	Area 3 rep (’14-16)
TBD	TBD	Area 3 dep rep (’14-16)
Justin Schoen	jwschoen@email.com	Area 4 rep (’13-15)
Jake Behren	behrens.jake@gmail.com	Area 4 dep rep (’13-15)
Justin Hunt	jbhunt@sbcglobal.net	Area 5 rep (’14-16)
Mark Haygood	Mhaygood78@gmail.com	Area 5 dep rep (’14-16)
Steve Koh (Chair)	shkoh77@yahoo.com	Area 6 rep (’14-16)
Larry Malak	lmalak@ucsd.edu	Area 6 dep rep (’14-16)
Josh Sonkiss	jsonkissmd@gmail.com	Area 7 rep (’14-16)
TBD	TBD	Area 7 dep rep (’14-16)
Molly McVoy	Molly.McVoy@UHhospitals.org	ECP Trustee (’12-’15)
Paul O’Leary	dr.paul.oleary@gmail.com	AMA YPS Rep (’12-’14)
Anish Dube	anish.dube@gmail.com	ACORF
Urysha Moseley	UMoseley@psych.org	Staff Liaison
Jon Fanning	JFanning@psych.org	Staff

Nominations

Rep	Alternate
Justin Schoen, MD	Mark Haygood, MD

Procedures

Rep
Jose Vito, MD

Public and Community Psychiatry

Rep
Larry Malak, MD

Rules

Rep	Alternate
Joshua Sonkiss, MD	Justin Hunt, MD

Awards

Rep
Sohrab Zahedi, MD

Reference

Reference Committee #1
Gwendolyn Lopez, MD
Reference Committee #2
Anil Thomas, MD
Reference Committee #3
Jake Behren, MD
Reference Committee #4
Sohrab Zahedi, MD
Reference Committee #5
Joshua Sonkiss, MD

2014 Activities

- Active participation in ASM action papers and committee work
- Work on ABPN MOC
    - Met with ABPN representatives on MOC related issues
    - Will work to be liaison between ABPN and Areas to facilitate ease of MOC fulfillment and to continue active communication between ABPN and ECP members
- Work with APA staff on communication and IT issues
    - Participation in communications and web-IT related groups and workshops
- Mentoring and networking events
    - Worked with APA, Inc to secure funding for annual meeting PsychSIGN/RFM/ECP social and networking event; approximately 300+ individuals in attendance at last event in NYC
- Active in mentoring and leadership roles in each respective areas
- Better coordination with other APA committees, workgroups, components, etc

In summary, your ECP committee continues to be very active in APA and ASM work. We have streamlined our work process and our conference calls. We have focused our attention to ECP related issues such as ABPN MOC and providing mentoring and leadership to our younger members. We continue to look forward to contributing to our APA.

Respectfully submitted by:
Steve Koh, MD, MPH, MBA
Chair, APA ASM ECP Committee

Item 2014A2 7.F
Assembly
November 7-9, 2014

Report of the Assembly Committee of Resident-Fellow Members

The Assembly Committee of Resident Fellow Members (ACORF) is off to a busy start this year. We welcomed our new deputy representatives to the group in July and are pleased with the diversity of talent and experience within the group. After briefly orienting the new members of the group, ACORF has been working on several key issues. Our group has a monthly conference call that is attended by all ACORF members, including the RFM trustee and trustee-elect, as well as Jon Fanning. Below are a few highlights:

1. ACORF Orientation Guide: Originating with an action paper submitted last spring by ACORF rep Matt McDougall, the ACORF Orientation Guide was drafted with the objective of having a cohesive guide for new ACORF members to have as a part of the orientation process. Our group developed a subcommittee to address this project and we are pleased to report that we now have a complete guide that can be used for future members when joining ACORF. This guide is a supplement to the orientation that is conducted during the Assembly in November.

2. Action Papers: There are several action papers originating from ACORF for the fall Assembly. We have papers addressing buprenorphine training, specifics surrounding training for nurse practitioners, and conversion of the components directory into an online-only version. We are also thinking about ideas for submission at the Assembly meeting in May. If you have any particular issue or concern that potentially impacts RFMs, please let our group know and we would gladly collaborate with others.

3. Communications Plan: Reps and Dep Reps within ACORF have been encouraged to reach out to RFM constituents in respective areas to introduce themselves. ACORF plans to send out periodic communications to RFMs throughout the year. We are also introducing ourselves to DB execs from our Ares to improve outreach between RFMs within the assembly and other RFMs involved at the distract branch level.

4. Work Groups: ACORF members serve on a variety of work groups within the APA. Committee members periodically update the group on our monthly conference calls.

5. Planned ACORF Activities: Our group is continually evaluating our current involvement during the Assembly and our scheduled activities to see how the RFM experience can be improved within the Assembly for ACORF members.

Item 2014A2 7.G
Assembly
November 7-9, 2014

Report of the
Assembly Allied Organizations and Sections Liaisons

Financial coverage of the travel costs of the liaisons was endorsed by the Assembly in the May 2013 plenary but has yet to be funded. The AEC set up a priority list of new funding requests. The AAOSL funding was placed at the bottom of the list, below block grants, and even below deputy funding (for which the Assembly specifically did not recommend funding), designating AAOSL the least important of the funding needs. Irrespective of the financial implications, the members of the Committee do find themselves questioning the Assembly's commitment to the allied organizations and their role in the APA. A number of district branch representatives remain aggressive about maintaining the dominance of geographic representation. Many APA members, however, may not be well represented by their geographic representatives who typically represent the most predominant interests in their district. Those APA members who strongly identify with their subspecialty may find their issues totally off the radar of geographic representatives who are attending to the needs of the larger majority. The AAOSL's were specifically brought in to the Assembly to make certain that those minority subspecialty interests are on the radar, particularly given that the AAOSL's represent over 15,000 APA members. Maintaining that representation remains a political challenge. The Assembly is planning to go to electronic voting which further threatens minority representation by making *votes by strength* quick and easy. In a *vote by streng*th, the district branch representatives control over 30,000 votes versus the 19 votes that the AAOSL control. In short, *votes by strength* disenfranchise the AAOSL's (as well as the RFM's, ECP's, MUR's, and the AEC). The AAOSL Committee will remain committed to establishing procedural steps to ensure that *votes by strength* are not too convenient for the district branch representatives to compel.

The committee itself has been well attended; more liaisons are present now for Plenary meetings than there has been at any time in recent memory. The liaisons remain committed to the Assembly and are very active and conscientiously involved in multiple Assembly tasks, projects, action papers, and committees.

Respectfully submitted,

David Scasta
Chair, AAOSL
scastadavid@msn.com

Council on Addiction Psychiatry

- The Council met with representatives of the White House Office of National Drug Control Policy, National Institute on Alcohol Abuse and Alcoholism, SAMHSA's Center for Substance Abuse Treatment, and Veterans Health Administration at its meetings in May and September.

- The National Institute on Alcohol Abuse and Alcoholism will present the featured research track at the 2015 APA Annual Meeting. The track consists of 13 sessions, including three lectures.

- In response to the epidemic of prescription drug and heroin addiction in the United States, SAMHSA, NIDA, and the Department of Health and Human Services are actively deliberating possible administrative changes to increase patient limits reflected in the Drug Addiction Treatment Act of 2000 (DATA), as well as other potential mechanisms to increase access to buprenorphine treatment. To inform the deliberations, SAMHSA urged the DATA organizations (APA, AAAP, AOAAM, and ASAM) to submit recommendations for review and consideration.

  Council developed a series of recommendations that would increase access to buprenorphine treatment by increasing the patient limits and authorize prescribing by physician extenders who are supervised by physicians certified in addiction psychiatry or addiction medicine. Additionally, it advocates for Federal support for expanded physician training. The recommendations were endorsed by the American Academy of Addiction Psychiatry (AAAP) and the American Osteopathic Academy of Addiction Medicine (AOAAM) and forwarded to ONDCP, NIDA, and SAMHA's Center for Substance Abuse Treatment.

  APA's Government Relations staff is actively discussing the APA-AAAP-AOAAM recommendations with US Senators Ed Markey and Carl Levin who have introduced legislation to expand treatment access.

- The council is collaborating with the National Institute on Drug Abuse, the Council on Medical Education and Lifelong Learning, and the American Association of Directors of Psychiatry Residency Training to develop open-source curricula on substance use disorders for general psychiatry programs. A needs assessment will be undertaken as well as several other activities that will inform and shape the development of an R25 grant application to be submitted to NIDA in May 2015.

- A council workgroup on Tobacco Use Disorders was formed in May 2014 and is chaired Douglas Ziedonis, MD. It will develop a strategic plan with multiple organizational approaches and programmatic activities to help psychiatrists reduce tobacco use among individuals with mental illness, including addiction. The group will update APA's position statement on nicotine dependence, organize a workshop for the APA Annual Meeting, and consider developing a new position statement on electronic cigarettes. Further it will outreach to the American Psychiatric Nurses Association and the American Academy of Family Medicine to obtain information about their successful initiatives and assess the

potential of adapting them for use in psychiatry. Contact will be made with leadership of the Smoking Cessation Leadership Center to seek a grant to support the Workgroup's activities.

- APA continues to present webinars once or twice a month on behalf of the SAMHSA-funded Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT). They offer free continuing medical education credit and attract large numbers of participants. A September 30 session on overdose prevention attracted more than 2,000 registrants. It was presented by Michael Botticelli, Acting Director, White House Office of National Drug Control Policy, and Elinore McCance-Katz, MD, SAMHSA's Chief Medical Officer. All webinars are recorded and available at www.APAeducation.org and www.psychiatry.org/pcssmatwebinars. The program's dedicated website is www.pcssmat.org

- SAMHSA recently awarded the American Academy of Addiction Psychiatry a $3 million grant to operate the Providers' Clinical Support System for Opioid Therapies (PCSS-O). This collaborative program includes 12 partner organizations, including the APA, American Medical Association, American Academy of Neurology, American Academy of Pediatrics, American Academy of Pain Medicine, and the American Dental Association. APA will contribute to the program by presenting webinars and developing online clinical case vignettes with self-assessment. The focus of the program is the appropriate use of opioids to treat chronic pain and the recognition and treatment of opioid use disorder.

- Position statements were reviewed for currency and ongoing relevancy. The Council will undertake revisions to five statements.

COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

Barry Bruce Perlman, M.D., Chairperson

The Council on Advocacy and Government Relations was established in May 2009, as part of the reorganization of APA councils and components. The Council was consolidated to include the charges of the Council on Advocacy and Public Policy, the former Committee on Government Relations, and the former Committee on Mental Health Care for Veterans and Military Personnel and their Families. The Council also absorbed some of the charges of the former Council on Social Issues and Public Psychiatry. The Committee on Advocacy and Litigation Funding was retained as a corresponding committee.

The Council continues to serve as the APA's coordinating body for all legislative activities involving the federal and state governments. Activities include analyzing problems and anticipating needs for policies and planning strategies; actively collaborating with allied groups with shared goals to progressively move towards improved quality of care; and working with agencies that set policy on funding, access and quality of psychiatric services at the federal, state, and local level to affect legislation, regulations, and guidelines.

Medicaid Bump

The Council and APA staff continues to track legislative activity on the extension of Medicare-Medicaid parity payments to physicians for certain primary services. Staff believes the issue will be an uphill battle with Congress in approving an extension, and is more likely to fall short. Currently, APA is working with obstetricians and neurologists presenting a strong specialty coalition. Two key factors working against an extension: one, it is tied to the ACA and it is expensive measure; a clean extension will be cost $11 billion over two years. And two, introducing additional specialty groups into the extension can increase the cost by more than 25 percent. The Obama Administration is in favor of a clean extension, and the primary care groups lead a major campaign to push an extension.

Excellence Mental Health Act Demonstration Program

Earlier this year, the President signed into law a demonstration program under the *Excellence Mental Health Act*. The legislation establishes pilot programs in eight states to increase access to community mental health centers and improve the quality of care at those centers. The Centers for Medicare and Medicaid Services (CMS) has been tasked with issuing guidance for the establishment of a prospective payment system that will apply to medical assistance for mental health services furnished by certified community mental health centers participating in the program. APA forwarded a letter to SAMHSA, CMS and ASPE containing five recommendations concerning the structuring and implementation of the demonstration; a public comment period is impending. The Council and APA staff will remain attentive of the development of the pilot program.

Comprehensive Mental Health Reform

The Council and APA staff continues to track the progress of comprehensive mental health reform, including the *Helping Families in Mental Health Crisis Act*, introduced in December 2013 by Representative Tim Murphy (R-PA). Upon introduction of this legislation, APA wrote to Representative Murphy noting the clear emphasis it places on the provision of psychiatric services and research supports. In May 2014, Representative Ron Barber (D-AZ) along with a group of House Democrat mental health advocates introduced the *Strengthening Mental Health in Our Communities Act*. APA's key interests include advocating for the House to move the process forward on bipartisan comprehensive mental health reform. Both the Council and APA

leadership have dedicated significant time to discussions on contents of Murphy and Barber legislation, political implications, and APA's position.

CY 2015 Medicare Physician Fee Schedule

In July, the Centers for Medicare and Medicaid Services (CMS) released the 2015 Physician Fee Schedule proposed rule. In response, APA submitted a comment letter to CMS Administrator Tavenner expressing APA's appreciation of the recent CMS proposal to expand payment for telehealth services including psychotherapy codes. APA, also, joined AMA in urging CMS to revise their proposal to compensate physicians for chronic care management (CCM), including the valuation of such codes and the required use of a certified EHR. APA urged CMS to drop the two year opt-out policy for Medicare, to rework several important aspects of the Physician Compare website, and urged CMS to reconsider a recent policy change on the Open Payment "Sunshine Act" system which would require reporting of accredited CME which had been previously excluded. APA commented strongly on proposed changes to the PQRS system, both with regard to specific measures and the general move away from claims based reporting, which is most valuable to APA members participating in the PQRS. Further, APA commented on the expansive proposed use of the PQRS data in programs such as Physician Compare and the value-based modifier program will be at increased risk for payment penalties. The Council and APA staff will continue to advocate on the aforementioned concerns before the release of the Final Rule expected early November.

Inpatient Prospective Payment System

In August, CMS published its fiscal year 2015 Final Rule for the Medicare Inpatient Prospective Payment System (PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) inpatient payment rates and policies based on regulatory changes adopted by CMS and legislative changes previously adopted by Congress. In response, APA submitted comments to CMS Administrator Tavenner listing a number of concerns regarding the rate at which the agency was adding new measures, many of which could negatively impact participation and inaccurately measure the quality of facilities. A few of the measures, such as: assessment of patient experience of care, 30-day psychiatric readmission, and use of electronic health record in the IPQFR program, were asked to be reconsider before moving forward with inclusion. The Council and APA staff will continue to track activity surrounding the changes that will take effect October 1.

APA*PAC*

The APA Political Action Committee (APAPAC), chaired by John Wernert, M.D., is governed by a Board of Directors that is composed of 12 APA members. APAPAC is the bipartisan political voice of the APA and enables APA to invigorate its patient and professional advocacy activities by supporting candidates for federal office. The PAC works to ensure the election of Members of Congress who share mutual principles and goals with APA and who stand up for psychiatry's position during the legislative process. The PAC raised about $155,000 from APA members during the calendar 2014. For the 2014 election cycle, the goal is to raise over $400,000. In 2014, the participation rate continues to be an issue, where only 4 percent of eligible APA members contributed to the PAC, one of the lowest participation numbers for a medical specialty PAC. Increasing this number is the top priority of APAPAC.

Engage 2014

One extremely important role of the Council on Advocacy and Government Relations and the Department of Government Relations (DGR) is to promote advocacy to APA membership in order to educate Members of Congress as to why they should support positions vital to our patients and our profession. In August, APA announced a grassroots campaign, Engage 2014,

designed to encourage members to advocate on behalf of the mental health community as well as increase participation in grassroots efforts among the APA membership. DGR will continue to operate the program through Election Day. APA will continue to engage its leaders and members to advocate on key priorities for the psychiatric physician community, including the impending Medicaid Bump.

APA Fellow Initiative

During the recent Component Meeting, the Council Chair, Dr. Barry Perlman, informed the Council members about a new APA initiative that would help improve the experience of APA fellows on each Council. In light of qualitative data obtained from a spring 2014 survey to APA Leadership Fellows, APA leadership has asked each Council to work closely with their Council fellows in order for fellows to gain mentorship and leadership experience. The Chair encouraged Council members to make geographic networks with fellows to stay involved. To date, the Council Chair and various Council members have extended open invitations to CAGR fellows to engage in local DB or SA events, as well as remain connected to the Council member as a mentor.

Jacob Javits Award for Public Service

Named for former Senator Jacob Javits of New York, this award is given annually, alternately to a state public servant and a federal public servant who have demonstrated distinguished leadership in supporting psychiatric medicine and mental health advocacy. This year, the Council on Advocacy and Government Relations selected for consideration California State Insurance Commissioner Dave Jones as recipient of the 2015 Jacob Javits Award for Public Service.

Jeanne Spurlock Congressional Fellowship

The Council and APA staff is currently soliciting applications for the Jeanne Spurlock Congressional Fellowship. The Fellowship is an opportunity for residents, fellows, and early career psychiatrists to represent the profession of psychiatry on Capitol Hill and work with federal policy makers to shape public policy. To better align with the academic year, APA has implemented a new timeline for this fellowship. The Spurlock Congressional fellow would begin their work on Capitol Hill on August 31, 2015 and complete the 10-month fellowship at the end of June 2016.

The Council on Government Relations in conjunction with the Department of Government Relations has seen success on a number of important issues impacting APA membership. Opportunities to advance the legislative goals of the APA will continue into 2015, as will the challenges to be overcome. APA is well-positioned to work with leadership on both sides of the aisle, particularly in the committees most relevant to our legislative agenda. As dynamic issues related to the practice of psychiatry have emerged and evolved over the last year, the members of the Council have served as key advisers to the Department of Government Relations and the Board of Trustees on pressing national priorities impacting psychiatrists and their patients.

Attachment 1

Assembly Action Item Number: ASMMAY1412.A
Title: Multiple Co-payments Charged for Single Prescriptions
Summary: The action paper asks for the APA to research the reasons for and legality of the practice of charging two co-payments for a single prescription; advocate for patients to not pay more than one co-payment for a one-month supply of medication; and draft policy opposing pharmacies charging multiple co-payments. The Council on Advocacy and Government Relations discussed the action paper and agreed it requires more data before drafting a comprehensive policy. To date, the Council has shared their recommendations to the Council on Healthcare Systems and Financing and the Joint Reference Committee. The Department of Government Relations will work with the Office of Health Care Systems and Financing to compile data to share with the Council on this issue.

Assembly Action Item Number: ASMMAY1412.K
Title: Remove Black Box Warning from Antidepressants
Summary: The action paper asks the APA to urge the FDA to reconsider the inappropriateness of the Black Box warning pertaining to suicidality with antidepressants. The Council on Advocacy and Government Relations discussed the action paper, considering the pros and cons of next steps. As there is currently no mechanism, for patient or provider advocacy groups, to alter or remove black box warning, the Council suggests to advocate for revising the word content. In consideration of the political and legislative ramifications, the Council suggests bringing a resolution to the APA AMA Delegation, hopefully opening a dialogue with the FDA, AMA, APA, and other medical specialties to consider how to reform the black box warning. The Council has shared their recommendations to the Council on Research and will await feedback from further investigation by said Council.

Assembly Action Item Number: ASMMAY1412.X
Title: Patient Safety & Veterans Affair Medical Center Participation in State PMPs
Summary: The action paper asks that the Council on Advocacy and Government Relations explore the federal legislation and regulatory opportunities for the APA to advocate the Veterans Health Administration to create a program that would allow licensed prescribers universal access to state PMPs. The Council on Advocacy and Government Relations is in support of the action paper's resolve to explore federal legislative and regulatory opportunities to advocate for the creation of a program to allow licensed prescribers universal access to state prescription monitoring programs. With current policy movement within the Veterans Health Administration, the Council agrees this is an ideal focus for advocacy efforts by APA. The Department of Government Relations will continue to pursue federal legislative and regulatory advocacy efforts.

Assembly Action Item ID: ASMMAY1412.C
Title: Maintaining Community Treatment Standards in Federal Correctional Facilities
Summary: The action paper asks for the APA to lobby the Federal Bureau of Prisons (FBOP): to ensure any policies and procedures for the delivery of mental health services comply with existing federal regulations and community standards of evidence-based treatment; oppose any treatment guidelines that minimize the treatment of severe mental disorders; and increase the number of employed psychiatrists by increasing the compensation packages for FBOP employed psychiatrists. The Council on Advocacy and Government Relations has requested a four week time span to gather more information about the issue and regroup for a conference

call to discuss further. APA staff will work with Council members and the author of the action paper.

Assembly Action Item ID: ASMMAY1412.H
Title: No Punishment for Choosing Not to Adopt Electronic Medical Records
Summary: The action paper asks that the APA adopt a general policy and begin advocating for the elimination of penalties of any kind for physicians who choose not to use EMRs. The Council on Advocacy and Government Relations favors a proposal for incentives; however, supports the recommendation for a “no penalty for non-adoption” position. APA should move forward advocating for an extension, a delay or the complete removal of penalties.

Council on Children, Adolescents, and Their Families

Following are discussion highlights at the recent meeting of the council during the September Components Meetings.

- Various council members volunteered to assess several child/adolescent-related position statements up for five-year review, agreeing to report back to the group in December. During the meeting, the council approved an update of the position statement on child abuse and neglect by adults. The council also supported a mildly revised version of the position statement on college mental health submitted by Leigh White, co-chairperson of the College Mental Health Caucus. The council is also exploring the idea of a position statement on transitional aged youth.

- The council observed the rarity of Assembly action papers pertaining to youth and resolved to rally their Area and DB reps to engage the Assembly in this regard.

- The council prepared an action item to the JRC requesting that APA fund the over ten-year-old APA Child and Adolescent Psychiatry Fellowship now that Shire is not backing the program.

- Council member Gabrielle Shapiro, MD, rallied the council to join coalitions aimed at providing treatment to the hundreds of Latino immigrant children in this country without their parents.

- RFM Kara Bagot will prepare a workshop submission for the 2015 Annual Meeting on behalf of the council on the topic of cannabis use – screening, prevention and the impact of changes in marijuana laws.

- Jean Thomas, MD, continues to amass support for the formation of an APA infant and early childhood caucus and anticipates making a formal request soon.

- The council was visited by some of APA's Leadership including Drs. Paul Summergrad and Renee Binder, who engaged the council in discussions about the Board of Trustees current strategic planning initiative. APA CEO Dr. Saul Levin and Heidi Fordi, Executive Director of AACAP, acknowledged the excellent relationship between the two organizations.

Council on Communications

The Council on Communications (COC), chaired by Jeff DePaulo, MD, met during the September Component Meetings. The agenda offered an opportunity to discuss a range of activities underway in the new Communications Division. Members of the council had the opportunity to meet Jason Young, the new Chief Communications Officer, and staff from the Office of Communications and Public Affairs, Psychiatric News and the Office of Integrated Marketing.

Senior council members discussed working with the younger fellows appointed and staff highlighted APA's public education/outreach opportunities available to them. The status of social media, video production, and publishing events/activities were discussed as well as the status of APA's website. The council conversed about actions referred to them and they also had a chance to meet with leadership: Drs. Summergrad, Binder and Levin.

Annual Meeting & IPS Communications
In response to the success of both the Annual Meeting and IPS app, APA will launch in early October an APA Meetings App. The APA Meetings App will house both the IPS and Annual Meeting apps under one roof. Users will download one app, where all APA meetings are accessible, including past & future meetings. Meetings will be conveniently organized by availability, and users will download the "APA Meetings App" by simply updating the app to access new meetings as they launch.

APA Video Production
The council reviewed a series of videos recently produced by Psychiatric News and OCPA. Members were skeptical of the effectiveness of the formats (usually "talking head" style videos) and they thought the videos were too long. APA should consider producing videos that would change the image of psychiatry by showing diversity, age differences, and interaction with patients outside of an office setting. The videos should also include multimedia components/animation, titles and display a relative hash tag such as #IAMAPA.

Division of Communications
Jason Young, Chief Communications Officer, discussed the recommendations of the Porter Novelli audit. He referenced the new Communications Office which has unified the Office of Communications and Public Affairs, Psychiatric News and Integrated Marketing. Jason said that the improved and empowered communications infrastructure will advance APA's strategic communications plan and re-energize the APA as a leading voice.

Improving Mentorship Within APA
The time spent on introductions at the start of the meeting offered members and especially the RFM's a better sense of the expertise of each council member. Such interaction allowed RFM's an opportunity to align their communication interest and mentors accordingly. These efforts were done in adherence to the recent call to improve mentorship opportunities with RFM's.

Mission of the Council on Communications
The council reviewed the council charge and they unanimously agreed that it should be amended to include the entirety of the new APA Communications Division (the Office of

Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing).

Role of Psychiatry in Health Reform
In response to the Health Care Reform Recommendations assigned to the council, members were in agreement that they cannot consider or create effective messaging until leadership outlines a vision/mission statement relative to psychiatry role in Health Reform. They did stress how important it is for members to be informed about the federal and private group pilot programs & new systems available, as well as highlighting SAMSHA's Health Reform site. In addition, the COC recommends that it's important to educate the younger member audience on how Health Reform will affect them in the future. The administration also provided an account of all the integrated care resources currently available via APA's communications outlets.

The State of APA's Brand and Message Architecture
A review of the Porter Novelli executive summary offered insight to the communication strategic imperatives, APA's brand and message architecture. The history of the APA brand (Ben Rush seal) and the APA family of brands clearly showed APA's need for a unified brand identity, the council said. The council was unanimous in its support for branding the APA consistently. Branding the association will convey what the APA stands for and brand identity will align the present and future of psychiatry

Website Update
The council was given a brief update on the redesign of APA's main website, psychiatry.org, which has commenced and a vendor is in place.

Council on Geriatric Psychiatry

The Council provides leadership in the field of geriatric psychiatry and undertakes this task by initiatives related to geriatric psychiatry education, research, and clinical care. The Council also strives to work collaboratively with other professional and advocacy groups to develop best practices in geriatric psychiatry while providing education and training to other physicians (including but not limited to psychiatrists), residents, and medical students, as well as to other allied mental health professionals (including but not limited to nurses and social workers) at scientific meetings and in other settings focused on the special needs of geriatric populations with mental illness.

In response to an Assembly action paper "Guideline for Caregivers", the Council is working with the Council on Psychiatry and Law to develop a resource document to guide members on how to interact with caregivers of the persons with mental illness. The Council reviewed the draft document and came up with various suggestions for revision. Hopefully the final draft will be by next month for review.

CMS had called for a meeting to seek assistance from APA since they are working to develop regulations and metrics associated with their initiative to reduce antipsychotic use in nursing homes by 15%. Dr. Roca attended the meeting with Karen Sanders and Irvin Muszynski. Karen and Dr. Roca briefed the Council about the meeting. The Council is concerned about the unintended consequences of poorly chosen metrics. This is the first input they have received from psychiatrists in this context. The Council anticipates that the new practice guidelines which are underway will help CMS to develop balanced measures.

The Council has reviewed the document and has submitted a detailed response to the questions. The members agreed that the APA should be working to ensure that psychiatrists have the right roles in evolving models of care and that psychiatrists are trained to play these roles. We should participate actively in the development of the specific metrics that will drive reimbursement for psychiatric services in the emerging world of pay-for-performance, value-based purchasing, and similar payment models. The APA should consider putting resources into the creation and testing of the measures of effectiveness and value by which our services will be judged and paid for.

The Council has proposed minor revisions to the "Choosing Wisely" item related to the use of antipsychotics. The current document makes a categorical statement that antipsychotics should never be used as first-line treatments for treatment of behavioral and psychological symptoms of dementia. While the members agree that they should rarely be used first, there are situations in which this is necessary. The council expects the document to allow for these circumstances.

The Council was assigned the task to review five position statements that have come due for review between 2012 and 2014. The members looked in the each statement and recommended the changes. The revised statements will be ready in next 2-3 weeks.

The members have reviewed the contents posted on the Geriatric Psychiatry webpage for its relevance and agreed that more resources should be made available, especially useful for training. The council will work towards putting a list of recommended resources that can be posted on the webpage. Few of the council members have also shown interest in working on contents for e-focus and other educational programs.

Council on Healthcare Systems and Financing
Harsh K. Trivedi, MD, MBA, Chair

Members of the CHSF had a robust meeting in September. The focus of the discussion was on health reform, emerging models of care, emerging payment models, and the increasing role quality measures and medical costs play in payment reform. The following are informational items for the Assembly.

Medicare Physician Fee Schedule
In the July 2014 Proposed Rule for the 2015 Medicare Physician Fee Schedule, CMS advances several initiatives that, in combination with already existing programs, can have an impact on the reimbursement physicians will receive from Medicare for the services they provide. There are initiatives related to ongoing the Physician Quality Reporting System (PQRS) and its reporting options/mechanisms as well as to the requirement to show meaningful use of electronic health records (EHR); the Value Based Modifier (VM), which will be activated for groups of 100 or more eligible providers in 2015, for groups of 10-99 in 2016, and for small practices in 2017; and Quality Resource Use Reports (QRUR). All of these are interrelated and could impose penalties as high as 9% for large practices (100 or more) in 2017. If a group were to be penalized the maximum 2% for failing to fulfill PQRS requirements, and the 3% for failing to show meaningful use of EHR, it is likely it would then be penalized the maximum 4% based on the VM, which, added to the current 2% drop in Medicare fees put in place by the federal sequester, would make for a total of 11% lower reimbursement for all Part B Medicare services rendered. The CHSF feels the APA needs to understand the impact of these emerging payment models have on psychiatric practice and psychiatric patients as these continue to evolve.

Outstanding Assembly/JRC Action Items, Old Business
6.1 Adequacy of Health Insurance Provider Networks (ASMNOV1212.A)
The APA AMA Delegation put forward a resolution asking the AMA to study the issue of network adequacy including tiered and narrow networks and report back with recommendations. A report is anticipated for the November 2014 AMA Interim Meeting. This, along with any substantive information from the PRN data will be shared with members of the CHSF. There was also a discussion regarding obtaining specific examples of violations and that perhaps APA should focus activities on a state by state basis with Attorneys General.

6.21 Proposed Position Statement on Improving Patient Access to Psychiatric Services through MCO Provider Panels (JRCJUNE128.F.2; ASMNOV124.B.5)
The CHSF will review this item in conjunction with the AMA report and PRN data noted above.

6.3 Mental Health Parity Act Compliance & Insurance Accreditation Organizations (ASMNOV1212.C)
OHSF continues to monitor and respond to parity compliance issues. In the discussion of this issue members raised concerns about the lack of any incentive for standards /accreditation bodies (NCQA, URAC) to do anything. Parity regulations do not deem entities in compliance with the law because they are accredited. A suggestion was made that legislation may be required. Data collection needs to continue to fully understand the scope of the issues. Questions were raised as to whether the Council on Quality could play a role in working with certifying organizations.

6.4 Update on 2002 Position Statement on Carve- Outs & Discrimination (ASMNOV1212.D)
The current APA position statement will be revised to reflect changes as a result of Mental Health Parity and Addiction Equity Act (MHPAEA). A review of the existing evidence will be undertaken as well.

Consideration as to what the necessary clinical, fiscal and administrative benchmarks are needed in either a carve-out or carve-in will be included as part of the process. This will be updated as part of the position statement review process.

6.19 Managed Care Misuse of FDA Labeling (ASMNOV1212.EE)
Discussion by the CHSF confirmed there is a need to document the problem. Is this a misinterpretation of the guidelines? CHSF members will consider this matter as the position statements on pharmacy issues are reviewed. OHSF will do outreach to pharmacy benefit managers as well.

6.17 Use of New CPT Codes in Health Insurance Exchanges (ASM Item # 2013A1 12.S)
We will be monitoring what is happening in the exchange plans; all laws which address these issues have been compiled and based on a review of those laws, exchange plans have no special status. HIPAA already requires the use of CPT codes. APA regularly advocates access to all CPT codes using CPT coding conventions. To date any compliance issues with the new CPT coding conventions has been handled on a case by case basis. OHSF will continue to do outreach to the major payers. We will continue to monitor what is happening in the exchange plans through the APA Practice Management line. This will take some time to get a clear picture of how the exchange plans will operate as detailed information as of yet has been unobtainable. A follow-up study to the National Study of Psychiatric Practice Under Health Care Reform would be helpful in terms of gauging the impact of reform. The issue of payment equity based on RVUs is not possible to analyze at present.

June JRC Action Items, New Business
6.1 Multiple Co-payments Charged for Single Prescriptions (ASMMAY1412.A)
OHSF has done a preliminary review of this issue. It is clear that there is government policy (e.g., Medicare Part D) and commercial practices which do not allow or require this. This may vary depending on whether the drug is schedule I, II, III, IV or V. Clarification of the facts which generated the action paper have been requested. A background paper summarizing current policy and practices covering public and private payors will be prepared. This will include direction for APA members as to who to contact when this occurs.

6.6 Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger (ASMMAY1412.F)
The CHSF discussed a number of options including the development of standards of care, level of care criteria or a practice guideline for risk assessment. It was mentioned that APA has something assessing risk and perhaps a starting point would be to review that document (2011 Resource Document Psychiatric Violence Risk Assessment). The point was made that the standard of care should be followed whether or not the service is covered/paid for. There was discussion that perhaps a task force should be created to define criteria as to when continued care is required.

8.G.3 Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project
A small workgroup was convened and developed a written response to concerns about the implementation of the Excellence in Mental Health Act. The APA letter to HHS Secretary Sylvia Burwell identified five key recommendations on how psychiatry best fits in the community behavioral health setting. The letter stressed the need for strong evidence-based quality metrics, psychiatrist leadership, and the need for the clarification of terms. It is important to note that SAMSHA is tasked with overseeing the implementation of this Act. APA will continue to work with the APA ad-hoc work group established to monitor and review activities related to this legislation going forward to offer more input.

Council on International Psychiatry

The Council on International Psychiatry was established by the APA Board of Trustees at their October 2013 meeting. The initiative for the establishment of the Council stemmed from an Assembly action paper and, with the support of the Board Ad Hoc Work Group on International Psychiatrists, was approved by the Board of Trustees. The charge of the Council (Attachment 1) was subsequently approved by the Board of Trustees at their March 2014 meeting. At present, the Council has one reporting component, the Caucus on Global Mental Health and Psychiatry.

The Caucus on Global Mental Health and Psychiatry was also established through an Assembly initiative and approved by the Board of Trustees at their December 2013 meeting as a special interest group of the APA. The Caucus focuses on global mental health education, research, and advocacy for improved mental health care for all through collaboration with health and mental health professionals. Per APA policy, the Caucus Chairperson, Milton Wainberg, M.D., was appointed by then APA President, Jeffrey Lieberman, M.D., and met for the first time at the 2014 APA Annual Meeting in New York City. After the meeting, several Caucus members collaborated to submit an abstract on models of education and training on global mental health for the 2015 APA Annual Meeting. The Caucus is also currently in the process of organizing journal article submissions for a special edition of the publication *Academic Psychiatry*.

Appointments to the 2014-2015 Council on International Psychiatry (Attachment 2) were made by then APA President-Elect, Paul Summergrad, M.D., and the Council met for the first time during the 2014 September Components meeting in Arlington, VA. As it was the first meeting of the Council with a new charge focused on international membership growth, the Council focused on reviewing current APA international activities including the following:

- **Education:** Domestic/International Live Learning and e-Learning Opportunities, Annual Meeting Attendance Figures and Annual Meeting Attendee Experience
- **Membership:** International Category Figures, Member Benefits, Recruitment Programs and International Dues Structures
- **Publications:** International Content and Distribution
- **Training:** Domestic/International Global Mental Health and Psychiatry Training Curriculums and Fellowship Opportunities

The Council plans to discuss several issues raised during the September meeting, corresponding to each of the categories listed above, in order to begin to formulate a strategy to influence international membership growth. The Council was unanimous in agreeing that a strategy should incorporate both measurable and sustainable objectives and that the APA should work organization-to-organization, rather than organization-to-individual or individual-to-individual, on programs and projects. This includes the Council working Component-to-Component on issues, such as with the Membership Committee on international membership dues structures and the Council on Medical Education regarding the development of fellowships and curriculum models and training opportunities on global mental health.

ATTACHMENT 1: Council Charge

The charge of the Council on International Psychiatry is as follows:

The purpose of the Council is to facilitate understanding of problems facing international psychiatrists and their patients. It will do so by focusing on international membership in the APA, and through increased membership in the APA, avail all members of the opportunities in education, advocacy, prevention and clinical care that membership in the APA provides.

1. *The Council works in collaboration with the Membership Committee to recruit international members.*
2. *The Council ensures APA policies and positions on international issues are current and appropriate.*
3. *The Council, working in collaboration with the Council on Research, provides recommendations and strategies to enhance the scientific base of international psychiatric care and global mental health.*
4. *The Council identifies opportunities for partnership with other organizations to foster the creation of financially self-sustaining international programs that will benefit all members of the APA and their patients.*
5. *The Council will strive to establish mutually beneficial relationships between the APA and other internationally focused psychiatric organizations. The Council may facilitate collaborative development of clinical, research, training, and forensic guidelines by these various organizations, including the APA, for use by psychiatrists globally, with appropriate modifications for specific countries or regions. The Council may facilitate publication of news about these organizations and their activities in Psychiatric News.*
6. *The Council promotes engagement to enhance shared learning and leadership to achieve participation of all APA members.*

The Council members are experts with experience in global mental health and who are broadly representative (geographically and culturally) of the APA international body. The Council has a standard council composition. APA members who have membership in international organizations may be appointed as corresponding members and serve as liaisons to their international organizations. The Council will utilize freely available electronic communication technology to interact and coordinate with organizations and individuals outside of the United States in lieu of international travel. No APA funds will be budgeted nor used for travel outside the United States by members of this council for the work of this council.

ATTACHMENT 2: 2014-2015 Council Composition

The 2014-2015 composition of the Council on International Psychiatry is as follows:

Chairperson	Dilip V. Jeste, MD	La Jolla, CA
Vice Chairperson	Ann Becker, MD, PhD	Boston, MA
Member	David Baron, DO	Altadena, CA
Member (ASM)	Ken Busch, MD	Chicago, IL
Member	James Griffith, MD	Washington, DC
Member	Nalini Juthani, MD	Scarsdale, NY
Member	John McIntyre, MD	Rochester, NY
Member	Samuel Okpaku, MD, PhD	Nashville, TN
Member (ECP)	Uyen-Khanh Quang Dang, MD, MS	San Francisco, CA
Member	Michelle Riba, MD, MS	Ann Arbor, MI
Member	Pedro Ruiz, MD	Miami, FL
Member	Allan Tasman, MD	Louisville, KY
Consultant	Edmond Pi, MD	Hacienda Heights, CA
Consultant	Mounir Soliman, MD, MBA	La Jolla, CA
Corresponding Member	Solomon Rataemane, MD	Pretoria, South Africa
Corresponding Member	Vihang Vahia, MD	Mumbai, India
Corresponding Member	Eliot Sorel, MD	Washington, DC
Fellow	Bibhav Acharya, MD	San Francisco, CA
Fellow	Mawuena Agbonyitor, MD	Baltimore, MD
Fellow	Suni Jani, MD, MPH	Houston, TX
Fellow	Michael Morse, MD	Washington, DC
Fellow	Lianne Smith, MD	Bronx, NY
Fellow	Christopher White, MD	Moss Beach, CA
Fellow	Rachel Winer, MD	Palo Alto, CA

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

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

REFERRAL UPDATES:

ASMMAY1412.E - Psychiatric Education with Respect to Patients at Risk of Violent Behavior

The JRC referred this paper to CMELL to consider including this within residency training education and also referred to the Scientific Program Committee asking them to consider including courses on this topic at the Annual Meeting.

The Council discussed the issue of violent patients in 2011 in the context of resident safety. AADPRT has developed de-escalation guidelines along with training director and resident protocols to respond to a traumatic event in residency. An outline of a 10-hour course of essential components of violence management is available from the AADPRT website and is intended to be taught in the first year of residency training.

The SPC added a topic "*Aggressive Behaviors: Etiology, Assessment & Treatment"* in the online abstract submissions system. The topic will be available to 2015 Annual Meeting abstract submitters. This action will allow interested parties to prepare submissions on the topic and permit attendees at the annual meeting to quickly locate sessions on that topic either in the *Program Guide* topic index or by using the Annual Meeting mobile/tablet app. In addition, the SPC will solicit a session from the practice guideline group working on the assessment of risk for aggressive behaviors for the 2015 meeting.

At the 2014 Annual Meeting there were two Seminars and one Symposium directly related to this topic. Seminars are submitted using the same criteria required for a 4 hour course but do not require the attendee to pay an additional fee to attend them. Seminar packets are available online for anyone wishing to attend the session. The course committee chair has been made aware of the interest in providing this information for annual meeting attendees. The seminars presented last year were reviewed at the July repeat course/seminar meeting of the Course/Seminar subcommittee.

The need has also been met by new educational resources in the field, including a curriculum written by Robert Feinstein entitled "Violence Prevention Education Program for Psychiatric Outpatient Departments" (Academic Psychiatry, July-August 2014).

ASMMAY1412.M - Addressing the Shortage of Psychiatrists with Sources of Funding

Federally-funded programs already exist that addresses the AP author request (psychiatry practice in an underserved area of a specific number of years.)

- National Health Service Corps http://www.psychiatry.org/practice/professional-interests/underserved-communities/national-health-service-corps
- NIH Loan Repayment Program for clinical research http://www.lrp.nih.gov/about_the_programs/intramural/Introduction.aspx
- State loan repayment and/or forgiveness scholarship programs (maintained by the AAMC) - https://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=7563505

The Council believes in advocating for creation of more federal reimbursement programs and refers this to the Council on Advocacy. However, if the American Psychiatric Foundation were to identify and obtain outside funding for scholarships, the Council will support this as well.

Position Statement Review: The Council reviewed and approved to support the draft position statement entitled "*Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness*" created by the APA Workgroup on Integrated Care and the Association of Medicine and Psychiatry.

INFORMATION ITEMS:

Mentorship of APA Fellows
Each Council was asked to help improve the experience of APA fellows who are on Councils by welcoming the fellows at the meeting and encourage members to actively seek out fellows to join in on projects/workgroups, as well as encourage APA fellows to volunteer for projects. Dr. Summers met with the fellows separately where they identified Council members who will be their mentors. At the meeting, each Fellow selected a mentor from the Council members. They have been asked to contact their Council Fellow Members every 2-3 months.

Training Psychiatrists for Integrated Behavioral Health Care
The Council is writing a white paper on integrated care education which covers the spectrum from undergraduate medical education to GME to CME. The paper also includes discussion on inter-specialty education and training. We anticipate completion of the paper in November.

Work Group on the Role of Psychiatry in Healthcare Reform
The Council responded to the recommendations referred by the JRC and the Office of the CEO. A summary of the response can be found on the attached draft meeting minutes.

Jeanne Spurlock Minority Fellowship Achievement Award 2015 – the Council reviewed and voted to approve the selection of Dr. Sheryl Kataoka as the 2015 recipient of the Jeanne Spurlock Minority Fellowship Achievement Award.

Next Meeting
Conference call in 2-3 months to discuss IOM Report on GME and will invite colleagues from the Council on Advocacy, and HSF.

Council on Minority Mental Health and Health Disparities

The council met on September 12-13 during the September Components Meeting held in Arlington, VA. Following are highlights of the council meeting.

- A subgroup of council members submitted feedback to the Board Work Group on Health Care Reform and the Role of Psychiatry. The crux of council's input is that the Work Group must globally incorporate and take into account throughout its recommendations underserved populations characterized by cultural identify variables (e.g., race, ethnicity, general, language abilities, etc.).
- The council reviewed several position statements for timeliness and recommended that the following position statements be retained: abortion, xenophobia, sexual harassment, and the right to privacy. The council formed work groups to review older position statements: bias related incidents, diversity, psychiatrists from underrepresented groups in leadership, and affirmative action. The council also plans to review the APA position statement on domestic violence from a diversity perspective in light of the overrepresentation of black males in recent media stories about domestic violence
- The council continued discussion about the draft position statement denouncing violence against Sikh Americans. The council is pondering how tie this position statement and its supporting resource document to other topic-related position statements including the statement on bias related incidents, the statement on xenophobia, immigration and mental health, and the statement on racism and racial discrimination and its adverse effects on mental health.
- The rape and human trafficking resource documents are in the final stages of editing. Ludmila De Faria, MD, is chairing these projects.
- Council member Nyapati Rao, MD, reported that the May 2014 IMG Summit in New York identified several workforce issues that the APA has to deal with: closing of the pipeline for new IMGs; decline in interest of IMGs in practice and further training in the US which is now perceived as inhospitable; impact on the delivery of care with declining numbers of IMG clinicians; and xenophobic stereotypes of IMGs. It is hoped that the proceedings will be published.
- Carmen Head, AACAP Director of Research, Training & Education, visited the council to propose the idea of collaboration between APA and AACAP around issues of culture and diversity.
- Gabrielle Shapiro, from the Council on Children, Adolescent and Their Families, reached out to promote a group called Urban Strategies which wants psychiatric volunteers to do assessments on unaccompanied Latino children in the immigration system. Interested members of the Council on Minority Mental Health will follow up with her offline.

Council on Psychiatry and the Law
Steven Kenny Hoge, M.D., Chairperson

The Council on Psychiatry and Law met during the September Components Meeting in Arlington, VA. The Council heard updates from a range of its committees and workgroups including the Workgroup on Persons with Mental Illness in the Criminal Justice System, the Mandatory Outpatient Treatment Workgroup and the Sex Predator Commitment Laws Workgroup.

The Council on Psychiatry and Law had a joint meeting with the Committee on Judicial Action on "The Civil Rights of Institutionalized Persons Act, Americans with Disabilities Act and the Department of Justice Investigations as Tools to Reform State Mental Health Services". Dr. Robert Bernstein from the Bazelon Center for Mental Health Law and Dr. Ezra Griffith, APA Member both gave presentations. The Council had a lively discussion which involved how they could get involved with CRIPA/Olmstead Litigation cases along with discussing how the APA overall can focus on care delivery and treatment.

The Council on Psychiatry and Law has been working on:

1. PROPOSED POSITION STATEMENT ON FIREARM ACCESS, ACTS OF VIOLENCE AND THE RELATIONSHIP TO MENTAL ILLNESS AND MENTAL HEALTH SERVICES – The Council has reviewed the existing array of position statements and resource documents related to firearms and mental illness to determine which to sunset, consolidate, and/or update. Based on this review, the Council on Psychiatry and the Law has updated a resource document, which was approved by the JRC in June and is bringing the proposed position forward to the Assembly for consideration at this meeting. (more information is available in your packet)

2. The Council has been working on several position papers and sent the following proposed position papers to the Joint Reference Committee in October for consideration:

    a) PROPOSED POSITION PAPER ON INQUIRIES ABOUT DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS IN CONNECTION WITH PROFESSIONAL CREDENTIALING AND LICENSING.

    b) PROPOSED POSITION STATEMENT ON PATIENT ACCESS TO ELECTRONIC MENTAL HEALTH RECORDS

    c) PROPOSED POSITION STATEMENT ON SEGREGATION OF JUVENILES WITH SERIOUS MENTAL ILLNESS IN JUVENILE DETENTION AND REHABILITATION FACILITIES

3. APA GUIDELINES ON PSYCHIATRIC SERVICES IN CORRECTIONAL FACILITIES, 3RD EDITION **-** The Council on Psychiatry and Law with help from their Workgroup on Persons with

Mental Illness in the Criminal Justice System have updated the "APA Guidelines Psychiatric Services in Correctional Facilities". Special thanks goes to the following members for their hard work on this project: Robert L. Trestman, Ph.D., M.D., Chair, Michael K. Champion, M.D., Elizabeth Ford, M.D., Jeffrey L. Metzner, M.D., Cassandra F. NewKirk, M.D., Joseph V. Penn, M.D., Debra Pinals, M.D., Charles Scott, M.D., Roberta Stellman, M.D., Henry C. Weinstein, M.D., Robert Weinstock, M.D., Kenneth L. Appelbaum, M.D., Consultant, and John L. Young, M.D., M.Th.,Consultant.

The Council on Psychiatry and Law reviewed several Assembly Action Papers that were referred from the Joint Reference Committee:

1. **ASMMAY1412.C MAINTAINING COMMUNITY TREATMENT STANDARDS IN FEDERAL CORRECTIONAL FACILITIES**
   The Council on Psychiatry and Law discussed the action paper and felt the 3rd edition of the APA Guidelines on Psychiatric Services addresses this issue. The Work Group on Persons with Mental Illness Involved in the Criminal Justice System (a workgroup of the Council) will review the issues raised, including staffing and salary concerns, and recommend an appropriate response, in the form of a position statement or resource document.

2. **ASMMAY1412.V REINSTATEMENT OF THE COMMITTEE ON PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM**
   The Council discussed the action paper and believes that the current structure and composition of the Council is conducive to accomplish the work of the criminal justice area. The Council would like to know from the JCR who the current APA Representative to the National Commission on Correction Health Care (NCCHC) and request that the Representative provide a report to the Council on a regular basis.

3. **ASMMAY1412.D HIPAA AND STATE RESTRICTIONS ON DUTY TO WARN**
   The Council discussed the action paper and reported that there appears to be some confusion regarding psychiatrists' duties to protect third parties. The Council recommended the following actions:

   a) That psychiatrists continue to be educated about the provisions of HIPAA. The Privacy Rule, Section 164.512(j) allows for the disclosure of information if the covered entity (psychiatrist) believes, in good faith, that disclosure is necessary to prevent or lessen a serious, imminent threat to the health of a person or the public.
   b) The Council developed a Resource Document and model legislation on this issue in 1987. The Council recommends that this document be made available on the APA website.

Council on Psychosomatic Medicine

The Council on Psychosomatic Medicine focuses on psychiatric care of persons who are medically ill and thus stands at the interface of psychiatry with other medical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being of patients and that full membership in the house of medicine is essential to the wellbeing of our profession.

In May 2014, David Gitlin, MD was appointed the new chair of the Council. Linda Worley, MD serves as Vice Chair. Both members are very involved in both the APA and the Academy of Psychosomatic Medicine and are working to forge closer ties between the two organizations. Most of the work conducted by the Council is done via e-mail, however, a face-to-face meeting during the fall Component meetings provided the opportunity to prioritize activity. Highlights of that meeting are below.

The Council's September meeting began with visits by APA President, Paul Summergrad, MD and President-Elect, Renee Binder. Both leaders briefed the group on the work that they hope to accomplish during their respective tenures. The Council expressed its support to help advance those objectives.

The Council is mission-driven and prioritizes activities around the charge set forth by the APA Board of trustees in late 2012. Since the May meeting, Council members have built on working relationships with the Council on Healthcare Systems and Financing and its' Workgroup on Integrated Care; the Council on Medical Education and Lifelong Learning; the Board of Trustees Work Group on Healthcare Reform; the Academy of Psychosomatic Medicine; and other medical specialties including AAN and AHA. The Council continues to submit abstracts for psychiatric and primary medical meetings for sessions designed to address the educational needs of psychiatrists who treat patients with complex comorbidities, and is currently looking at developing online educational content. And finally, the Council continues to advocate for the enhancement of training in psychosomatic medicine and recruitment of residents into fellowship.

Council Work Plan Initiatives

Healthcare Reform

Karen Sanders, Director of Delivery Systems Initiatives & Integrated Care, briefed the group on current Medicare activity around quality reporting, integrated care policy work, coding for chronic care management, and CMS' goal to reduce the use of antipsychotics in dementia and the "Incident to" rules changes.

In response to a request from APA leadership, Council provided feedback on the *BOT Ad Hoc Work Group on Healthcare Reform*, indicating areas of high importance to the Council. Drs. Gitlin, Worley, and Boland had met the evening before with Rick Summers, MD, chair of the Council on Education and Lifelong Learning and worked to complete the section on "Workforce, Work Environment, Medical Education and Training."

Council reviewed the Position Statement on the Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness. The statement has been reviewed and endorsed by APM, AMP, and AACP and was sent to the JRC in October.

Relationships with Allied Organizations

Dr. Gitlin introduced a discussion of building relationships with non-psychiatric physician organizations. The group discussed strategies to "shepherd" projects which might lead to opportunities to build closer relationships. To date, the Council has provided recommendations of clinical experts to Clinical Endocrinologists in the development of a consensus document on obesity; AAN on the development of measures for multiple sclerosis; and most currently, an author to work with neurologists on and article on post-stroke depression. Dr. Gitlin also urged members to think about leveraging the partnership between APA and APM.

- Academy of Psychosomatic Medicine (APM). Dr. Worley updated the group on APM initiatives. She reviewed a Thursday night meeting between APM leadership, APA Council leadership, and lead staff from both organizations. Discussions around bidirectional collaboration between the Associations carried through both meetings.
- AAN. Multiple Sclerosis quality measure development project- Dr. Schwartz reported that the group met just once last June in Minnesota. She described how important it was to have a psychiatrist at the table, and that the occurrence of comorbid depression would not have likely been addressed by the group at all if not for her presence at the table. The Council discussed how to promote the release of the guidelines including a piece in *Psychiatric News* and development of a brief education module for psychiatrists around it.
- The Stroke Council of the American Heart Association sent a request to APA Deputy Medical Director, Annelle Primm, MD, soliciting the participation of a psychiatrist in a writing group preparing a review paper on post-stroke depression for the journal *STROKE.* The Council identified an author through Robert Robinson, MD. In addition to working on the writing group, Ricardo Jorge, MD has agreed to mentor new SAMHSA fellow Rubi Vaughan, MD through the project.

Provider Education in Psychosomatic Medicine

- Council on Medical Education and Lifelong Learning (CMELL) - Dr. Gitlin briefed the group on a Thursday meeting with CMELL Chair, Rick Summers, MD. Drs. Gitlin, Worley, and Boland met specifically to discuss overlapping activity on the Workforce, Work Environment, Medical Education and Training portion of the BOT Work Group on Healthcare Reform Recommendations. The meeting was productive and it was determined that future collaboration would be beneficial. CMELL will be convening a second meeting of Education Directors from Specialty Societies and CPM members indicated a high level of interest in participating.
- ACGME Milestones- Dr. Boland briefed the Council on implementation of the psychosomatic milestones which are scheduled for release in October, with implementation to begin in July 2015. The Council offered the idea of a joint APA/APM webinar to familiarize fellowship directors with the milestones, and offer a venue for sharing ideas on implementation.
- APA 2015 Annual Meeting Activity- Drs. Crone again was invited to submit the Council's popular "Medical mimics…" program. She also reported that abstract submissions were due September 18. She and Dr. Worley also have encouraged presenters to submit abstracts to APA based on popular sessions offered at APM.
- APA Online Education Opportunities - APA offers a new format for online CME that provides 1-hour of credit. The case-based modules provide 3-4 multiple choice questions, rationale for correct answers, links to peer-reviewed articles, and feedback on how participants scored among their peers. Modules could be linked to products developed in partnership with Allied Organizations. Mentoring members and Council fellows may choose to develop cases together.

Fellow Recruitment and Retention

- SAMHSA and Public Psychiatry Fellows- New fellows were warmly welcomed to the Council and urged to fully participate in the day's discussions. The Fellows spoke about their diverse areas of interests including mortality gaps in patients with SPMI, psychiatric aspects of medical issues, novel CHF markers, immigrant access to healthcare, post-disaster community resources, and spirituality and mental health. Council members were subsequently paired with residents to act as mentors, staying in touch throughout the year. Council chairs met with Fellows after conclusion of the business meeting to answer any questions.
- Recruitment into Psychosomatic Fellowship- Dr. Bialer said that 1 new program has joined the Match in psychosomatic medicine. Registration is open now. Last year 105 slots were filled in the Match of the 112 total slots.
- Post-fellowship Survey- Dr. Norris has completed Council edits and the survey will be sent to APA's practice research network for their feedback before being sent to the field.

Research in Psychosomatic Medicine

- Dr. Shapiro discussed the status of research in the field of psychosomatic medicine. There was a consensus within the Council that although psychosomatic medicine is primarily a clinical field, there is an ongoing need for new knowledge, and therefore new research, to keep the field intellectually alive and growing. He added that this was a challenge as the opportunities for research training and funding are limited in current training and funding environments. The Council voted to request that APM and its Research Committee survey psychosomatic medicine training programs about the research training and activity of faculty and current and recent fellows. The goal of the survey is to provide a baseline "snapshot" of the state of research activity and training and the field's relationship to major research funders such as NIMH and SAMHSA, and to identify opportunities for improvement.

Council on Quality Care

Choosing Wisely: The Council on Quality Care is currently working with the Council on Geriatric Psychiatry to update the APA's Choosing Wisely Campaign statement on prescribing atypical anti-psychotics in patients with Dementia. Once approved by the Councils, the language will be sent to the JRC for approval. If approved, this language will be shared with the ABIM Foundation, so the official list can be altered.

Registry Workgroup: Chaired by Greg Dalack, M.D., the APA Registry Workgroup has been meeting since the spring of 2014. This group's main charge is to develop a document that will inform the organization of the options that exist around registries that could best respond to the needs of psychiatric clinicians.

Practice Guidelines:
Practice Guidelines on Psychiatric Evaluations for Adults were revised to incorporate the Assembly's feedback from May and were available to the Assembly as well as District Branch Presidents and Executive Directors for additional input and comment. The guidelines have been discussed and supported by a number of the Assembly Area Councils. The Steering Committee on Practice Guidelines and the writing group are currently reviewing the comments from the Assembly. A final version of the guidelines will be submitted to the Assembly for approval in November.

Committee on Mental Health Information Technology:
The Committee, along with representatives from AACAP, SAMHSA, ONC and HL7 presented a webinar for EHR vendors on June 27, 2014. Additional teleconferences with the vendors are planned for this fall to continue the dialogue concerning the specific needs of psychiatrists and other healthcare providers.

The Committee is also in discussions with SAMHSA in their efforts to coordinate HIT for mental health services and it continues to work with AmericanEHR in their surveys of practitioners regarding experiences with EHRs.

The Committee has two representatives on HL7. Along with SAMHSA they are currently the only behavioral health participants.

Performance Measurement: The AMA-convened Physician's Consortium for Performance Improvement transferred copyright and stewardship responsibilities of various sets of performance measures to professional societies with content expertise. The APA claimed and will now manage measures previously developed on Adult Major Depressive Disorder, Child and Adolescent Depressive Disorder, Substance Use Disorder, and Dementia. The Dementia measure set is a shared partnership with the American Academy of Neurology and will undergo a maintenance update in 2015.

Memo

October 8, 2014

To: APA Assembly
From: Michael J. Vergare, M.D., Chair, APA Steering Committee on Practice Guidelines
James E. Nininger, M.D. Vice-Chair
Joel J. Silverman, M.D., Chair, APA Work Group on Psychiatric Evaluation
Laura Fochtmann, M.D., M.B.I., Medical Editor, Practice Guidelines
Daniel J. Anzia, M.D., Chair of the Assembly Area Liaisons to Practice Guidelines
Cc: APA Board of Trustees
District Branch Executive Directors
District Branch Presidents
District Branch Presidents-Elect
Jack McIntyre, M.D.
Joel Yager, M.D.

Re: Revised APA Practice Guidelines for Psychiatric Evaluation

Dear APA Assembly members,

After the discussion at the APA Assembly meeting in May, we have sought and received feedback on the Assembly's major concerns regarding the APA Practice Guidelines for the Psychiatric Evaluation of Adults. We have revised the guidelines accordingly, and this revised set of guidelines was distributed to the Assembly Area Councils and District Branches Presidents and Executive Directors for their review and discussion.

We would like to inform you about the main issues that we have considered and the changes we made to the guidelines as a result of Assembly feedback. We ask that the revised guidelines be approved at the November 2014 Assembly meeting.

New Executive Summary and New Format of the Practice Guidelines

In response to the need for an overview of the guidelines, a new executive summary is included to supplement the revised practice guidelines. This executive summary provides an overview of the guideline development process and recommendations, and an outline of key components that may be considered for psychiatric evaluation. The executive summary also explicitly describes how the guidelines are expected to be used to address some of the issues mentioned by the Assembly – also noted in this memo. In addition, the executive summary explains a new format of the revised guidelines to enhance the utility of the guidelines for clinicians. Some of the repeated information that appeared across the guidelines such as disclosures, lists of references, and names of reviewers, will now be presented toward the back of the guidelines.

Ratings of Strength of Evidence and Recommendations

The Assembly expressed their concern about the repeated appearance of the term "insufficient" for rating strengths of the available research evidence. In the revised guidelines, a new number and letter system is adopted to rate strengths of the evidence and recommendations. This rating system is based on the GRADE approach, which is used by many professional organizations and other guideline developers. The new presentation of the ratings clarifies that many of the recommendations are strongly supported by the results of the expert opinion survey conducted by APA and described in the accompanying sections of the guidelines. In addition, the Rationale section of the guidelines explains that recommendations are made if the potential benefits of assessment clearly outweigh the potential harms. The executive summary also discusses the fact that many clinical questions in psychiatry and other specialties cannot be studied through randomized controlled trials. Consequently, many published practice guidelines base recommendations on knowledge from expert consensus when high quality research evidence is unavailable or impossible to obtain.

Update of literature search

As of September 2014, we have also completed an updated search of the literature. This search yielded 11, 644 citations, which have been reviewed for relevance to the questions addressed in the guideline. Several citations have been added to sections on rationale and implementation and one reference has been added to the detailed description of the evidence. The overall conclusions about the strength of research evidence and the recommendations for clinicians remain unchanged.

Statement of Intent and Exclusions: Not a Standard of Care and Not a Requirement

As noted by the National Guideline Clearinghouse[1], a clinical practice guideline "contains systematically developed statements including recommendations intended to optimize patient care and assist physicians and/or other health care practitioners and patients to make decisions about appropriate health care for specific clinical circumstances." The recommendations for practice that are included in the guidelines on psychiatric evaluation are intended to fulfill these aims and inspire psychiatrists to consider different components of an initial assessment in their practices.

The new executive summary and guidelines highlight in multiple places that the guidelines on psychiatric evaluation are neither a standard of care nor a requirement. The Statement of Intent section clarifies that these "should be considered guidelines only" and that they "are not intended to serve or to be construed as a standard of medical care." The guidelines acknowledge throughout that a psychiatric evaluation requires clinical judgment and depends on the individualized context of clinician and patient circumstances and settings.

An additional concern raised by the Assembly related to the time that would be needed to conduct the recommended elements of the psychiatric assessment and the impediments to conducting such an assessment across settings of care. To address these concerns, the executive summary and guidelines

[1] Agency for Healthcare Research and Quality. National Guideline Clearinghouse. Inclusion criteria. Accessed at http://www.guideline.gov/about/inclusion-criteria.aspx on June 28, 2014.

reiterate that recommended areas of inquiry may need to be postponed until later visits and that recommended questions will not always be indicated for a specific patient. The definition of an initial evaluation also recognizes that "several meetings with the patient (and family or others) over time may be necessary" to perform the assessment.

The executive summary and guidelines make clear that a psychiatric evaluation need not occur in a prescribed fashion. The Exclusions section notes that "psychiatrists may conduct other types of evaluations that have other goals (e.g., forensic evaluations) or that may be more focused and circumscribed than a psychiatric evaluation as defined" in these guidelines. The Implementation sections of the guidelines also discuss aspects of the assessment that are may vary with particular treatment settings or patient characteristics. Knowledge about a patient can be gathered in many ways and does not require that all elements be assessed through face-to-face examination. For example, necessary information can be obtained through review of medical records, physical examination (by the psychiatrist, another physician, or a medically trained clinician), diagnostic testing, or history-taking from collateral sources. The findings of the expert survey reiterate that experts vary in the extent to which particular elements of the psychiatric evaluation are assessed. This also highlights the importance of clinical judgment in tailoring the psychiatric evaluation to the unique circumstances of the patient and in determining which questions are most important to ask as part of initial and subsequent visits.

Quality Measurement

The Quality Measurement section of each guideline is included to explicitly discuss and provide guidance on whether quality improvement activities derived from the recommendations would be appropriate. Consensus based recommendations are less likely to become formal quality measures. However, potential development of quality measures or quality improvement activities derived from the guidelines by others, especially by other mental health and psychiatric organizations, cannot be overlooked. Therefore, APA should be proactive and lead the development of appropriate quality measures for psychiatrists.

Importance of Credible Practice Guidelines for Psychiatrists

The executive summary and revised guidelines re-emphasize the importance of developing practice guidelines according to more rigorous standards recommended by the Institute of Medicine in 2011. The ultimate goal is to develop guidelines for psychiatry that meet inclusion criteria of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse and may therefore inform a variety of important activities for the field, including clinical decision-making, medical education, maintenance of certification, quality improvement activities such as performance measures, and public policy. Availability of credible guidelines by APA that meet national standards will ensure that these activities are guided by psychiatry rather than by others from outside of our profession.

We hope that this memo and the attached executive summary provide a helpful overview of the APA Practice Guidelines for the Psychiatric Evaluation of Adults and sufficiently address the concerns raised by the Assembly. We appreciate your collaboration in revising these guidelines and ask that they be approved by the Assembly.

The Council on Research

Dwight Evans, M.D., Chairperson

There are currently no action items for the Assembly's consideration.

The following are informational items updating the last report to the Assembly:

1. Drs. Binder, Levin, and Summergrad met briefly with the Council to discuss the report from the BOT Research Workgroup. The Council was provided with clarification on aspects of the report and additional information about the state of research at the APA moving forward.

2. The Council has implemented the modifications to the position statement on HIV and HCV co-infection as requested by the Assembly. These modifications were sent to the JRC for review.

3. The revised charge for the COR was returned to the Council for consideration of comments made at the last assembly meeting. These were discussed at the COR meeting in September 2014. The Council appreciated the input by the JRC but did not believe the additional comments added substantively to the revised charge. They voted to approve their previous revision of the charge, which has been sent to the JRC for review.

4. Glenn Martin, M.D. presented an update on the AllTrials.com registry at the COR meeting in September 2014. Specifically, he presented detailed information about the purpose of signing the registry; a listing of more than 500 institutions and organizations that have already signed on; and a description of what APA signing the registry would signify. The Council discussed and voted to recommend the APA sign the registry. This was sent to the JRC as an action item.

5. The Council has been asked by the JRC to provide a listing of pros and cons to removing the black box warning from antidepressants. Prior to doing so, the Council wishes to enlist the input from two prominent researchers in this area (Robert Gibbons, Ph.D., and J. John Mann, M.D.) to ensure their recommendations are informed by data. A subset of members of the Council has been appointed to work closely with Drs. Gibbons and Mann to develop a brief white paper in response to the JRC's request.

Item 2014A2 9.A
All Areas: Primary- Area 3, Secondary- Area 4
Assembly
November 7-9, 2014

Report of the Ethics Committee

Currently, Section 9 "*A physician shall support access to medical care for all people"* of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" does not include any annotations. The Ethics Committee developed proposed annotations to this Section which it presented at the May 2014 Assembly meeting. The Assembly requested certain changes to the annotations which are attached to this report in redline and final form.

Actions:

The Ethics Committee asks:

1. **Will the Assembly approve the proposed annotations to Section 9 of "The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry?"**

REDRAFT ADDRESSING ASSEMBLY COMMENTS

9. "*A physician shall support access to medical care for all people."*

1. Psychiatrists should strive to support the same access to care for patients who are stigmatized or marginalized in society as for any other patient. This support should not be compromised by a psychiatrist's personal beliefs, including religious, moral and political convictions.

2. Psychiatrists should strive to advocate for psychiatric care to be available to all populations regardless of financial status, citizenship, incarceration or other institutionalization.

3. Compromised cognition and decision-making capacity in patients should not restrict access to care, although it may require a more complex consent process. To preserve access to care, psychiatrists should consider strategies such as discussing psychiatric advance directives with patients who are at high risk for compromised cognition.

4. Psychiatrists should avoid strategies which are designed solely to reduce costs of psychiatric care unless those strategies provide reasonable access to competent care for vulnerable populations.

5. A psychiatrist should strive to ensure equitable distribution of psychiatric care. Participation in activities that increase access to care for patients who cannot otherwise afford care is consistent with this principle.

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5. A psychiatrist should ~~shall~~ strive to ensure equitable distribution of psychiatric care. Participation in activities that ~~as pro-bono work~~ increase~~s~~ access to care for patients who cannot otherwise afford care is consistent with this principle. ~~encouraged~~.

October 6, 2014

To: APA Assembly

From: Carolyn B. Robinowitz, MD, Sr. Delegate, APA AMA Delegation, and Chair, AMA Section Council on Psychiatry

Re: Update on the Activities of the APA AMA Delegation/AMA Section Council on Psychiatry

Thank you for the opportunity to update you on the activities of the APA AMA Delegation and the Section Council on Psychiatry. As this report is being written, we are preparing for the 2014 Interim Meeting of the AMA House of Delegates with activities scheduled November 6 through 11. The focus of this meeting is on advocacy both for the profession and for patients. Additionally, the Section Council on Psychiatry will be preparing for the re-election of psychiatrist Patrice Harris, MD to the AMA Board of Trustees for a second term. Dr. Harris was elected Secretary by her colleagues on the Board of Trustees at the close of the June 2014 Annual Meeting. The following is a brief summary of the significant activities of the delegation since our last report to the Assembly in May 2014.

Members of the AMA Section Council on Psychiatry attending the APA Annual Meeting in New York met informally on Monday, May 5. The agenda included a review of the schedule and various activities occurring during the June HOD meeting in Chicago, a review and discussion of the Section Council resolutions and a discussion of psychiatrists' candidacy for elective office.

Our focus continues to be on activities that support our long range plan to ensure that Psychiatry has a well-respected and effective voice in the House of Medicine, and that AMA policies and programs are informed by and reflect important priorities for our profession and our patients. To that end, our Delegation focuses on two areas: the election and appointment of psychiatrists to positions within the AMA (e.g., councils and committees) in which policies and programs are developed and implemented; and the preparation of specific resolutions and other action proposals for the AMA's review and adoption. Since much of the implementation of resolutions and action proposals becomes the responsibility of the elected and appointed councils and committees, these two areas are closely interrelated. Our successful strategy for achieving these goals has been the development of a highly visible and well-respected Section Council whose members are actively involved in organized medicine through their state medical societies, academic medical centers, clinical care systems, and of course, the APA and psychiatric sub specialties. We interact closely with the Caucus of Psychiatrists representing their state medical societies at AMA, and that has become a very fruitful partnership both to expand psychiatric leadership throughout AMA, and to work collaboratively with other medical specialty organizations on topics of mutual interest and concern.

Elections

The Section Council supported the following psychiatrists in successful bids for elective office in 2014:

- Barbara Schneidman, MD (APA alternate delegate), elected to a one-year position on the Senior Physicians Governing Council
- Jerry Halverson, MD (APA delegate), elected member-at-large of the Service and Specialty Society (SSS) Governing Council
- Dionne Hart, MD, (Minority Affairs Section rep) elected as a delegate to the AMA House of Delegates from the Minority Affairs Section
- Frank Clark, MD (Minority Affairs Section rep), elected as the Young Physician Section (YPS) Representative on the Governing Council of the Minority Affairs Section (position previously held by Dionne Hart).
- Michael Miller, MD, (Wisconsin delegate), elected as a member of the Council on Science and Public Health

These individuals join 8 other psychiatrists, including AMA BOT member Patrice Harris, MD, who hold appointed or elected leadership positions within the AMA governance structure. Dr. Harris announced her bid for re-election to the AMA Board of Trustees at the close of the June HOD meeting. The AMA Section Council's Candidate Selection Committee continues its work to identify candidates for office both from within the AMA Section Council on Psychiatry and the AMA Psychiatric Caucus.

Of note, this was the final meeting for Jeremy Lazarus, MD who rotates off the AMA BOT following his term as Immediate Past-President. During his terms as President-Elect, President and Immediate Past-President, Jeremy brought additional attention to issues of importance to psychiatry and public health.

As part of our commitment to continuous quality improvement, we are well into planning for the Interim Meeting (November 2014); our highest priority is the re-election of Dr. Patrice Harris to the Board of Trustees for a second term and what strategic as well as tactical activities are needed not only to ensure her re-election in June 2015, but to maintain our overall effectiveness in the HOD. To that end, we are focusing on strengthened communication with and support of the psychiatrists who are active in the councils and committees, various Sections (e.g., Minorities, IMG, Medical Schools, Organized Medical Staff) as well as State Delegations. We also are considering possible topics for submitting advocacy-based resolutions. Finally, we continue to consider transitions in the Delegation's membership, noting the balance between the lengthy time it takes to be recognized (and trusted) at AMA, and the need to bring more younger members into the Delegation. A number of our older and longer term Delegates will be retiring. The two "Young" (early career) psychiatrists representing APA will be "aging out" of that category, and we anticipate their appointment as alternate delegates for APA. Additionally, we are seeking new members for the Delegation who have had experience with AMA as trainees—medical students/residents and/or in their local and state medical societies who will be mentored for future leadership roles.

AMA House of Delegates Meeting, June 7 -11, 2014

The following delegates and alternate delegates attended the June, 2014 Annual Meeting of the AMA House of Delegates on behalf of the APA: Carolyn Robinowitz, MD (senior delegate and chair of the Section Council on Psychiatry), Jeffrey Akaka, MD, Kenneth Certa, MD, Jerry Halverson, MD, Jack McIntyre, MD, Harsh Trivedi, MD, Paul Wick, MD, delegates; and alternate delegates Renee Binder, MD (President-Elect), Donald Brada, MD, Saul Levin, MD, MPA (CEO, Medical Director), Glenn Martin, MD (Speaker-Elect), Barbara Schneidman, MD, John Wernert, MD, Ray Hsiao, MD, Paul O'Leary, MD, Simon Faynboym, MD, and Sean Moran, MD. The American Academy of Child and Adolescent Psychiatry (AACAP) was represented by Louis

Kraus, MD, David Fassler, MD, Sharon Hirsch, MD, Anita Chu, MD and AACAP President Paramjit Joshi, MD. The American Academy of Psychiatry and the Law (AAPL) was represented by Barry Wall, MD, Ryan Hall, MD, and Jennifer Piel, MD. The American Academy of Geriatric Psychiatry (AAGP) was represented by Allan Anderson, MD. The Section Council on Psychiatry was assisted in its efforts by staff including Erin Connors, Jon Fanning, Kristin Kroeger Ptakowski, Deana McRae, Mark Moran, and Becky Yowell (APA staff), Heidi Fordi, and Ronald Szabat (AACAP staff).

In addition to the routine monitoring of reports and resolutions moving forward at the AMA House of Delegates meetings, the AMA Section Council on Psychiatry, which includes APA, AACAP, and AAPL, co-sponsored four resolutions (see Attachment 1) summarized below.

- Network adequacy (as recommended by the Joint Reference Committee): The Section Council on Psychiatry submitted *Resolution 113, Network Adequacy*, which asked the AMA to study the issue of network adequacy, advocate for adherence to existing statutory and regulatory measures, work with state medical societies to advocate for the same in states where measures do not currently exist, and support the right of physicians and patients to seek appropriate recourse when and if harmed by inadequate networks. The resolution was widely supported by other state and specialty groups, with all expressing concerns about payer networks. The Council on Medical Service welcomed the referral, noting this was an issue they had been planning to review.

- Assisting Medical Students Applying for Away Rotations: The HOD adopted the Psychiatry Section Council-sponsored *Resolution 318, Assisting Medical Students Applying for Away Rotations,* which asked AMA to encourage appropriate stakeholders to develop, promulgate, and adopt a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.

- Evaluating and Reducing the Risk of Youth Sports Concussions: *Resolution 410, Evaluating and Reducing the Risk of Youth Sports Concussions* asked the AMA to charge the Council on Science and Public Health to prepare a report summarizing the existing data on the risk of concussion in youth sports. It also asked the Council to develop specific recommendations designed to help physicians work toward reducing the risk of concussions and asked AMA to work with all appropriate state and specialty societies to enhance access to appropriate continuing education for physicians emphasizing evolving literature on the diagnosis and management of concussion, and to work with all appropriate state and specialty societies to help educate the general public about the established risks of concussion associated with participation in youth sports, as well as theoretical risks under study. This resolution was combined with two others focused on concussions. Testimony was supportive and included suggestions to include recommendations for both return-to-play and return-to-classroom authorizations, as well as information on the additive effect of subconcussive injuries. The HOD and the Council on Science and Public Health supported the referral.

- Integrating Physical and Behavioral Health: The AMA Section Council on Psychiatry co-sponsored this resolution with Colorado at the suggestion of Jeremy Lazarus, MD. *Resolution 723 Integrating Physical and Behavioral Healthcare,* asked the AMA to study issues related to integrating physical and behavioral health care. APA delegates submitted relevant background materials including the recently released Milliman

Report. We also expressed our interest in working with the Council on Medical Services on the report. The resolution had solid support and was adopted by the AMA HOD.

More information on other actions of the House is provided later in this report.

Speeches

In his address to the AMA HOD Dr. James Madara, MD, CEO and EVP, noted that the three key AMA initiatives he outlined in November 2013 - improving health outcomes, accelerating change in medical education, and shaping healthcare delivery and payment models - were moving forward. He reported on pilot projects focused on preventing type 2 diabetes and on improving hypertension control to prevent cardiovascular disease. He also provided an update on the AMA's effort to accelerate change in medical education, noting that the eleven medical schools chosen to receive one million dollar grants for projects aimed at transforming medical education have met and are working to implement innovative curricula and educational experiences to better prepare the next generation of physicians. These new curricula focus on key areas and disciplines that are important cornerstones for the future of care delivery and include, for example: chronic health management, population health, team-based care and improved utilization of health technologies. The remainder of Dr. Madara's comments concentrated on the work the AMA has done to enhance physician satisfaction and practice sustainability, and the goal of the AMA to unify and leverage the voice of physicians. He commented, "First, we must understand and respond to the needs of physicians who today are immersed in often chaotic environments. Doing so will help unify our physician community. Second, we must harness our collective voice – by striving for more consistency and thus more effectiveness." He noted the recent Rand study which identified factors that lead to physician satisfaction: http://www.rand.org/pubs/research_reports/RR439.html (AMA logon required). Results of the study as well as on going work to understand the needs of AMA members in light of healthcare delivery reforms will inform AMA's advocacy efforts. The goal is to continue to speak with one voice as much as possible to ensure physicians are adequately and appropriately represented.

President Ardis D. Hoven, MD, an internist and infectious disease specialist, highlighted the AMA's successes since her initial address to the group in November, 2013, including securing delays in meaningful use requirements, and awarding innovation grants. She then spoke of the SGR battle, calling it both a success and a failure: a success in that it united physicians, resulting in an unprecedented 600 medical groups signing on in support of the SGR repeal legislation; and a failure in that Congress failed to act despite the overwhelming support for repeal.

Dr. Hoven offered three solutions to achieving the AMA's advocacy goals in a difficult political environment:

1. Hold politicians accountable – they failed to act (SGR Repeal). "We need to use our votes. We need to remind our elected officials that the nation's physicians and the nation's patients matter."
2. Educate – educate others as to all that AMA is doing. "The more people who know about the AMA – who we are, what we are, and what we're fighting for – the stronger we will be….when we educate people, we empower them. And when we empower them, we can make a difference."
3. Be leaders in our communities. "At the end of the day, health care is local. And if we want to improve health care in this country, it starts at home."

In closing, Dr. Hoven said, “A year ago I stood before you and said that organized medicine stood at a crossroads. Ahead of us were two paths. One was the path of glorifying the past, lamenting the changing health care environment, and thwarting any attempt to move forward. The other was the path of action, of collaborating, innovating, and leading the drive toward productive change. I am happy to say the AMA took the second path.”

Continuing the theme in his inaugural address, incoming AMA President Dr. Robert M. Wah, a reproductive endocrinologist and OB-GYN, emphasized both the importance of tradition and the courage to embrace change. A retired Navy officer, he compared being a physician to life in the military. Both groups must prepare for the unexpected while being mindful of strong professional traditions. He encouraged physicians to embrace change and help move things forward, developing new traditions to provide better care for all patients.

Communication
News from the AMA Annual Meeting was shared with APA membership during the meeting via Psych News Alerts and social media (Twitter and Facebook).

- Psych News Alerts and Blogs: Psych News posted 6 blogs and 6 alerts on activities at the AMA HOD meeting. July editions of Psych News will feature several articles on the activity at the June AMA HOD meeting.
- Facebook: 18 items along with 22 pictures and 6 videos were posted to Facebook which generated over 37,000 views with 161 “likes.”
- Twitter: There were 36 tweets along with 31 pictures posted to Twitter with 105 re-tweets (including AMA and AACAP) and 76 “likes.”

Video interviews of Dr. Levin http://psychiatry.org/advocacy--newsroom/newsroom/presidents-video-messages and Dr. Harris http://www.psychiatry.org/advocacy--newsroom/newsroom/video-news were posted on the APA website.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-14)

Introduced by: American Psychiatric Association,
American Academy of Child and Adolescent Psychiatry,
American Academy of Psychiatry and the Law

Subject: Network Adequacy

Referred to: Reference Committee A

Whereas, the stated goals of healthcare reform include increasing access to care, and

Whereas, a recent study by McKinsey & Company found that approximately two-thirds of health plans effectively decrease access by utilizing narrow or ultra-narrow hospital networks, and

Whereas, some insurers are further limiting access to providers by significantly narrowing or tiering provider networks, and

Whereas, inadequate networks force patients to incur higher out-of-pocket costs if they access services outside the narrow networks, and

Whereas, physicians have been forced to take legal action against insurers for being excluded from plan networks, and

Whereas, this has led several states to intervene by preventing insurers from selling narrow network plans, therefore be it

RESOLVED, that our AMA study the issue of network adequacy, including the impact on access to and quality of care, with a report back by I14, (Directive to Take Action) and be it further

RESOLVED, that our AMA advocate for adherence to existing statutory and regulatory measures designed to ensure network adequacy, and work with state medical societies to advocate for the same in states where measures do not currently exist, (Directive to Take Action) and be it further

RESOLVED, that our AMA support the right of patients and physicians to seek appropriate recourse when and if harmed by inadequate networks. (Directive to Take Action)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-14)

Introduced by: American Psychiatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Psychiatry and the Law

Subject: Assisting Medical Students Applying for Away Rotations

Referred to: Reference Committee C

Whereas, it is useful for medical students to do rotations at teaching hospitals other than their home institution;

Whereas, host hospitals require verifications to ensure that students are in good standing and meet health requirements;

Whereas, the Visiting Student Application Service (VSAS) of the American Association of Medical Colleges satisfies most of these requirements;

Whereas, requirements for immunization history have become increasingly complicated, and differ between hospitals, limiting the use of the VSAS for this purpose;

Whereas, medical students and home institutions spend considerable time and money getting immunization documentation forms completed, often repeating the same information with slight variations;

Whereas, the VSAS has so far been unable to develop an agreed-upon, uniform immunization verification form for use in their program; therefore be it resolved:

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges and other stakeholders to develop, promulgate, and have adopted a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions. (New HOD policy)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-14)

Introduced by: American Academy of Child and Adolescent Psychiatry
American Psychiatric Association
American Academy of Psychiatry and the Law
American Academy of Family Physicians
American Academy of Neurology
American College of Preventive Medicine

Subject: Evaluating and Reducing the Risk of Youth Sports Concussions

Referred to: Reference Committee D

Whereas, it is estimated that over 3.8 million children, adolescents and adults experience at least one concussion in any given year as a result of participation in youth sports and recreation; and

Whereas, football, soccer, basketball, ice hockey, lacrosse and equestrian activities carry the highest risk of concussion; and

Whereas, the risk of concussion from girls soccer approaches that of boys football; and

Whereas, research suggests that multiple episodes of minor head trauma may have a cumulative effect; and

Whereas, while many young people recover fully from a concussion, a significant number experience serious and lasting consequences including headache, difficulty concentrating, impaired memory, irritability, photophobia, sleep disturbance and depression; and

Whereas, such consequences can interfere with the ability to function at school, at work, at home or with friends; and

Whereas, research suggests that most parents, teachers and coaches underestimate the risk and potential consequences of concussion as a result of participation in youth sports; therefore, be it

RESOLVED, that our AMA ask our Council on Science and Public Health to prepare a report summarizing the existing data on the risk of concussion in youth sports (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the Council on Science and Public Health to develop specific recommendations to aid physicians in efforts aimed at reducing the risk of concussion as a result of participation in youth sports (Directive to Take Action), and be it further

RESOLVED, that our AMA work with all appropriate state and specialty societies to enhance access to appropriate continuing education for physicians emphasizing evolving literature on the diagnosis and management of concussion resulting from participation in youth sports (Directive to Take Action); and be it further

RESOLVED, that our AMA work with all appropriate state and specialty societies to help educate the general public about the established risks of concussion associated with participation in youth sports, as well as theoretical risks under study (Directive to Take Action).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 723
(A-14)

Introduced by: Colorado
American Psychiatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Psychiatry and the Law

Subject: Integrating Physical and Behavioral Healthcare

Referred to: Reference Committee G

Whereas, Many parts of our health care system are integrating in various ways though Patient

Centered Medical Homes, Accountable Care Organizations and other models of integration; and

Whereas, There have been previously studied models of successful integration of physical and behavioral healthcare; and

Whereas, There are pilot and emerging models and studies of integration of physical and behavioral healthcare; and

Whereas, Our AMA has previously studied interprofessional teams but not specifically integration of physical and behavioral healthcare; and

Whereas, It would be beneficial for our AMA to consolidate all of the existing information for both policy development and tools for physicians and healthcare systems to utilize as they consider such integration; therefore be it

RESOLVED, That our American Medical Association, with interested specialty and state societies, study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral healthcare including any recommendations for further study, implementation of models of physical and behavioral healthcare integration, and any other tools or policies that would benefit our patients and our healthcare system by the integration of physical and behavioral healthcare. (Directive to Take Action)

Actions

The following are just a few of the actions taken by the HOD at the 2014 Annual meeting. For all of the AMA HOD Annual Meeting highlights including speeches go to: http://www.ama-assn.org/sub/meeting/index.html (some areas require a username and password).

Cmte	Item	Title / Recommendations or Resolves	
Con	BOT 26	Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients (Resolution 5-A-13) The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 5-A-13 and the remainder of this report be filed: 1. That our AMA Policy H-65.967 be reaffirmed. 2. That our AMA support elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and support modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates. 3. That our AMA support that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.	Adopted
Con	CEJA 01	Physician Exercise of Conscience The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed: Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life. Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities. Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician. In following conscience, physicians should: a. Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients. b. Prospectively notify patients about those services the physician declines to offer for reasons of deeply held, well-	Referred

Cmte	Item	Title / Recommendations or Resolves	
		considered personal belief that a patient might otherwise reasonably expect the physician to provide. c. Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust. d. Be mindful of the burden their actions may place on fellow professionals. e. Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects. f. In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services. g. Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethical guidelines.	
Con	Res 007	Establish a Moratorium on the Medicalization of Capital Punishment Resolved, That our American Medical Association request that all states with active capital punishment statutes enforce a moratorium on all future executions until the legion problems associated with the medicalization of the death penalty be resolved or until such time as a non-medical method of capital punishment that is not cruel or unusual is adopted.	Reaffirmed existing policy
A	CMS 02	Extending Medicaid Primary Care Payment Increases to Include Obstetricians and Gynecologists (Resolution 116-A-13) The Council on Medical Service recommends that the following be adopted in lieu of Resolution 116-A-13 and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-385.959, which recognizes obstetricians and gynecologists as capable of providing both primary care and consultative care. 2. That our AMA advocate that the Affordable Care Act's (ACA's) Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as a qualifying specialty. 3. That our AMA reaffirm Policy H-290.976[2], which advocates that Medicaid payments to physicians must be at a minimum 100 percent of Medicare payment rates. 4. That our AMA advocate for the ACA's Medicaid primary care payment increase to continue past 2014.	Referred
A	CMS 07	Coverage of and Payment for Telemedicine The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That American Medical Association (AMA) policy be that telemedicine services should be covered and paid for if they abide by the following principles: a) A valid patient-physician relationship must be established before the provision of telemedicine services, through at minimum a face-to-face examination provided in person or virtually using real-time audio and video technology, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine. b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements. c) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services. d) The delivery of telemedicine services must be consistent with state scope of practice laws. e) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit. f) The standards and scope of telemedicine services should be consistent with related in-person services. g) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to	Adopted

Cmte	Item	Title / Recommendations or Resolves	
		ensure patient safety, quality of care and positive health outcomes. h) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine. i) The patient's medical history must be collected as part of the provision of any telemedicine service. j) The provision of telemedicine services must be properly documented, which should include providing a visit summary to the patient and a copy of the medical record to any identified primary and/or referring physician, in order to facilitate continuity of care. k) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services. 2. That AMA policy be that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information. 3. That our AMA encourage additional research to develop a stronger evidence base for telemedicine. 4. That our AMA support additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine. 5. That our AMA support demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models. 6. That our AMA encourage physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service. 7. That our AMA encourage national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. 8. That our AMA reaffirm Policies H-480.974, H-480.968 and H-480.969, which encourage national medical specialty societies to develop appropriate and comprehensive practice parameters, standards and guidelines to address the clinical and technological aspects of telemedicine.	
A	Res 118	Facilitating State Licensure for Telemedicine Services RESOLVED, That our American Medical Association study the issues of telemedicine and telehealth services, as well as issues of state licensure, to aid in the development of national standards to facilitate state licensure for telemedicine services.	Adopted
	Res135	Prescription Drug Plans and Patient Access RESOLVED, That our American Medical Association explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.	Adopted
B	BOT 22	Restricting Prescriptions to Medicare Beneficiaries (Resolution 212-A-13 and Resolution 230-A-13) The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolutions 212-A-13 and 230-A-13 and the remainder of the report filed: That our AMA work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and reduce the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs.	Adopted

Cmte	Item	Title / Recommendations or Resolves	
		That our AMA support federal legislation to eliminate the burden of provisions in the PPACA that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs.	
B	BOT 23	Non-Physician Practitioners Certifying Medicare Patients' Need for Therapeutic Shoes and Inserts (Resolution 213-I-12) The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 213-I-12 and that the remainder of the report be filed. Our American Medical Association supports authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts. (New AMA Policy)	
B	Res 204	Medicare Claims Data Release RESOLVED, That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; and be it further RESOLVED, That our AMA engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs.	Adopted substitute resolution
B	Res 209	Improvement of Electronic Prescription Software RESOLVED, That our American Medical Association advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner ; and be it further RESOLVED, That our AMA work with the national pharmacy bodies and other appropriate entities which set standards for the software that allows electronic transmission of prescriptions to encourage the addition of a feature to that software that would allow the transmission of short messages regarding prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using.	Adopted
B	Res 210	Medical Textbooks and Peer-Reviewed Journal Reprints per the Sunshine Act RESOLVED, That our American Medical Association work, first, with the Centers for Medicare & Medicaid Services (CMS) to administratively expand the Sunshine Act exception that covers "…educational materials that directly benefit patients or are intended for patient use" to include medical textbooks and peer-reviewed journal articles provided to physicians; {given that such resources are, in fact, 'continuing educational materials' that assist physicians to become better informed about their clinical decision-making and thus "…directly benefit patients..."} ; and be it further RESOLVED, That if no redress is obtained from CMS, our AMA will work with the Congress to legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include medical textbooks and peer-reviewed journal articles provided to physicians.	Adopted
B	Res 215	Reducing Gun Violence RESOLVED, That our American Medical Association support Congressional passage of legislation requiring criminal background checks for all gun sales, public and private.	Referred
	Res 230	Development and Promotion of Use of Single National Prescription Drug Monitoring Program RESOLVED, That our American Medical Association encourage the creation of one national prescription drug monitoring program (PDMP) database of controlled substances for physicians to detect and monitor prescription drug abuse; and be it further RESOLVED, That our AMA oppose requirements that physicians must consult prescription drug monitoring	Referred

Cmte	Item	Title / Recommendations or Resolves	
		programs before prescribing medications; and be it further RESOLVED, That a national PDMP not add undue burden onto patients who need chronic controlled substance treatments or the physicians that prescribe them.	
	Res 231	Ensuring Access to Care for our Veterans RESOLVED, That our American Medical Association encourage all physicians to participate, when needed, in the health care of veterans; and be it further RESOLVED, That our American Medical Association support providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner; and be it further RESOLVED, That our AMA advocate strongly that 1) the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion, 2) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans, and 3) that the AMA issue a press release regarding these actions by June 12, 2014; and be it further RESOLVED, That our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.	Adopted
C	CME 03	Competency-based Medical Education Across the Continuum of Education and Practice The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of the report be filed. 1. That our American Medical Association Council on Medical Education continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. 2. That our AMA Council on Medical Education work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, pedagogy and assessment implementation.	Adopted
C	CME 06	Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure The Council on Medical Education recommends that the following recommendations be adopted, and that the remainder of the report be filed. 1. That our American Medical Association Council on Medical Education continue to review published literature and emerging data as part of the Council's ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. 2. That our AMA continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians' practices, including, but not limited to physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access. 3. That our AMA work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 4. That our AMA work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician's decision to retire and have a direct impact on the US physician workforce.	Adopted

Cmte	Item	Title / Recommendations or Resolves	
C	Res 306	Endorsing Standardized Core Curricula on Disability Education in Medical School RESOLVED, That our American Medical Association continue to work with medical schools and their accrediting/licensing bodies to require disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.	Adopted
C	Res 308	Competency and the Aging Physician RESOLVED, That our American Medical Association study the issue of competency in aging physicians and develop guidelines, if the study supports such a need, for appropriate mechanisms of assessment to assure that America's physicians remain able to best care for their patients ; and be it further RESOLVED, That there be a report back to the House of Delegates.	Adopted
C	Res 310	Physician Reentry and Licensure RESOLVED, That our AMA encourage each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a nondiscriminatory category of licensure for physicians during their reentry process.	Adopted as amended
D	Res 416	Gun Violence Prevention as a Continuing Medical Education Topic RESOLVED, That our American Medical Association encourage inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.	Adopted
D	Res 420	Support FDA Regulation of All Tobacco Products RESOLVED, That our American Medical Association support the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products ; and be if further RESOLVED, That our AMA strongly oppose any FDA rule that exempts any tobacco product, including certain cigars, from FDA regulation ; and be if further RESOLVED, That our AMA join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.	Adopted
E	Res 501	H-145.977 Use of Tasers Conducted Electrical Devices by Law Enforcement Agencies Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized approach to protocol developed with the input of the medical community for the medical evaluation, management and postexposure monitoring of subjects exposed to CEDsDevelopment of a Standardized Post-Conducted Electrical	Adopted
	POLICY H-495.973 AMENDED IN LIEU OF RES 511, 518,	H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products Our AMA ~~will urge~~ supports: (1) the US Food and Drug Administration's (FDA) proposed rule ~~to immediately~~ that would implement ~~the~~ its deeming authority ~~written into the FDA tobacco law to~~ allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other nonpharmaceutical tobacco/nicotine products not currently covered by the FDA tobacco law.; (2) legislation and/or regulation addressing the minimum purchase age, locations of permissible use, the use of secure, child- and	Adopted amended HOD policy

Cmte	Item	Title / Recommendations or Resolves	
	519 AND 521	tamper-proof packaging and design, advertising and promotion activities, and sponsorship of e-cigarettes and all other non-pharmaceutical tobacco/nicotine products; (3) transparency and disclosure concerning the design, content of, and emissions from e-cigarettes and all other non-pharmaceutical tobacco/nicotine products; (4) restrictions on the use of characterizing flavors that may enhance the appeal of such products to minors, and the development of strategies to prevent marketing to and use of e-cigarettes and all other non-pharmaceutical tobacco/nicotine products by minors; and (5) the prohibition of claims of reduced risk and/or the marketing of e-cigarettes as tobacco cessation tools until such time that credible evidence is developed that supports such claims.	
E	Res 511	Regulation of Electronic Nicotine Delivery Systems RESOLVED, That our American Medical Association support labeling and regulating Electronic Nicotine Delivery Systems (ENDS) as tobacco products and drug delivery devices ; and be it further RESOLVED, That our AMA support legislation that addresses the minimum purchasing age, locations of permissible use, advertising, promotion, and sponsorship of Electronic Nicotine Delivery Systems (ENDS) in a manner similar to those of tobacco products ; and be it further RESOLVED, That our AMA support transparency and disclosure concerning the design, content and emissions of Electronic Nicotine Delivery Systems (ENDS) ; and be it further RESOLVED, That our AMA support secure, child-proof, tamper-proof packaging and design of Electronic Nicotine Delivery Systems (ENDS) ; and be it further RESOLVED, That our AMA support enhanced labeling that warns of the potential consequences of Electronic Nicotine Delivery Systems (ENDS) use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS ; and be it further RESOLVED, That our AMA support basic, clinical, and epidemiological research concerning Electronic Nicotine Delivery Systems (ENDS).	
E	Res 518	Treating E-Cigarettes as Tobacco Products RESOLVED, That our American Medical Association support the concept that e-cigarettes be considered tobacco products with all of the legal and policy restrictions with smoking in post-acute and long-term care facilities.	
E	Res 519	Sales and Marketing of E-Cigarettes to Minors RESOLVED, That our American Medical Association opposes the marketing, sales, and use of e-cigarettes and other nicotine delivery products to minors ; and be it further RESOLVED, That our AMA work with federal and state lawmakers and officials to develop strategies to prevent marketing, sales, and use of e-cigarettes and other nicotine delivery products to minors.	
E	Res 521	E-Cigarettes to be Treated the Same as Tobacco Products RESOLVED, That our American Medical Association seek federal legislation that would place “e-cigarettes” and all nicotine delivery devices under the purview of the US Food and Drug Administration.	
E	Res 512	Risk Evaluation and Mitigation Strategies (REMS) for Methadone RESOLVED, That our American Medical Association urge the US Food and Drug Administration to require an “individual” Risk Evaluation and Mitigation Strategy (REMS) for the clinical use of methadone in pain management) ; and be it further RESOLVED, That our AMA advocate that the manufacturer deemed responsible for developing a methadone-specific REMS consult experts in pain medicine in designing the program.	Referred

Cmte	Item	Title / Recommendations or Resolves	
F	BOT 06	AMA 2015 Dues 2015 Membership Year The Board of Trustees recommends no change to the dues levels for 2015, that the following be adopted and that the remainder of this report be filed: Regular Members $420; Physicians in Their Second Year of Practice $315; Physicians in Military Service $280; Physicians in Their First Year of Practice $210; Semi-Retired Physicians $210;Fully Retired Physicians $84; Physicians in Residency Training $45; Medical Students $20	Adopted
F	Res 608	Onerous Restrictions on Travel of Government Scientists RESOLVED, That our American Medical Association take legislative or regulatory action to achieve easing of travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures, to include a simplified approval process.	Adopted
F	Res 609	AMA Participation in Reducing Medical Student Debt RESOLVED, That our American Medical Association explore the feasibility of the development of an affinity program in which student members of the AMA could obtain loans from one or multiple national banks or other financial intermediaries. Membership in the AMA would be required during the life of the loan (typically 10 years or more following medical school) ; and be it further RESOLVED, That such activities or program would neither result in the AMA becoming subject to regulation as a financial institution nor impair the AMA's ability to continue to be treated as a not-for-profit entity ; and be it further RESOLVED, That our AMA HOD receive a progress report on these discussions by the 2014 Interim Meeting.	Adopted
G	BOT 12	Mental Health Services for School-Aged Children (Resolution 708-A-13) The Board of Trustees recommends that the following statement be adopted in lieu of Resolution 708-A-13 and the remainder of the report filed. That our American Medical Association recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.	Adopted
G	CMS 06	Development of Models/Guidelines for Medical Health Care Teams That our AMA support the following elements that should be considered when planning a team-based care model according to the needs of each physician practice: Patient-Centered: a. The patient is an integral member of the team. a. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient. b. Patient and family-centered care is prioritized by the team and approved by the physician team leader. c. Team members are expected to adhere to agreed upon practice protocols. d. Improving health outcomes is emphasized by focusing on health as well as medical care. e. Patients' access to the team or coverage as designated by the physician-led team is available twenty-four hours a day, seven days a week. f. Safety protocols are developed and followed by all team members. Teamwork: h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final	Adopted as amended

Cmte	Item	Title / Recommendations or Resolves	
		decisions about the composition of the team. i. All practitioners commit to working in a team-based care model. j. The number and variety of practitioners reflects the needs of the practice. k. Practitioners are trained according to their unique function in the team. l. Interdependence among team members is expected and relied upon. m. Communication about patient care between team members is a routine practice. n. Team members complete tasks according to agreed upon protocols as directed by the physician leader. Clinical Roles and Responsibilities: o. Physician leaders are focused on individualized patient care and the development of treatment plans. p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader. q. Care coordination and case management are integral to the team's practice. r. Population management monitors the cost and use of care, and includes registry development for most medical conditions. Practice Management: s. Electronic medical records are used to the fullest capacity. t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments. u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling. v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.	
G	CMS 08	Clinical Data Registries The Council recommends that the following be adopted, and that the remainder of the report filed: 1. That our American Medical Association (AMA) encourage multi-stakeholder efforts to develop clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs. 2. That our AMA encourage national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries. 3. That our AMA support flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients: a) Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data. b) Data elements, risk-adjustment models and measures used in the registry should be fully transparent. c) Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level. d) Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner. e) Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry	Adopted

Cmte	Item	Title / Recommendations or Resolves	
		in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry. 4. That our AMA encourage physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices. 5. That our AMA will continue to advocate for and support initiatives that minimize the financial burden to physician practices of participating in clinical data registries. 6. That our AMA support that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles: a) Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services. b) Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information. c) Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data. d) Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients. e) When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.	
G	Res 708	Protecting Physicians Who are Participating in Physician Health Programs from Arbitrary Delisting by Insurance Carriers Resolved, That American Medical Association Policy H-285.991, Qualifications and Credentialing of Physicians in Managed Care (1) (d), be amended by addition as follows: "(d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine <u>(required participation in a Physician Health Program in and of itself shall not count as a limit on the ability to practice medicine)</u>. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician's case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was received to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing." (Modify Current HOD Policy)	Adopted as amended

Item 2014A2 11.A
Assembly
November 7-9, 2014

Area I Report

The Area I Council met at the May Assembly meeting in New York, NY, and on September 20, 2014, in Portland, Maine. Recent concerns of the Council have included the following:

Communication between the DB/State Association/Provincial Association Reps and their constituent members, and within the APA at other levels, continues to be a focus of attention of the Area I Council. The AEC Rep-member communication Ad Hoc Work Group, chaired by Joe Napoli, MD, recommended distribution of centrally prepared Assembly meeting reports with DB Rep personalized information added, utilizing a template that Reps could access and customize. The Area I Council remains committed to making communication between Reps and general members efficient and user-friendly and will implement as many of the Work Group suggestions as feasible at the November meeting.

Dr Boyer and Dr Martin met with the Area I Council at the September meeting to further the dialog begun with Dr Young's AEC Communications Initiative. Other suggestions discussed included: designation of a dedicated ombudsman/triage expert at the APA central office who could assist Reps in addressing member concerns; "Action Paper 101" sessions at DB meetings to help members learn to translate concerns to action; technical assistance for improved DB/Area websites and initiation of services such as MailChimp or Constant Contact; creation of a "how to get involved with the APA" section of the psychiatry.org website, similar to the Grassroots section of aafp.org; addition of more media alternatives to the organization website. Dr Weker will be bringing a video camera to the November Assembly and creating a short video for his DB. Council members expressed support for requiring accountability re: Rep-member communication, but only if Reps are also helped to succeed in this, such as with the tools that were recommended by the Ad Hoc Work Group.

The strategic planning process of the APA, including strengthening the "state voice" and membership recruitment, in service of the larger goals of the profession, is of crucial importance. The organization of the Assembly will be part of that process. At the September meeting, Dr Eyler summarized a few points from the AEC discussion on that topic: (a) the concept that the Assembly is about the right size currently; (b) the sense of the smaller DBs that they need the "deeper bench" that having the Rep and Dep Rep (or 2nd Rep) provide; (c) the information that the AAOLs are not all equal in size and resources; some have difficulty sending a Rep without funding from APA, others could share the expense or offer a reciprocal courtesy to APA. Members expressed support for the need for adequate representation of the smaller DBs (as above) with the counterbalance of the option for vote by strength.

Dr Oquendo's presentation of the draft report of the MUR work group at the May Area I Council meeting was much appreciated and discussed. The Area I Council is enriched by MUR member participation, as well as diversity in (bi-national) political representation. It was noted that women psychiatrists have made quite a bit of progress within the organization, but that women remain

significantly underrepresented in leadership positions. For example, all 14 of the current AEC Area Reps and Dep Reps are male, though one transitioned gender of record after being elected. The Area I Council has benefitted from close relationships with the leadership of the Women's Caucus, AGLP and OMNA (now DDHE) for many years, including seasoned advice to members facing problems related to discrimination and diversity concerns. In May, the Quebec Rep and Dep Rep made the Council aware of proposed legislation that would have been extremely burdensome to members of religious minorities in the province, which fortunately was subsequently defeated.

Parity, access to care, "broken systems of care," and the sense of erosion of the profession of psychiatry remain major concerns of the Area I Council. Dr Binder's visit to the May Council meeting to ask about most pressing concerns was timely. Members responded that a central theme should be "Taking Back Psychiatry," as more and more, psychiatrists are not even "at the table" in the decision-making process regarding treatment planning and resource allocation. ACOs bring some opportunities and many challenges. Ms Sanders' information regarding the rapidly evolving political aspects of contracting, reporting requirements, coding and remuneration, etc have been extremely helpful.

Rhode Island psychiatrists are struggling with problematic contracts, including more restrictive non-compete clauses and lower salaries; ineffective staffing patterns, etc, as the ACA has fostered a process in which the hospitals have formed larger and larger "vertical"organizations. Mental health care is included but psychiatry is not necessarily at the table, despite many new enrollees in need of psychiatric care. The problems of the public mental health system of care in New Hampshire have been highlighted recently, in the cases of Community Mental Health patients who have been admitted to the state hospital, assaulted staff, been sent to corrections, suggesting a need for earlier intervention. Waits in emergency departments remain problematic; CMH psychiatrists may start rounding in the EDs. Managed Medicaid has created additional barriers to appropriate care, especially in requiring prior authorization (PA) for long-acting injectable antipsychotic medications, and requiring patients to switch medications after long periods of stability. Medicaid expansion is needed in Maine but will probably not occur without a change in governor. Vermont awaits announcement of the governor's financial plans related to healthcare reform.

Opiate abuse and addiction remain significant problems throughout Area I. Access to buprenorphine treatment remains limited by insufficient numbers of prescribing physicians and practice cap regulations. Access to Narcan for emergency overdose treatment has improved in Rhode Island and Massachusetts, but shortages may be developing.

Some positive developments have occurred, further illustrating the importance of advocacy on behalf of psychiatry, psychiatrists, and persons suffering from psychiatric illness. In Massachusetts, managed Medicaid has been dropping the extremely burdensome PA requirements. The state has been sponsoring "listening sessions" re: access to care and parity problems, in response to widespread physician concerns. In Connecticut, the CPA annual meeting was very well attended, with Patrick Kennedy as the featured speaker. He reiterated that psychiatrists should be the team leaders and was openly critical of the governor, potentially paving the way for additional political efforts. Several

psychiatrists have been elected to other positions in the state medical society. Children in DCF custody now receive mental health services but there is need to broaden the mandate. A new psychiatric hospital has opened in Vermont, though it is much smaller than the older facility, and additional advocacy efforts will be needed to achieve adequate access to inpatient psychiatric services.

Dr Pinals presented the updated Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services. The members of the Area I Council expressed thanks to Dr Pinals and the work group for this comprehensive effort.

Resident and Fellow members and the Early Career Psychiatrists sponsored a number of activities at the May Annual Meeting, and made a strong effort to welcome the Canadian RFM who came to the meeting. The Ontario DB remains strongly committed to education through its Salon program and RFM activities; members are looking forward to hosting the Annual Meeting in May 2015.

Respectfully submitted,

Brian T. Benton, MD, Area I Representative
A Evan Eyler, MD, MPH, Area I Deputy Representative

Area 3 Report

Member Services - Area 3 is addressing member recruitment and retention by adding value to APA membership with its Area 3-wide educational activity to support members through the American Board of Psychiatry and Neurology Maintenance of Certification process. The training is called *Maintenance of Certification: Navigating the Process*. Key aspects of this program are: 1) demonstrates commitment of Area 3 and its District Branches to help APA members through the Maintenance of Certification process, 2) supported financially by Area 3, 3) supported in part by an APA grant, 4) only a token registration fee for APA members, 5) conveniently brought to Area 3 members via multiple locations throughout Area 3, 6) opportunity to learn MOC requirements from the experts in person and have questions answered, 7) true workshop: hands-on, computer-based experiential learning with guidance, 8) earning CME credits needed for MOC (each training approved for 4.5 AMA PRA Category 1 Credits), 9) non-APA members welcome to register and participate but registration fee is 3 times higher than the APA member registration fee. 10) Area 3 DB Executive Directors initiative led by Kery Hummel, Executive Director, Maryland Psychiatric Society

Dr Napoli, Area 3 Deputy Representative, welcomed the participants at the NJPA training on September 27 and highlighted the fact that APA members only paid a registration fee of $50 because Area 3 financially supported the program with $17,000 and the APA provided a $10,000 grant. He informed the non-members in the audience that they can get this value of membership by joining the APA.

Financial: Area 3 opposes any block grant reformulation that would reduce the amount that Area 3 receives annually, especially if the reduction would provide funds only for the Area 3 business meetings and the travel for those meetings. Area 3 has used its block grant funds to add value to APA membership for APA members in Area 3. For example: Area 3 funded: 1) the Washington Psychiatric Society's "Developing Our Careers; Enhancing Our Leadership Skills" program for Members-in-Training and Early Career Psychiatrists, (2) The New Jersey Psychiatric Association adoption and adaptation of the WPS career and leadership program, and 3) the reconstruction of Maryland Psychiatric Society Website, and thus, improved communication with its members.

Actions of Assembly Representatives – Dr Napoli, Area 3 Deputy Representative, chaired the Assembly AHWG on SA/DB Rep Actions that was charged in July 2013 "to study what actions that SA/DB Representatives/Deputy Representatives might implement to improve communications with and service to their constituents and decide upon at least three actions that the AHWG shall recommend to the AEC. The AHWG made its final report to the AEC in July 2014 and recommended that the three actions should be: 1. communicate bidirectionally with their constituents via electronic bulletins, 2. promote best practices, and 3. establish and use area Websites and there should three tools to support these actions: 1. electronic templates for bulletins, 2. digital directory of best practices, and 3. APA IT technical support for area websites

Action Papers: Area 3 has six of the 19 action papers on the agenda for the November Assembly.

Area 3 Website: Since it went online in September 2013, the Website has facilitated the business of Area 3.

Mentorship – Dr Brandt, Area 3 Representative, chaired the Assembly Committee on Mentorship, 2011-2014

Resident-Fellow Members: Area 3 has promoted involvement of Resident-Fellow Members in the APA. By engaging RFMs, they want to belong to and remain members of the APA. Urooj Saeed, MD, Immediate Past Resident Fellow Representative (WPS member), Shalice McKnight, DO, Resident Fellow Representative (WPS member and former NJPA member), Jessica Abellard, MD, Resident Fellow Deputy Representative (NJPA member)

Scope of Practice: By providing a network, intra-organization communication and a source of information, the Assembly has been instrumental in the New Jersey District Branch's fight against the New Jersey psychologist prescribing privileges bills.

Respectfully submitted,
Joseph C Napoli, MD, Area 3 Deputy Representative

Area 4 Report

DRAFT
Area 4 Council Meeting Minutes
JW Marriott, Indianapolis, Indiana
August 2 and 3, 2014

Attendance
Area 4 Rep: Bob Batterson
Area 4 Dep Rep: Bhasker Dave
Area 4 Trustee: Judith Kashtan
Illinois: Ken Busch [R], Lisa Rone [R], Shastri Swaminathan [R]
Indiana: Brian Hart [DR]
Iowa: Laura Van Cleve [Acting R]
Kansas: Chester Day [R], Moneesh Mittal [Acting DR]
Michigan: William Sanders [R]
Minnesota: Michael Koch [DR]
Missouri: Arshad Husain [R]
Nebraska:
North Dakota: Ronald Burd [R]
Ohio: Jonathan Dunn [R], Brien Dyer [R], Eileen McGee [R]
South Dakota:
Wisconsin: Clarence Chou [R], Jacob Behrens [DR]

RFM: Sarit Hovav [Area 4 RFM DR], Frank Shin [SD], Yon Chong [NE], Nicole Albrecht [MI], Dan Dawis [MI], Matt Kruse [MN], Stephen Pesanti [OH], Semyon Faynboym [IN]

ECP: Justin Schoen [Area 4 ECP R], Jacob Behrens [Area 4 ECP DR], Ammar Ali [SD], Maria Harmandayan [MN], Megan Testa [OH]

AAOL: Cheryl Wills [AAPL/AAOSL]

APA Staff: Jeffrey Regan [APA Deputy Director, Government Affairs]

Guests: Jenny Boyer [Assembly Speaker], Daniel Anzia [Assembly Recorder], Paul O'Leary [Presenter, RFM Seminar], Lara Cox [RFM Trustee, and Presenter, RFM Seminar], David Diaz [Indiana Psychiatric Society]

Saturday, August 2, 2014

1. Call to Order and Introductions

Dr. Batterson called the meeting to order at 1:10 p.m. Introductions were made of those attending the meeting, with each attendee reporting any pertinent conflicts.

The agenda was reviewed and accepted as distributed. Mentors were assigned for three new Assembly members.

2. Minutes of the Previous Meeting

Minutes of the May 2 and 3, 2014, Area 4 Council Meeting at the New York Marriott Marquis were reviewed. Dr. Anzia pointed out a correction in Item 10 in the minutes. The minutes were corrected to read that the repeated statements were about "evidence was insufficient." There were no other corrections noted. **A motion was made and seconded to accept the minutes with the above correction. The motion passed.**

3. Treasurer's Report

Dr. Dave presented the Treasurer's Report on behalf of the new Treasurer, Dr. Busch. He distributed a written report and reviewed key items from the report. He reported that he has received the annual dues for 2014 from all 12 DBs. The Block Grant for the year was increased from $21,943 to $28,000 by a transfer of $6,057 from Area 5's Block Grant. Despite that, only $11,548 remains in the Block Grant Account for 2014. Dr. Dave expects that we will have to cover approximately $7,000 for the expenses for the Indianapolis Meeting from our checking account. **A motion was made and seconded to approve the Treasurer's Report as presented. The motion passed.**

4. Area Representative's Report

Dr. Batterson shared information regarding the RFM Seminar that was going on at the same time as the Area 4 Council Meeting. Area 4 Council has contracted with Ms. Sara Stramel (Executive Director, Indiana Psychiatric Society) to organize the Seminar and to seek sponsors for the meeting. She has also arranged for the Speakers for the seminar. Dr. Batterson announced that there would be a reception with all Residents who were attending the seminar at 6:30 p.m. He encouraged all Area 4 Council Members to attend.

5. Area 4 Trustee Report

Dr. Kashtan presented the Area 4 Trustee Report.

- APA office lease is up and plans are in process to choose a new location and contract - either buy or lease. Opinions on both sides were expressed.
- Membership is up, income up from DSM-5 and NY annual meeting, but expenses will also be going up.
- A strategic planning process was started at a Board Executive retreat in July and will be finalized by March, 2015.
- Reports on a number of Board workgroups were presented including one on RFMs, MURs, Research, DSM, and Integrated Care.
- The results of psychologist prescribing legislation in Illinois were presented and the question of a national policy on legislation (oppose 100% versus work on enacting strictly restricted prescribing) were discussed. There is much difference of opinion among DBs on this issue.

6. Central Office Report

Mr. Jeffrey P. Regan, M.A., Deputy Director, Government Affairs, APA, provided a report from the Central Office. He distributed a handout and discussed several pertinent items:

- Environmental scan of Washington with possible scenarios following the mid-term elections.
- Comprehensive Mental Health Reform – H.R.3717, The Helping Families in Mental Health Crisis Act, introduced by Representative Tim Murphy and H.R. 4574, the Strengthening Mental Health in Our Communities Act, introduced by Representative Barber.
- Veterans' Mental Health.
- Extension of "Medicaid bump"
- A proposed rule under Medicare Part D to remove protected status for antipsychotics and antidepressants was rescinded. APA successfully challenged several CMS arguments for the proposed rule.
- Physicians' Payment Sunshine Act – APA has sent e-mails to members encouraging all members to register with CMS, review any data reported on them, and dispute any erroneous data with manufacturers. This has to be done by August 27, 2014. APA has provided detailed registration instructions.
- Excellence in Mental Health Act. APA sent a letter to HHS emphasizing psychiatric leadership of Community Behavioral Health Clinics and utilization of evidence-based services with measured outcomes.
- State legislative issues being monitored include psychologist prescribing, nurse practitioner scope of practice, firearms reporting, telehealth, medical marijuana and involuntary commitment.

7. Legislative Report

Illinois Representatives provided an update on Illinois scope of practice.

- Dr. Swaminathan described the history of effort by psychologists to gain prescribing privileges in the state over the past 14 years.
- Dr. Rone described the public affairs efforts undertaken in Illinois to raise concerns arising from the original bill introduced on this topic and getting support from key allies such as the NAMI Board to oppose the bill.
- Dr. Busch described the advocacy efforts and the lobbying strategies to amend the original bill to the one that ultimately got approved.

8. Practice Guidelines Report

Dr. Daniel Anzia, Assembly Recorder and Chair of the Assembly Area Liaisons to Practice Guidelines, reported that an e-mail was sent on August 1, 2014, to members providing a link to the Practice Guidelines for the Psychiatric Evaluation of Adults. He informed the Council that the Guidelines have been extensively revised in response to the concerns raised by the Assembly in May 2014. He also reported that AEC positively reviewed the new Executive Summary and the communication from the Practice Guidelines group. Dr. Anzia urged the Council Members to review these Guidelines and to ask their DB members to do the same and give feedback. Dr. Anzia asked everyone to send their comments by September 21, 2014. He also reported that the Assembly will be asked to approve these Guidelines at the November meeting.

9. Speaker's Report

Dr. Jenny Boyer, Assembly Speaker, presented a report.

- Dr. Boyer informed the Council that AEC had met on July 25 & 26, 2014 in Long Beach, California. This was a productive meeting.
- Dr. Boyer reviewed line items from a request made to the Finance and Budget Committee by AEC to increase the Assembly budget for 2015 by $223,500 over the 2014 budget. If approved, this will provide additional funding for:
    - Increase in funding for Area Councils.
    - Reimbursement for travel by representatives from the Allied Organizations.
    - Funding for the DB Dep Reps to attend the Fall Assembly Meeting.
- Dr. Boyer described a proposed reorganization of the Assembly structure, that was considered by the AEC.
- Dr. Boyer reported that a speaker survey was sent to Assembly members and the DB/SA Executive Staff.
    - The goal of the survey was to prioritize issues facing the field of psychiatry in order to focus member services.
    - Responses were received from 62.8 percent of the individuals invited to participate.
    - Dr. Boyer shared a few of the findings identified by the respondents.

- Dr. Boyer urged Council Members to communicate with and seek input from their constituents on issues of concern, and to educate members on APA services that provide value.

10. Action Papers

The Area Council reviewed four Action Papers.

1. Dr. Dunn reviewed his Action Paper titled "Encourage the use of DSM-5 Diagnostic Criteria in APA sponsored meetings, educational activities, publications and outreach."
2. Dr. Burd reviewed his Action Paper titled "Telepsychiatry."
3. Dr. McGee reviewed an Action Paper titled "Governmental Required Misuse of the 90863 Code."
4. Dr. Dyer reviewed an Action Paper titled "Increase Access to Care and Improve Quality by Changing the Documentation Requirements Associated with New E/M and Psychotherapy Codes."

There was discussion on all four Action Papers with suggestions for improvement. After considerable deliberation, **motions were made and seconded to endorse in principle the Action Papers related to DSM-5, Telepsychiatry, and the 90863 Code. These three motions passed.**

Council Members offered suggestions to the authors regarding the Action Paper on New E/M and Psychotherapy Codes. A small workgroup was appointed to review this Action Paper further and to suggest changes.

Dr. Batterson reminded all that the Action Paper deadline is September 18, 2014.

The Area Council Meeting recessed at 5 p.m. on August 2, 2014.

The Area Council Meeting resumed at 8:30 a.m. on Sunday, August 3, 2014.

Dr. Batterson provided a brief report on the Assembly Workgroups. He indicated that the AEC was recommending sunsetting workgroups on DSM-5, global psychiatry, membership, and DB site visit. AEC also recommended that workgroups on access to care, communications and MOC be continued.

11. Nominating Committee

- Dr. Dave provided the Nominating Committee report. He indicated that the Committee had met to determine a slate for the Area 4 Trustee position. The Area Council has to select two nominees for this position and one alternate nominee, for the election that will occur in 2015. The Nominating Committee presented a slate of three candidates: Dr. Ron Burd, Dr. Judith Kashtan and Dr. Shastri Swaminathan.
- An election followed. Dr. Burd and Dr. Swaminathan were elected as the two nominees. Dr. Kashtan was elected as the alternate nominee. This slate would be submitted to the National Nominating Committee for the election of Area 4 Trustee next year.
- Dr. Dyer reviewed the "Assembly Profile of Courage Award." He encouraged Council Members to seek appropriate nominees for this award. He informed the Council that nominations should be submitted to Ms. Jessica Hopey at the APA Central Office by September 1, 2014.
- Dr. Dave has served as the Chair of the Nominating Committee since 1997. However, since he is now the Area Deputy Representative a new Chair needs to be appointed. Dr. Batterson announced that he has appointed Dr. Rone as the Chair of the Nominating Committee.

12. RFM Report

- Dr. Hovav reported that the RFM seminar on Practice Management, which was held the previous day, had a good turnout of residents and was well received by those attending.

- Dr. Hart was the moderator for the seminar. Dr. Hart submitted the following report on the speakers at the seminar:
    - The first speaker was Charles David Cash, JD, LLM of PRMS. He spoke on the topic of risk management. He briefly discussed basic principles of how to approach reading an employment contract. Then there was a more thorough discussion of malpractice insurance, different types of plans and coverage, and what to consider when looking at employer provided plans.

    - The second speaker was Paul J. O'Leary, MD, Alabama Dep-Rep to the Assembly, who spoke in more detail about contract negotiation and life-satisfaction considerations when considering an employment opportunity.

- The third speaker was David Safani, MD, MBA, consultant to the National Membership Committee of the APA, who spoke on networking and financial planning. The discussion covered basics of establishing and protecting your credit, as well as the basics of investing and retirement planning.
- The final speaker was Lara J. Cox, MD, MS, the RFM Trustee. Her talk was on the organizational structure of the APA, leadership opportunities and fellowships available to RFMs and ECPs, and finished with instruction on how to be the most effective advocate for our patients and our profession.

13. ECP Report

Dr. Behrens provided an oral report with a subsequent e-mail to the Area Dep Rep. with the highlights of his report.

- ECPs met with staff from ABPN to discuss both MOC requirements and website concerns. Physician folios and PIP changes (lessened requirements) have since been evolving
- ECPs are connecting with AMA and vendor staff to further understanding of difficulties of e-prescribing of controlled substances and steps to increased integration within EHR.

14. District Branch Reports

I. **Wisconsin:**

Dr. Chou presented an oral report.

- He indicated that issues pertaining to psychiatry have been fairly stable in Wisconsin since the May Council Meeting.
- Dr. Behrens reported that Dr. Jerry Halverson, a psychiatrist, is the new President-Elect of the Wisconsin Medical Society.
- He also reported that Dr. Michael Miller, an Addiction Psychiatrist, was recently elected to the AMA's Council on Science and Public Health and should be the new Speaker of the Wisconsin Medical Society.

II. **South Dakota:**

Dr. Shin presented an oral report with a subsequent e-mail to the Area Dep Rep. with the highlights of his report.

- The DB is in the process of working with the local legislature in proposing a state bill that further addresses the legal responsibilities of psychiatrists as pertains to patient care.
- The DB has supported resident involvement in the local and national psychiatric and medical associations in order to foster better relationships both with the congressional representatives as well as with the fellow physicians. This effort has led to more active involvement of the

psychiatry residents, such as being selected for the APA/SAMHSA fellow award for 2014-2015 to improve cultural training, representing the residents at the South Dakota State Medical Association, and being part of the AMA resident committee.

III. **Ohio:**

Dr. McGee presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of his report.

- Some Ohio pharmacists are seeking the support of the OPPA and other groups to seek legislation to give them the ability to administer long-acting antipsychotic injections in a pharmacy.
- Earlier this year, the Ohio Supreme Court's Death Penalty Task Force recommended that individuals with SMI at the time of their crime or at the time of the execution be excluded from the death penalty. NAMI Ohio has asked OPPA to participate in a Workgroup to come up with a definition of SMI in legislation that addresses the Supreme Court's recommendation.
- There have been many bills introduced dealing with the opiate epidemic in Ohio. The DB has created an Addictions Committee that has been meeting with the legislators to try to make these bills appropriate for proper treatment of addiction issues.
- OPPA is advocating for at least one member of the Ohio Medical Board to be a Psychiatrist, preferably with an addiction background. There are concerns about discriminatory questions about mental health and addiction on the licensure application.

IV. North Dakota:

Dr. Burd presented a written report and discussed key items from his report.

- Because of a strong economy, due to oil production, there has been a growth in population with increased demands on the medical services.
- Shortage of psychiatric beds is exacerbated by similar shortage in Minnesota with Minnesota patients often transported hundreds of miles for hospitalization in a North Dakota facility.
- There is a great psychiatric workforce shortage.
- The Human Services Committee in the Legislature has hired an outside consultant firm to study the current mental health system and recommend changes for improvement.
- There is concern regarding scope legislation.
- Organized medicine is seeking a 4% increase in Medicaid reimbursement.

V. Nebraska:

Dr. Hovav presented an oral report with a subsequent e-mail to the Area Dep Rep. with the highlights of her report.

- The DB desires to learn about:
    - The proper way to accept or reject a membership application based on previous ethical (or lack thereof) conduct, and legal issues not necessarily leading to a revocation of the applicant's medical license.
    - In preparing for the district branch representative to answer high profile questions, or using social media to increase visibility, how to find the APA stance on the topics, and whether a DB can have different viewpoints from the APA.
- Council members discussed both issues noted above and suggested possible answers and resources.

VI. Missouri:

Dr. Husein presented a written report. He reviewed pertinent items.

- A law has been enacted which will allow medical school graduates who have not yet passed their final credentialing examinations to treat patients in primary care settings under supervision of a "collaborative" physician.
- A bill allowing Medicaid expansion did not pass, but will be presented again this year.
- Budget was approved to construct a new mental health facility at the Fulton State Hospital.
- Dr. Husein was awarded "Doctor of the Year" by the National Council for Behavioral Health.

VII. Minnesota:

Dr. Koch presented a written report. He reviewed pertinent items.

- MPS Council Members are traveling across the state to meet with local psychiatrists to get feedback regarding their issues and concerns.
- A past president of MPS has joined the NAMI Board.
- An advanced practice nursing bill was passed, requiring newly graduated APRNs to practice under physician collaboration for one year.
- A medical cannabis bill was passed which defines eligible conditions. The bill allows two manufacturers and eight distribution sites. Cannabis will be available in liquid or pill form.

VIII. Michigan:

Dr. Sanders presented a written report. He reviewed pertinent items.

- Enabling legislation was passed to accept the federal Medicaid expansion under the ACA. This was accompanied by general fund reduction with the anticipation that the reduction would be covered by additional federal funds due to the expansion. However, this reduction has caused concerns regarding potential cuts in non-Medicaid services.
- PTSD has been added as an approved condition under the medical marijuana program. Legislature is holding hearings to amend bills that would allow medical marijuana dispensaries and create regulations. Bills authorize non-smokable forms of marijuana. MPS has issued a statement regarding concerns about medical marijuana as medicine, particularly for PTSD.

IX. Kansas:

Dr. Day presented an oral report with a subsequent e-mail to the Area Dep Rep with the highlights of his report.

- Kansas has a severe shortage of psychiatrists, especially in the western part of the state.
- Kansas income tax cuts have left the state with a large budget deficit, which will likely result in still further cuts in social services and in funds for community/public health, already insufficient.
- Kansas Governor and Legislature have not expanded Medicaid.
- Kansas Legislature has no plans to fund additional psychiatric residency slots either at KU Medical School in Kansas City or UKSM in Wichita.
- Kansas Psychiatric Society is developing a strategic initiative to increase membership, especially encouraging psychiatric residents and fellows to join.
- KPS desires to develop a Foundation and a Political Action Committee and desires assistance from the APA in this regard, and understands the need to change from a C-3 to C-6 status.
- KPS will present a fall CME meeting on Health Care Reform in November in Olathe, Kansas.

X. Iowa:

Dr. Van Cleve presented an oral report with a subsequent e-mail to the Area Dep Rep. with the highlights of her report.

- Iowa has a shortage of Psychiatrists, making it a prime target for those advocating that Psychologists should be allowed prescribing privileges.
- Poor reimbursement and rural nature of Iowa complicate recruitment and retention of Psychiatrists.
- A legislator is attempting to draft a bill in support of telepsychiatry.
- There is concern regarding scope legislation.
- Iowa Medical Society has been very supportive of IPS position on this issue.

XI. Indiana:

Dr. Hart presented an oral report with a subsequent e-mail to the Area Dep Rep. with the highlights of his report.

- In April the DB hosted the 5th annual Regional Integrated Mental Health Conference with Kentucky. Plans are underway for the 2015 event, April 17-19.
- The DB will host a fall symposium on MOC on September 6 using content from the summer Train the Trainers program.
- Dr. Wernert has become the new director of the Indiana Family & Social Services Administration.
- Gov. Pence has had conversations with the Obama administration in an attempt to get HIP 2.0 passed, a hybrid plan that expands Medicaid and HIP in Indiana (described as hybrid since some people will have to make payments towards their insurance based on a sliding salary scale).

XII. Illinois:

Dr. Swaminathan, Dr. Rone and Dr. Busch provided an oral report. They amplified on their earlier report regarding Psychologist Prescribing Bill.

- Clinical Psychologist Licensing Act which was passed by the Legislature included amendments by IPS and Illinois State Medical Society.
- The amendments made significant changes in the original bill introduced in the Legislature.
- One amendment added new stringent training requirements for clinical psychologists similar to physician assistant education and training.
- Psychologists will not be allowed to prescribe for patients under age 17 or over age 65, to patients who are pregnant, or have serious medical conditions or developmental/intellectual disabilities.
- Psychologists will not be allowed to prescribe Benzodiazepines, Narcotics, or any Schedule II Controlled Substances.
- The prescribing Psychologist will have to have a written collaborative agreement with a physician who treats patients with mental illness.

- Pursuant to a strong public affairs and lobbying effort, the Psychologists agreed to all amendments supported by IPS.

15. Communication Platform for Area 4

Dr. Batterson briefly discussed a communication platform for Area 4. He requested suggestions from the Council Members on this topic.

16. Future Meetings

- Fall Assembly in Washington D.C. from November 7-9, 2014.
- Area Council Meeting in Chicago from March 7-8, 2015.
- The APA Annual Meeting in Toronto with the Assembly Meeting from May 15-17, 2015.

The Area Council Meeting adjourned at 11:10 a.m.

Respectfully submitted,

Bhasker J. Dave, M.D., D.L.F.A.P.A.
Area 4 Deputy Representative

Area 4 Special Report on an RFM Seminar at the Summer 2014 Meeting

Background: Area 4 is a widely spread geographic area comprising 11 states in the North Central Region of the US. Residents and Fellows in the Area come from large to Medium sized metropolitan areas with a few programs in smaller cities. Area 4 has reimbursed 1 Resident/Fellow Member (RFM) per District branch for the past decade or longer and they generally sit in on the Area Council meeting as well as have a break-out session to discuss some specific issues. We have offered special programs for Legislative Representatives at our Spring meeting but we have not offered anything specifically for the RFMs in the past. Our Past Speaker, Dr. Young encouraged us last year to look at ways to make the area meetings more relevant to psychiatrists who live in the city where we meet and to look at other events or meetings that might run concurrently with the Area Council.

Residency training programs must focus on the requirements of the ACGME and therefore are not focused on subjects such as practice or personal financial management, contracting, or the interface between the APA and the practicing psychiatrist.

In consideration of these gaps and a strong need to engage our Resident members, I conferred with our area leadership and the RFM Reps to see if a Resident Seminar at our summer meeting in 2014 would be a welcome addition. The response was positive from all segments and our CEO/Medical Director was also in strong support of this at the APA national level. We contacted the RFM liaison, Jon Fanning in moving this forward and we engaged the Executive Director of the Indiana Psychiatric Society Sara Stramel to be the coordinator for the meeting.

We chose Sara because she has a history of coordinating successful multi-state meetings, has contacts in the APA and the meeting was to be held in Indianapolis where she resides. We planned on a meeting that would last approximately 4 to 5 hours and would include lunch as well as an after-meeting reception with Area Council members for networking. We did not charge a fee and sought sponsors from the financial and insurance sectors as well as from some select physician recruitment firms. We did not have to offer CME since our audience was in training. Sara used her contacts to locate speakers with experience on topics in our areas of interest and for sponsorship of the program. Her time was also reimbursed out of the money raised for sponsorship.

We counted on most of the RFMs from the 11 DBs to attend and were hoping to get local resident attendance from the Indiana University Program. We estimated about 20 attendees initially. Here is a snapshot of the results:

- 30 attendees from most of the Area 4 states
- Income from sponsors was $5,320
- Expenses were $5,190 which allowed $135.00 to be applied to the reception
- Responses in a post conference survey were positive uniformly
- Our primary sponsor indicated a strong desire to sponsor more of these events and indicated she had not recently seen an audience so engaged.

- The Seminar was held on a Saturday in early August starting at 11:00 AM and ended at 4:00 PM. The area council meeting started at 1:00 PM and ended at 5:00 PM.

The RFM group joined the Area 4 Council meeting in progress later in the day and then for the reception as well as a PAC reception. We also had a joint dinner for all attendees. The response about networking was very positive. My hope is that this seminar will lead to greater likelihood of continued APA membership and engagement in the organization.

We plan to repeat this meeting at the 2015 Area 4 Summer Meeting.

We thank Sara Stramel for her work in arranging this successful program.

Area 6 Report

Area 6 Council Highlights

Area 6 met in conjunction with our annual meeting in Yosemite in September. Our council agenda was packed, so we will focus on some of the issues discussed at the state level. One of the biggest changes for our organization is that Barbara Gard, our California Psychiatric Association Executive Director for the past 26 years and who helped to found the organization, will be retiring at the end of the year. We are welcoming Lila Schmall, who has been our assistant executive director, into the role of director.

We have been successful in several legal endeavors, the largest (and costliest) of which is prevailing in a case involving parity called Rea vs. Blue Shield specifically involving coverage of residential care for eating disorders, with a statement that "parity requires treatment to reach the same quality of care". The California Supreme Court refused to hear the case, upholding our favorable opinion from the lower court. We have also written notices to several University of California schools to "cease and desist" in representing psychologists as physicians. In their websites, in their "Find a Doctor" sections, they list "medical school attended" with "medical degrees" and providing "medical services" for their listing of psychologists.

We had discussion around the California action paper submitted in response to the Illinois legislation and the Psych News article regarding "Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders". Kristin Kroeger from the APA discussed the exploration of team-based care that is going on with the AMA, which does not change our policy on these issues but has brought up discussion around related issues. The area voted to endorse the paper to be amended to add, "in order to promote public safety" to the first resolved, and "in order to uphold the standards of competent medical care " in the second resolved. We summarized our APA assembly rep conference calls and the thrust to increase communication at all levels. Mentorship for new assembly reps, the upcoming deadline for feedback on the practice guidelines and and assignments to committees were also discussed. The area voted to support the practice guidelines at the November meeting.

Resolutions regarding the IMD exclusion and LPS reform (our involuntary commitment laws) were endorsed and will be taken to our state medical organization meeting in December.

State legislative update – we had advances in parity this year, the struggle going forward will be to get enforcement of the structures that are in place. We continue to need accountability for pupil mental health and are working on this administratively. There continues to be struggles around the use of psychotropics

in foster children. We continue to work on our involuntary treatment regulations – including working on issues of dangerousness and consistent applications of the law, perhaps by modifying the form that is filled out when someone is placed on an involuntary hold to emphasize the ability to utilize past history and family collateral information. We are addressing issues of access to medications and the situation where a "reverse carveout" means that patients are not getting medications that are not covered by their secondary insurance but would be covered by the state if the pharmacy billed there. We had a watch list of over 100 bills this year in many areas. Scope issues continue to surface in the legislature – the one most recently defeated had to do with optometrists. We have updated and developed a legislative priority platform that came out of our Child and Adolescent Committee, and priorities from the Public Psychiatry Committee., including strengthening our statement about the need for standards that ensure safe, integrated and competent medical treatment of persons afflicted with mental illness. We discussed the possible upcoming lawsuits from Disability Rights California against counties who are implementing Assisted Outpatient Treatment programs and the options to support the counties by providing resources for expert testimony, filing amicus briefs in support of the county, and look for partners to perhaps intervene in the lawsuits (this latter would be quite expensive), as well as writing letters to decision makers, reporters, etc. to stress the benefits of AOT.

Our annual meeting committee is looking to expand, including developing a Primary Care Psychiatric Conference, which could bring in additional income to our organization. The managed care committee continues to actively monitor issues in the state. The state facility task force continues to monitor issues around infringement on medical staff rights and prescribing issues in these institutions.

Joseph Mawhinney and Barbara Yates Weissman, Area 6 AEC Representatives.

Item 2014A2 11.G
Assembly
November 7-9, 2014

Area 7 Report

Membership

Continuing its tradition, the area 7 Council, reflective of its geographic area and area membership, remains diverse. Specialty interests, such as academic, private and public psychiatry are among those represented, as are varied cultural and ethnic backgrounds, and ages.

Area 7 also remains an amalgam of diverse district branches, some sizable, but many relatively small, and often challenged to engage enough members to remain active in their basic functions.

Finances

Given the present block grant funding of the area councils, and the rising costs of travel, especially the long distances in the Western US between district branches, area 7 at times in recent years has been unable to afford to meet twice a year. We are grateful to other areas who in the past have contributed to our finances and made our meetings possible during times of financial constraint. We find this a serious concern since our small district branches rely more on the area council meetings to serve purposes the executive committees of larger district branches often serve. Area 7 receives a block grant of $35,000, and as of the second quarter of 2014, $24,833 remain.

Similarly, although or larger district branches enjoy a solid financial foundation, our smaller district branches rely on infrastructure grants from the APA to fund basic support functions. Their membership is too small to finance the district branch with dues income alone.

Advocacy

Our district branches, as represented by Hawaii, are very active in advocating in their legislatures, and also find themselves facing legislative issues very important to the general membership across the nation.
Also, in recent years our area has
brought action papers generated by both Assembly members and also general members, for discussion in the Assembly.

Meetings

It has been our approach to meet if possible at sites that would allow us to bring area and national leadership to District branches that are struggling. Our recent meeting in Bozeman, where we were joined by our Speaker Dr Boyer and also by Dr Barbara Schneidman of the ABPN represented such an effort to engage local members and have them experience what APA does for them. Our meeting was especially pleasant this Summer because our local representative, Dr Green, invited attendees to her home for a home cooked dinner.

Respectfully Submitted,

Craig Zarling, MD

Item 2014A2 12.A
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Direct to Consumer Advertising

WHEREAS:

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

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

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

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

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

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

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

It is well known that non-psychiatric medications can negatively impact an individual's mental status so medications that are not medically indicated should be avoided;

It is well known that drug-drug interactions of a psychiatric medication and a non-psychiatric medication can increase the blood levels of either, decrease the effectiveness of either, have side effects neither medication would have alone so medications that are not medically indicated should be avoided;

The current position statement of the APA on Direct to Consumer advertising, an adoption of AMA policy (see attachment A), is neither meaningful nor effective:

- The structure and actions the position paper calls for have either never been created or never been implemented (see Attachment B)

- The research called for has never been done (see Attachment B)
- The safeguards, particularly physician involvement, have never been put in place
- What actions the FDA has taken has very rarely applied to psychotropic medication (see Attachment C)

BE IT RESOLVED:

1. The American Psychiatric Association shall sunset: Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices Adoption of AMA Policy H-105.988, approved 2010.
2. The American Psychiatric Association shall adopt the Position Statement on Direct to Consumer Advertising, 2014.

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ESTIMATED COST:
Author: $0
APA: $700

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: $5,000
ENDORSED BY: Area 1

KEY WORDS: Direct to consumer advertising

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

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[Position Statement is on the next page]

Position Statement

American Psychiatric Association

DIRECT TO CONSUMER ADVERTISING

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

Attachment A

Position Statement on Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices
Adoption of AMA Policy H-105.988
Approved by the Board, December 2010
Approved by the Assembly, November 2010

"Policy documents are approved by the APA Assembly and Board of Trustees…These are…position statements that define APA official policy on specific subjects…" – *APA Operations Manual*.

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

It is the policy of our AMA:

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

a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical to distinguish such advertising from other advertising for nonprescription products.

d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.

i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

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

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

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

5. DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device.

   The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implant-able medical device for physicians who are most likely to prescribe it.

6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements.

7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTC, they assume an increased for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.

9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion.

10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.

11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary.

12. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical and are not regulated by the FDA).

(BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation 1-99; Appended & Reaffirmed: Sub. Res. 503, A-O I; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, 1-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07)

Attachment B

Power and Scope of the FDA

The current APA Position Paper depends heavily on the functioning of the FDA in the area of Direct to Consumer advertising. But the FDA actually has limited authority and is not performing adequately in the areas within its scope. From the FDA:

Does the FDA review and approve all advertisements for drugs before their release? **NO**

Does Federal law ban ads for drugs that have serious risks? **NO**

Can the FDA limit the amount of money spent on prescription drug ads? **NO**

Does the FDA work with drug companies to create prescription drug ads? **NO**

Does the FDA approve ads for prescription drugs before they are seen by the public? **NO.** ***"****This means that the public may see ads that violate the law before we can stop the ad from appearing or seek corrections to the ad. Consumers should know that they may not necessarily be able to tell whether any specific DTC ad includes false or misleading information.****"***

What are ads not required by the FDA to tell you?

- Cost
- If there is a generic version of the drug
- If there is a similar drug with fewer or different risks that can treat the condition
- If changes in your behavior could help your condition (such as diet and exercise)
- How many people have the condition the drug treats
- How the drug works (its "mechanism of action")
- How quickly the drug works
- How many people who take the drug will be helped by it

Has FDA done research on DTC advertising? **Yes, but**

in the last 10 years, the FDA has not done one controlled study of the effects of Direct to Consumer ads. Their work has been almost exclusively surveys and literature reviews.

Attachment C

FDA Office of Prescription Drug Promotion

	No. Warning Letters	No. Psychotropic Meds
2014	6	0
2013	24	1
2012	28	2
2011	31	1
2010	40	2
4.75 years	129	6

Item 2014A2 12.B
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: E-prescribing of Controlled Substances

WHEREAS:
Providing the appropriate standard of care to our patients may include the prescribing of controlled substances;

As with all other prescribed medications, there are certain advantages for patients, providers, and pharmacies that come with electronic prescriptions and this practice is currently the most popular means of prescribing in this country.

On June 1, 2010, the DEA's Interim Final Rule titled "Electronic Prescriptions for Controlled Substances" became effective and revised DEA regulations to provide practitioners with the option of writing prescriptions for controlled substances electronically.

As of 9/1/14, 49 states have adopted regulatory status to allow for the e-prescribing of controlled substances (stats unclear in MT, CIII-V in KS and VT, CII-V in all other states).

The process of e-prescribing controlled substances requires a higher level of authentication and security on both the sending side (e-prescribing module often bundled with EHR) and the receiving side (pharmacy). This technology currently exists and is in place with certain e-prescribing vendors and pharmacies including many of the larger national pharmacy chains.

The inability for most patients, pharmacists, and physicians to have the option for the advantages of e-prescribed controlled substances is neither a legal nor an undue technologic matter.

BE IT RESOLVED:

1. That the APA refer this issue to our delegation to the AMA to support the option for electronically prescribed controlled substances as aligned with federal regulations and express the importance of adopting such standards to allow for this to the relevant components of the e-prescribing chain.
2. The APA will develop a position statement supporting the options of electronic prescribing of controlled substances.

AUTHOR:
Jacob Behrens, M.D., ECP Deputy Representative, Area 4

ESTIMATED COST:
Author: $8,000
APA: $2,080

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Assembly Committee of Early Career Psychiatrists

KEY WORDS: e-prescribing, controlled substances

APA STRATEGIC GOAL: Advocating for the Patient, Advocating for the Profession

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

Item 2014A2 12.C
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Telepsychiatry

WHEREAS:
Technology has evolved to the point where secure and confidential psychiatric care can effectively and efficiently be delivered through computerized interactive video connections;

There exist restrictions, limitations and impediments to the full deployment and use of this technology;

There exist problems with access to general and specialty psychiatric care as well as regional distribution issues;

Telepsychiatry has the potential to deliver psychiatric care to underserved areas and populations;

The American Medical Association House of Delegates has recently approved guiding principles on telemedicine which may not be appropriate to telepsychiatry;

Numerous states are in the process of drafting legislation regarding telepsychiatry and their efforts would benefit from standardization;

BE IT RESOLVED:
That the Council on Quality Care be charged to develop and recommend a plan to the Board of Trustees facilitating the defining of, adoption and use of telepsychiatry, including but not limited to research priorities, standardization of regulation, training, development of evidence based treatment guidelines, resolution of impediments, and addressing incentives/disincentives to its adoption.

That the Board of Trustees of the American Psychiatric Association act to review, revise, approve and implement said plan.

AUTHOR:
Ronald M. Burd, M.D., DFAPA, Representative, North Dakota Psychiatric Society

ESTIMATED COST:
Author: $1,953.34
APA: $3,380

ESTIMATED SAVINGS: APA minimal

ESTIMATED REVENUE GENERATED: APA: Minimal. Membership value: Positive. Members: Potentially substantial.

ENDORSED BY: Area 4 Council (in principle)

KEY WORDS: telepsychiatry, telemedicine, access to care

APA STRATEGIC GOAL: Advocating for the Profession, Advocating for the Patient

REVIEWED BY RELEVANT APA COMPONENT:
Council on Quality Care, Committee on Mental Health Information Technology: Their comments are below, noting that developing the plan is a relatively low cost item, but that implementation is likely to require substantially higher resources including possibly full-time staff and consultants.

Comments of Steve Daviss, M.D., Chair of Committee on Mental Health Information Technology (CMHIT): Great to see a desire to standardize around telepsychiatry. This will be a huge lift, of course, impacting standards of care, regulations (state, national), health IT (EHRs, HIEs, documentation, technology), government relations, billing, etc. My concern would be for having the bandwidth to develop this in a reasonable timeframe using our current committee structure, whether if falls to CMHIT or to the Council on Quality Care. It is certainly an endeavour that is needed, but we'd need a full-time APA staff person, preferably a psychiatrist with relevant experience, to pull it all together and keep us on track, in my opinion, with another FT support person. So, BOT would need to commit resources to make it happen.
More thoughts...

- AATP (American Association for Technology in Psychiatry), John Luo's (et al) group, has an overlapping interest here.

- Marlene Maheu (from the other APA) has a parallel effort to unite the various mental health orgs around "telemental health." Our committee (i.e., me) is having preliminary discussions with her group. Having different "standards" for telepsychiatry, telemedicine, telemental health, teletherapy ... is where we are heading, though not sure if it's where we want to be. The guild issues combine with healthcare policy, regulatory practicality, payer policies, and clinical and service needs of patients, to make a potentially big mess. First mover advantages are potentially huge, but require a lot of effort.

- This area is of higher interest to younger members, so getting it right, and involving them in the process, should have a positive impact on recruitment and retention of younger members.

- A standards body that involves certification of some sort seems likely to grow out of the regulatory need for bodies that can keep pace with the rapidly changing quality and technical standards in this area. Might be an opportunity to plant a flag AND a revenue center, if not for us then maybe another org.

So, the short version of my comments, after reading through Ron's AP again, is that I would personally fully support the action paper's Resolved, except I point out that the "implementation" part will require more than the Council can manage on its own, so maybe change from "develop and implement a plan" to "develop and recommend a plan to the BOT".

Comments of Joel Yager, M.D., Chair of Council on Quality Care: Suggested refer to Council on Quality Care, rather than the Committee on Mental Health Information Technology and specify that this effort might require additional resources allocated to the Council.

Item 2014A2 12.D
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Critical Psychiatrist Shortages at Federal Medical Centers

WHEREAS:
Whereas Estelle v Gamble guarantees inmates timely access to treatment by physician without deliberate indifference and

Whereas the Subcommittee on Intellectual Property and Judicial Administration Committee on the Judiciary House of Representative requested an evaluation of the adequacy of the Federal Bureau of Prison's (BOP) medical services and the effectiveness of its medical service's quality assurance program and that report was published on February 10, 1994 and

Whereas the report concluded the BOP does not have the capacity to provide appropriate medical and psychiatric care because it has been unable to recruit and retain qualified health care staff; staffing shortages at the medical centers are chronic and show no sign of improving; and patients are and will continue to be at risk of receiving poor care and

Whereas staffing levels have significantly declined in the 20 years since that report was published and

Whereas 61% of females and 44% of males have mental health problems and

Whereas United States Medical Center for Federal Prisons Springfield has three of seven psychiatry positions filled, Federal Medical Center (FMC) Butner has three of six psychiatry positions filled, FMC Carwell has three of six psychiatry positions filled, FMC Rochester has three of six psychiatry positions filled, and FMC Devens has two of five positions filled to fulfill their mental health missions and

Whereas efforts to recruit new psychiatrists have failed due to the Office of Personnel Management (OPM) failure to respond to the pay differential between community compensation and benefits compared to the federal bureau of prisons and

Whereas current psychiatrists are currently on call for one week periods every three weeks without compensation and

Whereas at one-third of the thirty-five current full-time psychiatrists are mandated to retired within the next five years and

Whereas there are active lawsuits related to the inadequate staff levels within the BOP and the physical and mental harm suffered by inmates who were denied mental health care and

Whereas current lawsuits are challenging the treatment of individuals with mental illness at Administrative Maximum Facility (ADX) Florence, where media coverage uncovered evidence of psychotic patients who engaged in serious self-injurious behaviors or ate their own feces, along

with at least one suicide and

Whereas the leadership of the Bureau of Prisons has failed to address the shortage of psychiatrists and its potential impact upon the safety of the patient within the BOP and

BE IT RESOLVED:

Be It Resolved that the American Psychiatric Association's Council on Advocacy and Government Relations design and implement a plan to best address the compensation and benefits of Bureau of Prisons psychiatrists that is substantially below community levels including other federally employed physicians as it prevents recruitment and retention of medical providers.

AUTHOR:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society

ESTIMATED COST:
Author: $2,174
APA: $11,040.67

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4

KEY WORDS: Correctional psychiatry, psychiatry shortage, CME restrictions

APA STRATEGIC GOAL: Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT
Council on Psychiatry and Law: Chair was ok with the paper.

Item 2014A2 12.E
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: EHR for Psychiatrists

WHEREAS:

Whereas, APA Members and non-members are interested in concrete benefits of APA Membership,

Whereas, APA Members are under pressure from several sectors to adopt EHR,

Whereas, the APA Staff, in comments to the original Action Paper 12E eloquently described the complexities of choosing an EHR,

Whereas, most members of the APA lack Internet Technology and Business expertise, and are unable to properly evaluate the multiple products available,

Whereas, most EHR's are not "psychiatry friendly,"

Whereas, EHR vendors do not have long term business stability,

Whereas, EHR vendors with larger psychiatry clienteles would be more capable of maintaining and supporting their product,

Whereas, the APA has vetted and sponsored other programs beneficial to members such as malpractice insurance,

Whereas, the Texas Medical Association has successfully undergone a similar process of endorsing vendors for their members which include four companies,

Whereas, similar activities involving medical association in North Carolina are also successful in the general medical community,

BE IT RESOLVED:

1. That the APA Administration assist the Committee on Mental Health Information Technology to explore the feasibility of sending out a Request for Proposal to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of one or more products for consideration by members.
2. That the APA Administration report their progress to the Assembly via the Assembly listserv by March 1, 2015.

AUTHORS:
Elias H. Sarkis, MD, DFAPA, Representative, Florida Psychiatric Society
John T. Bailey, DO, DFAPA, Representative, Florida Psychiatric Society

ESTIMATED COST:
Author: $ 92,280
APA: Cost Prohibitive

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED: $150,000.00

ENDORSED BY:

KEY WORDS: Electronic Health Records

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession
Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.F
Assembly
November 7-9, 2014

ACTION PAPER
FAILED

TITLE: Training and Regulatory Standards for the Practice of Medicine Pertaining to the Treatment of Patients with Mental Disorders

WHEREAS:
Whereas there is a growing demand for mental health care, both psychotherapeutic and psychopharmacological;

Whereas this creates a need for additional well-trained clinicians who can safely and skillfully prescribe psychiatric medication;

Whereas some states may consider expanding the categories of licensed health care specialists permitted to prescribe psychiatric medication;

Whereas the safe prescribing of psychiatric medication cannot be separated from the general practice of medicine, requiring a complete and thorough medical education based on biological science, along with supervised training in clinical settings;

Whereas the licensing and regulation of any clinical professional category that includes prescribing medication should be accomplished by a governmental board experienced at assessing the quality of medical practice;

Whereas clear principles and guidance from APA, emphasizing the requirements of quality care and patient safety, will inform policymakers seeking to expand access to psychiatric treatment;

BE IT RESOLVED:
1. The APA will publically reaffirm its position that the practice of medicine, including the prescription of medication, requires a biologically based medical education and supervised clinical training;
2. Individuals practicing medicine, including those who prescribe medication, should be licensed and regulated by governmental boards with expertise and experience in the practice of medicine.

AUTHORS:
Maria Tiamson-Kassab, M.D., Representative, California Psychiatric Association
Robert McCarron, D.O., Representative, California Psychiatric Association
Lawrence Gross, MD, Representative, California Psychiatric Association
John Onate, M.D., APA Member
Richard Altesman, M.D., APA Member

Edward Herman, MD, Representative, New York Psychiatric Association
Mary Ann Schaepper, M.D., Representative, California Psychiatric Association
Thomas Lian, M.D., APA Member

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: NA

ESTIMATED REVENUE GENERATED: NA

ENDORSED BY: Area 6

KEY WORDS: scope of practice, prescription of medications

APA STRATEGIC GOAL: Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.G
Assembly
November 7-9, 2014

ACTION PAPER

TITLE: Integrating Buprenorphine Maintenance Therapy with Mental Health

WHEREAS:

1. Opioid use disorders are reaching epidemic proportions in many areas of the United States, resulting in significant mortality and morbidity.
2. Buprenorphine is an effective maintenance treatment for opioid use disorders that has many advantages over methadone treatment. Patients are not required to attend a clinic every day, thus increasing their occupational potential, reducing stigma, and reducing contact with other opioid users. Buprenorphine does not produce opioid intoxication symptoms to the same degree that methadone does, and buprenorphine alone or in combination with other opioids is much less likely to lead to fatal overdoses than methadone. As such, increasing numbers of opioids users are seeking buprenorphine treatment.
3. The number of buprenorphine providers in many areas falls below patient demand for such services. This results in many patients continuing to use street opioids rather than buprenorphine to avoid withdrawals, with significant ongoing mortality and morbidity.
4. The majority of buprenorphine prescriptions currently being written are by non-psychiatrists, many of whom will only accept patients that are able to pay out of pocket. Furthermore, the treatment for co-morbid psychiatric disorders is deferred to the patient's outpatient psychiatrist, translating into additional costs for an already vulnerable patient population. As such, patients may be forced to choose between treatment for their primary mental health disorders or their opioid dependence.
5. Such separation of mental health care from substance use treatment may reflect psychiatrists' own biases, personal discomfort with the treatment of substance use disorders or an attempt to profit from this desperate and treatment seeking patient population.

BE IT RESOLVED:

That APA create a task force composed of appropriate council membership to focus on issues salient to integrated Substance Use Disorders and MI treatment including buprenorphine therapy.

AUTHORS:
Elie G. Aoun M.D., RFM Representative, Area 1
Loreen Pirnie M.D., RFM Deputy Representative, Area 1
Anish Dube M.D., APA Member

ESTIMATED COST:
Author: $340
APA: $2,610

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: ACORF, Council on Addiction Psychiatry, Area 1

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

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry

Item 2014A2 12.H
Assembly
November 7-9, 2014

ACTION PAPER
WITHDRAWN

TITLE: Production and Distribution of the APA Mini Reference to Inform Patient Care during Training and Lifelong Practice

WHEREAS:

1. Clinical decision making by trainees should be evidence-based and in accordance with practice guidelines set out by governing bodies such as The American Psychiatric Association (APA).
2. It is one of the APA's stated strategic goals to support resident education and training along with recruiting and retaining new members into the organization.
3. Concise, accessible resources that can be used by trainees efficiently are noticeably lacking in the field of psychiatry.
4. Psychiatric trainees are expected to participate in psychiatric clinical decision making during residency, often at a rapid pace.
5. Resident and fellow members of the APA are a group of particular interest to the organization with regards to recruitment and retention.
6. A model for quick reference exists in internal medicine in the form of mini guides or pocket handbooks and is successfully used by residents and fellows across the country (*Pocket Medicine: The Massachusetts General Hospital Handbook of Internal Medicine* is one such example).
7. A similarly designed mini reference intended to quickly point trainees to relevant practice guidelines, drug dosing, and diagnostic criteria would find broad usage among psychiatry residents and fellows and facilitate standardization of evidence-based practice across practice environments while familiarizing trainees in the benefits of APA membership.

BE IT RESOLVED:

1. That the APA, in conjunction with the Council on Medical Education and Lifelong Learning and the Membership Committee explore the creation and distribution of a clinical reference handbook, available as a material and electronic book, that would be provided free of charge to resident and fellow members of the APA but at a fee for other interested parties such as residency training programs, and general APA members.
2. That the APA leadership in conjunction with the Council on Medical Education and Lifelong Learning nominate a task force constituted of resident and fellow members interested in being involved with the APA's governance and be assigned with the writing of the initial draft of this resource to be later approved by the council.
3. This mini reference would include fundamental clinical information necessary in the day to day practice of psychiatry. Such information could include but is not limited to the APA clinical practice guidelines summarized in tabular and figure forms, concise presentation of evidence-based medications use and dosing guidelines, commonly used clinical rating.

AUTHORS:
Loreen Pirnie, M.D., RFM Deputy Representative, Area 1
Elie G. Aoun, M.D., RFM Representative, Area 1
Brian Benton M.D., Area I Representative
Lisa K. Catapano-Friedman, M.D., DFAPA, Deputy Representative, Vermont Psychiatric Association
Samuel Ridout M.D., Ph.D., APA Member
Kathryn Ridout, M.D., Ph.D., APA Member

ESTIMATED COST:
Author: $7,673.33
APA: $67,270

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: On a per order basis from mini reference

ENDORSED BY: ACORF, Area 1

KEY WORDS: The APA Mini Resource

APA STRATEGIC GOAL: Supporting Education, Training and Career Development, Defining and Supporting Professional Values, Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.I
Assembly
November 7-9, 2014

ACTION PAPER
WITHDRAWN

TITLE: Addressing the Educational Specifics and Training Needs of International Medical Graduates

WHEREAS:

Whereas international medical graduates (IMGs) constitute one-third of all psychiatric trainees and one-quarter of practicing psychiatrists in the United States;

Whereas residency training fails to address some of the challenges and difficulties that IMGs face as they move into a new system and try to understand the changing rules and expectations;

Whereas IMG physicians have specific, additional educational needs, and training programs have a duty to recognize and address these needs accordingly;

Whereas IMGs are not a homogenous group; but, as a group, IMGs, although different from USMGs, have proven to provide services comparable in effectiveness with USMGs.

BE IT RESOLVED:

- The APA will partner with appropriate agencies to establish guidelines to be used by residency training programs to help IMGs integrate into mainstream American psychiatry
- The APA will encourage and promote IMGs participation, especially RFMs and ECPs, in activities that assist them in integrating into American psychiatry, such as departmental and hospital committees and professional organizations.

AUTHORS:
Ludmila De Faria, M.D., Representative, Women Psychiatrists
Nyapati Rao, M.D., Representative, International Medical Graduate Psychiatrists
Francis Sanchez, M.D., Deputy Representative, Asian-American Psychiatrists
Jose de la Gandara, M.D., Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists

ESTIMATED COST:
Author: $510
APA: $510

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Hispanic Psychiatrists, International Medical Graduate Psychiatrists

KEY WORDS: IMGs, education and training, mentorship

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.J
Assembly
November 7-9, 2014

ACTION PAPER
WITHDRAWN

TITLE: The Impact of the Diminishing Number of IMGs on the Care of the Underserved Populations

WHEREAS:

Whereas international medical graduates (IMGs) constitute one-third of all psychiatric trainees and one-quarter of practicing psychiatrists in the United States;

Whereas the care of the chronically mentally ill, the uninsured, prison inmates, minorities, Medicaid beneficiaries and other under-served populations, have relied heavily on IMGs;

Whereas the US is increasing access to 30 million Americans through the recently enacted Affordable Care Act and there is already a shortage of qualified psychiatrists in the workforce;

Whereas IMGs are a very culturally diverse group who can enhance the care of minorities and underserved populations by appreciating and understanding of the cultural conceptualizations, psychosocial stressors, and cultural features of the relationship between the clinician and patients.

BE IT RESOLVED:

- The APA will collaborate with health workforce experts to assess the impact that diminishing number of IMGs will have on the care of the underserved populations;
- The APA will educate the public about the coming doctor shortage crisis and its relationship to poverty and healthcare disparities, and to address them together in a system model, which will improve the incomes and healthcare of all;
- The APA will educate the public about the key role of IMGs in delivery of care to underserved health constituencies

AUTHOR or AUTHORS:
Ludmila De Faria, M.D., Representative, Women Psychiatrists (Ldefariamd@gmail.com)
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Francis Sanchez, M.D., Deputy Representative, Asian-American Psychiatrists
Jose de la Gandara, M.D., Representative, Hispanic Psychiatrists
Oscar Perez, M.D., Deputy Representative, Hispanic Psychiatrists

ESTIMATED COST:
Author: $510
APA: $510

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Hispanic Psychiatrists, International Medical Graduate Psychiatrists

KEY WORDS: IMG, minority and under-represented groups

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.K
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Standardization of Psychiatric Nurse Practitioner Training

WHEREAS:
There is a documented need for increased access to mental health providers;

The number of psychiatrists generated annually has not been sufficient to meet the needs of mental health patients;

There are a growing number of Psychiatric Nurse Practitioner (PNP) programs to train mid-level providers of mental health;

There is variation in program length and structure for Psychiatric Nurse Practitioners;

This variation does not allow for consistent training outcomes and measures of skills sets and knowledge;

BE IT RESOLVED:
That the American Psychiatric Association (APA) liaise with the American Nurses Credentialing Center and American Psychiatric Nurses Association to standardize Psychiatric Nurse Practitioner Programs to ensure consistent training across programs.

AUTHORS:
Chaitanya Pabbati, M.D., RFM Representative, Area 6
Lawrence Malak, ECP Deputy Representative, Area 6

ESTIMATED COST:
Author: $340
APA: $2,673.33

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Assembly Committee of RFMs, Assembly Committee of ECPs

KEY WORDS: Psychiatric Nurse Practitioner, Access to Care

APA STRATEGIC GOAL: Advocating for the Profession, Supporting Education, Training and Career Development, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.L
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Conversion of the Components Directory to an Online-only Format

WHEREAS:
The components directory is currently organized and printed on an annual basis by APA staff.

Information contained within the directory is changing throughout the year, resulting in static printed materials that are inaccurate, which can potentially lead to incorrect information for members.

Directory information is currently available online, with updated information being consistently changed by staff in real time.

There is appreciable cost associated with staff time and directory printing costs.

National organizations are moving to online resources with less emphasis on printing materials, being more environmentally sound.

BE IT RESOLVED:

That the APA transition the component directory information to a printable online-only format, beginning with the creation of a fully functional online version.

That staff create a simple “user guide” for member instructions on accessing directory information via the online-only format.

That APA members would have the option to print the directory from the online version

That the APA staff report progress on this action paper to the November 2015 Assembly.

AUTHORS:
Edward Thomas Lewis, M.D., RFM Representative, Area 5
Candes Dotson, D.O., RFM Deputy Representative, Area 5
Mark Haygood, D.O, ECP Deputy Representative, Area 5

ESTIMATED COST:
Author: $0
APA: $4,200

ESTIMATED SAVINGS: $4000 (for printing materials), costs associated with staff time for creation of printed directory

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Assembly Committee of Resident-Fellow Members, Assembly Committee of Early Career Psychiatrists

KEY WORDS: Components Directory

APA STRATEGIC GOAL: Supporting Education, Training and Career Development

REVIEWED BY THE RELEVANT APA COMPONENT:

Item 2014A2 12.M
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Assembly DSM Component

WHEREAS:

1] The Assembly should have components that are very relevant to the interests of the Members.

2] The most important clinical decisions the APA makes are relative to the DSM.

3] Beginning with DSM-III's development, 1970s, the Assembly has had a component addressing the content of the DSMs.

4] There are already DSM issues to address.

5] The Assembly comprises a diverse group of practicing psychiatrists who are uniquely positioned to identify problems in the implementation of the DSM in clinical practice.

BE IT RESOLVED:

1] The Assembly establishes a DSM eleven person Committee composed of:

- each of the seven Areas,
- an M/UR Representative
- an RFM Representative
- an ECP representative
- an AAOL representative

2] That the above representatives be chosen by the Members they represent, i.e., Area 1 selects their representative.

3] The Speaker shall recommend that the Chair and Vice-chair be appointed as full members to the APA's DSM Steering Committee.

AUTHORS:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society
Richard Ratner, M.D., DLFAPA, Liaison, American Society for Adolescent Psychiatry

ESTIMATED COST:
Author: $2,350
APA: $2,425

ESTIMATED SAVINGS: none

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM, Assembly

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.N
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Exploration: Whether to Add some Symptoms to the Next DSM

WHEREAS:
1] DSM-5 conditions with a known etiology are not usually syndromes. [Two of thirteen, one of seven, and so forth is not a syndrome.]

2] DSM-5 conditions where the etiology is not stated, are presented as syndromes.

3] When further etiologies are uncovered, there is no reason to believe they will be syndromes like those in DSM-5.

4] Patients often present with an assortment of symptoms that poorly fit DSM-5's syndromes.

5] With almost no exceptions, DSM-5 does not inform the reader of mental symptoms that are used in the rest of medicine.

6] Psychiatrists and other mental health clinicians should not be discouraged from using the symptom designations available in the rest of medicine.

7] Using the symptoms available in the rest of medicine may sometimes better capture the patient's condition than a DSM-5 syndrome.

8] Where data collection is important, useful to have a recognized code for the conditions of interest, which may be a symptom, not a syndrome.

9] The National Center for Health Statistics makes the decisions as to ICD-CM codes.

10] There are already more than two dozen mental symptoms used in the rest of medicine, ICD-9-CM, as listed below alphabetically – but not yet available in DSM-5 as a coded option:

Altered mental status, 780.97
Apathy, 799.25
Attention deficit, 799.51
Cachexia, 799.4
Cognitive deficit, 799.52
Decreased libido, 799.81
Delayed milestones, 783.42
Demoralization 799.25
Emotional lability, 799.24
Excessive crying of adolescent, 780.95
Excessive crying of adult, 780.95
Excessive crying of infant, 780.92
Failure to thrive, adult, 783.7
Failure to thrive, child, 783.41

Fussy infant, 780.91
Hallucinations
    Auditory, 780.1
    Gustatory, 780.1
    Olfactory, 780.1
    Tactile, 780.1
    Visual, 368.16
Impulsivity, 799.23
Irritability, 799.22
Lethargy, 780.79
Memory loss, 780.93
Nervousness, 799.21
Polyphagia, 783.6
Psychomotor deficit, 799.54

BE IT RESOLVED:
1] That the DSM Steering Committee explores adding some mental health symptoms and codes, available to rest of medicine, to the next update of DSM-5

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM, Symptoms

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.O
Assembly
November 7-9, 2014

ACTION PAPER
FAILED

TITLE: Medical Term for "Lack of Physical Exercise"

WHEREAS:

1. Health care was enhanced by developing a medical term for “fat,” that is "obesity."
2. Obesity now has a specific meaning, severity scale, and treatment approaches.
3. The same strategy is needed for “lack of physical exercise," which contributes to the occurrence of a very wide range of major illnesses: cardiovascular diseases, cancer, depression, hypertension, and diabetes.
4. “Lack of physical exercise” already has code in ICD-9-CM [V69.0] and in ICD-10-CM [Z72.3]. What's missing is a medical term.

BE IT RESOLVED:
The APA’s AMA team should encourage the AMA to coin a medical term for "lack of physical exercise" and encourage its definition, severity scale, and its treatment.

AUTHOR:
Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:

Author: $0

APA: $933.33

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: Prevention, Exercise, Nomenclature

APA STRATEGIC GOAL: Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.P
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Neurodevelopmental

WHEREAS:

The entity "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" is the term used in DSM-5, page 86.

"Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" is part of the chapter on Neurodevelopment Disorders and its 29 Disorders.

The location of "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" in the ICD-9-CM is in section pertaining to developmental disorders.

Inexplicable, the term "Neurobehavioral Disorder associated with Prenatal Alcohol Exposure" is used in DSM-5 on page 798 in DSM-5.

"Neurobehavioral" is an idiosyncratic term not otherwise used in DSM-5.

Unlike "neurodevelopmental," there is no chapter in DSM-5 to place "neurobehavioral."

Unlike "neurodevelopmental," there is no location in ICD-9-CM to place "neurobehavioral."

These patients are broadly impacted by their condition, which is a brain-based phenomenon caused by the effects of alcohol on neural development. It is not accurate to narrow their signs and symptoms to "behavior," a more pejorative choice. We do not need a term that suggests the behavior is bad.,

The medical literature finds greater use of "neurodevelopmental" than "neurobehavioral" and more use of Neurodevelopmental disorder associated with prenatal alcohol exposure" than Neurobehavioral disorder associated with prenatal alcohol exposure" as indicated by a PubMed searches on June 29, 2014:
a] "Neurobehavioral," 449
b] "Neurodevelopmental," 12,891
c] "Neurobehavioral disorder associated with prenatal alcohol exposure," 16
d] "Neurodevelopmental disorder associated with prenatal alcohol exposure," 30.

BE IT RESOLVED:
That future printings of DSM use "Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure" throughout DSM-5.

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ESTIMATED COST:
Authors: Unknown
APA: $340

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: Unknown

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT: Sent to Chair, DSM component

Item 2014A2 12.Q
Assembly
November 7-9, 2014

ACTION PAPER
FAILED

TITLE: Replacing “Personality Disorder” with “Syndrome”

WHEREAS:

1] DSM-5 has a chapter on "Personality Disorders"

2] "Personality Disorder" is pejorative and more uncomfortable for patients than most diagnoses. See “9]” as to “disorder” being more pejorative than “syndrome.”

3] The APA should not advocate diagnostic terms that are painful for patients when less pejorative are available.

4] Being pejorative, the “personality disorder” decreases the patient's willingness to accept that label and, thus, accept treatment for that condition.

5] Insurance companies have been reluctant to pay for treatment of “personality disorders,” not eager to conceptualizing them as a medical condition.

6] When a patient has the signs and symptoms of a "personality" disorder, it is not uncommon for clinicians to select another diagnosis, e.g., Bipolar II, instead of a personality disorder diagnosis to avoid problems listed supra. That is often unfortunate because guides to the treatment of personality disorders stress the need for psychotherapy and without that diagnosis, the patient may not receive the psychotherapy they need, may only be given a prescription.

7] The DSM-5 version of personality disorders is not tied to the science of personality. This motion would leave the door open for DSM entities tied to the science of personalities.

8] “Syndrome” is a medical term* that implies a grouping of symptoms and is less pejorative than “disorder.” For example, alternative terms could be:

Paranoid syndrome
Schizoid syndrome
Schizotypal syndrome
Antisocial syndrome
Borderline syndrome
Histrionic syndrome
Narcissistic syndrome
Obsessive-compulsive syndrome
Avoidant syndrome
Dependent syndrome
Other syndromes of untoward interpersonal functioning
Unclassified conditions of untoward interpersonal functioning

9] *"Syndrome" is more medical than "disorder." In the Random House Dictionary of the English Language:

> Disorder 1. Lack of order or regular arrangement; confusion: *your room is in utter disorder*. 2. an irregularity: *a disorder in legal proceedings*. 3. breach of order; disorderly conduct; public disturbance. 4. a disturbance in physical or mental health or function; malady or dysfunction: *a mild stomach disorder*.
>
> Syndrome 1. Pathol., Psychiatry. A group of symptoms that together are characteristic of a specific disorder, disease, or the like. 2. a group of related or coincident things, events, action, etc. 3. the pattern of symptoms that characterize or indicate a particular social condition. 4. a predictable, characteristic pattern of behavior, action, etc., that tends to occur under certain circumstances: the retirement syndrome of endless golf and bridge games; the feast-or-famine syndrome of big business
>
> "Syndrome" appears in ICD-9-CM more than twice as frequently as "disorder."

10] The author of ICDs is the National Center of Health Statistics [NCHS].

BE IT RESOLVED:

1] That the Assembly propose to the APA DSM Steering Committee that the APA recommend to the National Center of Health Statistics [NCHS] that for all of DSM-5's "Personality Disorders," the names of the conditions use "syndrome" rather than "personality disorder."

2] Once approved by NCHS, that these additions be reflected in the subsequent update of DSM-5.

AUTHOR:
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ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: DSM

APA STRATEGIC GOAL: Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT: Sent to Chair, DSM component

Item 2014A2 12.R
Assembly
November 7-9, 2014

ACTION PAPER
WITHDRAWN

TITLE: District Branch President-Elect Orientation

WHEREAS:
Whereas, the timing of the District Branch President-Elect orientation should occur concurrently with the Fall APA Assembly meeting.

Whereas, one of the current major goals of the APA is to improve APA-District Branch communications,

Whereas, the orientation was previously scheduled during the Fall APA Assembly meeting.

Whereas, scheduling the meeting in the fall during the time of the Assembly meeting would improve interaction between District Branch leadership, the Assembly, the APA staff, and the Board of Trustees.

Whereas, by increasing face-to-face interactions, communication between the District Branches and the APA leadership would improve all year long.

BE IT RESOLVED:
The District Branch President-Elect orientation should occur concurrently with the Fall Assembly meeting.

AUTHOR:
Elias Sarkis, M.D., Representative, Florida Psychiatric Society

ESTIMATED COST:
Author: $45,462.67
APA: $45,322.67

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY:

KEY WORDS: District Branch, Orientation, District Branch Relations

APA STRATEGIC GOAL: Advocating for the Profession Supporting Education, Training, and Career Development, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

Item 2014A2 12.S
Assembly
November 7-9, 2014

ACTION PAPER
FINAL

TITLE: Assembly Allied Organizations and Sections Liaison (AAOSL) Committee Name Change

WHEREAS:
Whereas: the AAOSL has added section liaisons to the allied organizations liaisons

Whereas: the full title of the AAOSL Committee is long and tedious to use;

BE IT RESOLVED:
That the Assembly Allied Organizations and Sections Liaisons will be renamed the Assembly Committee of Representatives of Subspecialties and Sections (ACROSS). Members of ACROSS shall be called Subspecialty Representatives or Section Representatives, as appropriate.

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ESTIMATED COST:
Author: $0
APA: $93.33

ESTIMATED SAVINGS: 0

ESTIMATED REVENUE GENERATED: 0

ENDORSED BY: AAOSL Committee, Area 3

KEY WORDS: Liaisons, AAOL

APA STRATEGIC GOAL: Advocating for the Profession

REVIEWED BY RELEVANT APA COMPNENT: Assembly Allied Organizations and Sections Liaison (AAOSL) Committee

Item 2014A213.A
Assembly
November 7-9, 2014

ACTION PAPER
POSTPONED TO MAY 2015

TITLE: Psychiatric Treatment of High Risk Patient – Community Role

WHEREAS:

Whereas the psychiatric management of a patient with violent mindset towards self or others is a problem for the community as well as for the patient and treating psychiatrist, and

Whereas when treating the high risk patient the psychiatrist is often isolated and vulnerable, and

Whereas the availability of crisis teams in the community, of enlightened police departments and local courts, of available facilities prepared to treat the patient, and of anger management programs, all promote resolution of danger and precipitating factors, recovery of the patient and the safety of the community

BE IT RESOLVED:

The APA should work nationally and through its District Branches to promote the development of community facilities and programs that provide the psychiatrist additional crisis intervention and anger management programs; and to educate the local courts and police departments about diagnostic and treatment options.

APA should promote a peer support network among psychiatrist members to reduce the isolation of the treating psychiatrist. Peer collegial consultants should be immune in legal proceedings, and the consultation should be non discoverable.

APA should promote education of the public about recognizing origins, risk factors, symptoms and behaviors that indicate higher risk levels. This can be done through APA website, press releases, and medical brochures.

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ESTIMATED COST:
Author: $0
APA: $450,000

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: High risk patient; community role; public mental health; community education

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: Submitted to Council on Psychiatry and Law.

Item 2014A2 13.B
Assembly
November 7-9, 2014

ACTION PAPER
POSTPONED TO MAY 2014

TITLE: Allow Deputies to Vote

WHEREAS:
1. There are duly elected Members of the Assembly who are allowed to speak, but not to vote: Seven Deputy Representatives of the Minorities, seven Deputy Representatives of ECPs, seven Deputy Representatives of MITs, and about three dozen Representatives of smaller District Branches.

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

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

4. To say that a DB with 451 members should have twice as many votes in the Assembly as a DB with 449 achieves what?

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

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

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

8. There are reviews of the APA's governance taking place in one or more parts of the organization over the years. While these reviews take place, Deputes could be allowed to vote.

BE IT RESOLVED:
1. That the Assembly allows its elected Deputies to vote and attend both meetings of the Assembly and to pay their way to the November meeting.

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

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ESTIMATED COST:
Author: $0
APA: $0

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Washington Psychiatric Society, January, 2011

KEY WORDS: Deputy Representatives, a climate of equality, Respect for the members

APA STRATEGIC GOAL: Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: