American Psychiatric Association
Board of Trustees
December 13-14, 2014
Materials included in this document

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Draft Summary of Actions

Final Agenda

AMERICAN PSYCHIATRIC ASSOCIATION
BOARD OF TRUSTEES

SUMMARY OF ACTIONS

December 13-14, 2014

Agenda Item #	**Title/Action**	**Responsible Office/Component**
2.A	**Requests to Remove Items from the Consent Calendar Item 9.A.8**	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
5.A	**Minutes of the September 9-10, 2014 Board of Trustees Meeting** The Board of Trustees voted to approve the minutes of its September 9-10, 2014 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 • 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

Agenda Item #	Title/Action	Responsible Office/Component
7.A.1	**Joint Reference Committee** The Board of Trustees voted to approve, as a pilot program, that each ABPN subspecialty (Addiction; Child; Forensic; Geriatric and Psychosomatic Medicine, identify one individual [Medical Director or equivalent] to hold an ex-officio, non-voting position on its corresponding APA council. Costs of participation would be shared equally between APA and the participating subspecialty organization.	Chief of Policy, Programs, & Partnerships Chief Operating Officer • Association Governance
7.A.2	**Joint Reference Committee** The Board of Trustees voted to approve forming a work group to review and revise the 2008 Task Force Report to Update the Ethics Annotations. The group will include representation from the Ethics Committee, the Assembly, The Council on Psychiatry and Law. The work group tenure will continue to May 2015 with extensions if approved by the Board of Trustees. Drs. Laura Roberts and Paul Appelbaum will serve as consultants to the work group.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Ethics
7.A.3	**Joint Reference Committee** The Board of Trustees approved the 2015 nominee for the Jacob Javits Award, Dave Jones - California State Insurance Commissioner. **[CC]**	Chief of Government Affairs Council on Advocacy and Government Relations
7.A.4	**Joint Reference Committee** The Board of Trustees approved the 2015 nominee for the Human Rights Award nominee, Chester Pierce, MD. [CC]	Chief of Government Affairs Council on Psychiatry and the Law
7.A.5	**Joint Reference Committee** The Board of Trustees approved the 2014 Jack Weinberg Memorial Award in Geriatric Psychiatry nominee, Robert G. Robinson, MD. **[CC]**	Chief of Policy, Programs, & Partnerships • Diversity & Health Equity Council on Geriatric Psychiatry

Agenda Item #	Title/Action	Responsible Office/Component
7.A.6	**Joint Reference Committee** The Board of Trustees approved the nominees for the 2014 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society. **[CC]**	Chief of Communications • Communications and Public Affairs Council on Communications
7.A.7	**Joint Reference Committee** The Board of Trustees approved the 2015 nominee for the Adolf Meyer Award, Dr. Karl Deisseroth. **[CC]**	Chief of Policy, Programs & Partnerships • Education Council on Medical Education and Lifelong Learning
7.A.8	**Joint Reference Committee** The Board of Trustees approved the 2015 nominee for the Patient Advocacy Award, Patrick J. Kennedy. **[CC]**	Chief of Policy, Programs & Partnerships • Education Council on Medical Education and Lifelong Learning
7.A.9	**Joint Reference Committee** The Board of Trustees approved the 2014 nominees for the Psychiatric Services Achievement Awards. **[CC]** **Gold Award for Academically or Institutional Sponsored Programs:** Alliance Health Project Department of Psychiatry, University of California, San Francisco, San Francisco, CA **Gold Award for Community-based Programs:** Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, MA **Silver:** Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, PA **Bronze:** Shared Psychiatric Services, LifeWorks, Austin, TX **Certificate of Significant Achievement:** • The Mental Health Crisis Alliance, St. Paul MN • GATE-Utah (Giving Access to Everyone) Salt Lake City UT • Behavioral Health Integration Program, University of Washington, Seattle WA	Chief of Policy, Programs & Partnerships • Healthcare Systems & Finance

Agenda Item #	Title/Action	Responsible Office/Component
7.A.10	**Joint Reference Committee** The Board of Trustees approved the 2015 John Fryer Award nominee, Laverne Cox. **[CC]**	Chief of Policy, Programs, & Partnerships • Diversity & Health Equity Council on Minority Mental Health/Health Disparities
7.A.11	**Joint Reference Committee** The Board of Trustees approved the 2014 Bruno Lima Award nominees, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD. **[CC]**	Chief of Membership & RFM-ECP • International Affairs Committee on Psychiatric Dimensions of Disaster
7.A.12	**Joint Reference Committee** The Board of Trustees approved the revision to the charge to the Council on Communications to include the entirety of the APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies. **[CC]**	Chief of Communications • Communications and Public Affairs Council on Communications
7.A.13	**Joint Reference Committee** The Board of Trustees voted to approve the Council on Communications recommendation and support the APA branding initiative to help brand the APA consistently and demonstrate its value.	Chief of Communications • Communications and Public Affairs Council on Communications

Agenda Item #	Title/Action	Responsible Office/Component
7.A.14	**Joint Reference Committee** The Board of Trustees approved the revision of the charge to the Council on Research as follows. **[CC]** The Council on Research carries out activities to ensure that the substance and significance of research on mental health/illness remain integral parts of the APA mission and in the forefront of the national health agenda. The Council embodies the Association's commitment to advance evidence-based psychiatric knowledge ~~through the conduct of research by physician scientists~~ across a broad range of research fields and issues, which include, but are not limited to, basic science, clinical diagnosis and assessment, treatment research, research training, health services, ~~and~~ prevention research, and research ethics, and through the recognition of psychiatrist researchers who have made significant contributions to psychiatric knowledge and practice. These areas ~~are~~ may be represented by the Committees and Task Forces under the Council's jurisdiction, and others may be established in response to emerging needs relevant to the Council.	Chief of Policy, Programs & Partnerships • Research Council on Research
7.A.15	**Joint Reference Committee** The Board of Trustees approved the APA signing onto the AllTrials registry. **[CC]**	Chief of Policy, Programs & Partnerships • Quality Improvement
7.A.16	**Joint Reference Committee** The Board of Trustees approved transferring the administration of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry with the requisite changes to each council's charge editorially revised. **[CC]**	Chief of Membership & RFM-ECP • International Affairs Chief of Government Affairs • Regulatory Advocacy Council on Psychiatry and the Law Council on International Psychiatry

Agenda Item #	Title/Action	Responsible Office/Component
7.A.17	**Joint Reference Committee** The Board of Trustees approved allowing the Council on Medical Education and Lifelong Learning to seek publication of the resource document entitled *Training Psychiatrists for Integrated Behavioral Health Care: A Report of the American Psychiatric Association* outside of the American Psychiatric Association. **[CC]** The Council on Medical Education and Lifelong Learning has approached *Academic Psychiatry* regarding potential publication. APP, Inc. **If published, the final version of the resource document should have the recommendations removed.**	Chief of Policy, Programs & Partnerships • Education Council on Medical Education and Lifelong Learning
7.B	**Report of the President-Elect** The Board of Trustees voted to approve the revised composition and charge to the Scientific Program Committee of the Institute of Psychiatric Services. Note change made to composition: Composition: Twelve members (no less than 50% of the entire IPS Scientific Program Committee shall have attended three IPS Meetings) and 2 consultants (including advocacy representative and a local member), three liaisons (for example, an APA Fellow, a representative from Psychiatric Services Journal, and the chair or a member of the Annual Meeting Scientific Program Committee.)	Chief of Policy, Programs, & Partnerships • Education Chief Operating Officer • Association Governance
8.A.1	**Membership Committee Report** The Board of Trustees voted to approve the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report.	Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
8.A.2	**Membership Committee Report** The Board of Trustees voted to defer any decision on the recommendation by the Membership Committee to establish a new category of International Resident-Fellow Members for applicants who meet the following criteria, and returned it to the Membership Committee for clarification. *Proposed: Physicians enrolled in an accredited residency-training program in psychiatry or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, which is verified by the training program director. International Resident-Fellow Member status shall not exceed ten years, and upon completion of approved residency training, members shall be advanced to International Membership.* The Board suggested additional review of the proposal, particularly clarification of the term "accredited residency program in psychiatry" as it applies to international members and the reasoning behind the suggested ten-year tenure for this position.	Chief of Membership & RFM-ECP • Membership
8.A.3	**Membership Committee Report** The Board of Trustees voted to approve the recommendation of the Membership Committee to approve the concept of offering lump sum dues rates to International Members (Fellows and Distinguished Fellows) and request that the Finance & Budget Committee propose specific amounts to the BOT for approval.	Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
8.A.4	**Membership Committee Report** The Board of Trustees voted to approve the following recommendations of the Membership Committee to change the dues policies as outlined below, effective with the 2016 dues year The three actions below were approved en bloc: 1. Change the payment deadline to March 31 each year; a. Reaffirm that the current administrative reinstatement period of six months be continued (full year of dues must be paid to be administratively reinstated retroactive to March 31); b. Declare the first quarter of the year as a grace period; dropped members will not have any dues obligation in the first quarter in order to reinstate, unless they do so during the administrative reinstatement period; *after* the administrative reinstatement period, payment of future dues (only) will be required. 2. Require new and reinstating members to pay dues in advance, prior to enrollment (new members) or reinstatement (former members); 3. Offer Final Dues Amnesty Program will: a) Extend to the approximate 750 psychiatrists who have received it in the past; b) Extend to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty, and c) Allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in a new DB jurisdiction), even if dues are owed to the former DB (i.e., because it doesn't offer amnesty).	Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
8.A.5	**Membership Committee Report** The Board of Trustees voted to approve the Members listed in Attachment F for Fellowship and Life Fellowship. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.6	**Membership Committee Report** **[CC]** The Board of Trustees voted to approve the Members listed in Attachment G for International Fellowship. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.7	**Membership Committee Report** The Board of Trustees voted to approve the Members listed in Attachment H being advanced to Distinguished Fellow or Distinguished Life Fellow. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.8	**Membership Committee Report** The Board of Trustees voted to approve the nomination listed in Attachment J for International Distinguished Fellow of the APA. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.9	**Membership Committee Report** The Board of Trustees authorized dropping from APA membership the Members listed in Attachment M for failure to meet the requirements of membership. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.10	**Membership Committee Report** The Board of Trustees voted to approve the applicants listed in Attachment O for International Membership. **[CC]**	Chief of Membership & RFM-ECP • Membership
8.A.11	**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.A.12	**Membership Committee Report** The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment P. **[CC]**	Chief of Membership & RFM-ECP • Membership

Agenda Item #	Title/Action	Responsible Office/Component
8.B.1	**Finance and Budget Committee Report** The APA Board of Trustees approved the proposed amendment to the travel policy to allow "an upgrade to the next class of service" when airtime exceeds 12 hours, and to the Officers Reimbursement policy when airtime is greater than 5 hours. [Abstentions: Drs. Binder, Martin, Akaka, Geller & Pender)	Chief Financial Officer • Finance & Business Operations
8.B.2	**Finance and Budget Committee Report** The APA Board of Trustees approved the proposed amendment to the travel policy to allow reimbursement of costs associated with upgraded economy class seats when no other seat is available.	Chief Financial Officer • Finance & Business Operations
8.B.3	**Finance and Budget Committee Report** The APA Board of Trustees approved the establishment of a lump sum dues program for International Members, with rates as proposed [effective FY 2015]	Chief Financial Officer • Finance & Business Operations Chief of Membership & RFM-ECP ▪ Membership
8.B.4	**Finance and Budget Committee Report** The APA Board of Trustees approved the establishment of a lump sum dues program for Canadian Members, with rates as proposed [effective FY 2015]	Chief Financial Officer • Finance & Business Operations Chief of Membership & RFM-ECP ▪ Membership
8.B.5	**Finance and Budget Committee Report** The APA Board of Trustees approved the adjustment of the lump sum dues amounts for US Members, as proposed (effective FY 2016)	Chief Financial Officer • Finance & Business Operations Chief of Membership & RFM-ECP ▪ Membership
8.B.6	**Finance and Budget Committee Report** The APA Board of Trustees approved the APA Reserve Spending Policy as proposed.	Chief Financial Officer • Finance & Business Operations

Agenda Item #	Title/Action	Responsible Office/Component
8.B.7	**Finance and Budget Committee Report** The APA Board of Trustees voted to allow the use of the June 30 balance of the prior year as the base for calculations for budget years 2015-2017, with the three-year averaging to begin in 2018 budget year.	Chief Financial Officer • Finance & Business Operations
8.B.8	**Finance and Budget Committee Report** **Capital Budget:** The Board of Trustees approved the 2015 Capital budget as proposed.	Chief Financial Officer • Finance & Business Operations
8.B.9	**Finance and Budget Committee Report** **American Psychiatric Foundation Operating Budget:** The Board of Trustees approved the 2015 American Psychiatric Foundation Operating Budget as proposed.	Chief Financial Officer • Finance & Business Operations
8.B.10	**Finance and Budget Committee Report** **APA Operating Budget:** The Board of Trustees approved the 2015 APA Operating Budget as proposed.	Chief Financial Officer • Finance & Business Operations

Agenda Item #	Title/Action	Responsible Office/Component
8.D	**Nominating Committee** The Board of Trustees voted to accept the report of the Nominating Committee as presented. 2015 APA Election Slate: President-Elect Barton J. Blinder, MD Maria A. Oquendo, MD Charles F. Reynolds, MD Secretary Rahn K. Bailey, MD Altha J. Stewart, MD Early Career Psychiatrist Lama Bazzi, MD Paul O'Leary, MD Minority/Underrepresented Representative (M/UR) Trustee Curley L. Bonds, MD Gail E. Robinson, MD Area 1 Trustee Jeffrey L. Geller, MD, MPH Anthony J. Rothschild, MD Area 4 Trustee Ronald M. Burd, MD Shastri Swaminathan, MD Area 7 Trustee Jeffrey Akaka, MD Stephen L. Brown, MD Annette M. Matthews, MD Resident-Fellow Trustee-Elect (RFMTE) Alicia Barnes, DO, MPH Stella Cai, MD Sarah Schmidhofer, MD	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Responsible Office/Component
8.F	**Conflict of Interest Committee** The Board of Trustees approved the participation on the DSM Steering Committee of the following individuals, as recommended by the Conflict of Interest Committee. Paul Appelbaum, MD – Chairperson Kenneth Kendler, MD – Vice Chairperson Renato Alarcon, MD – Member Deanna Barch, PhD – Member Patricia Collins, MD, PhD – Member Michelle Craske, PhD – Member Michael First, MD – Member Dilip Jeste, MD – Member Ellen Leibenluft, MD – Member Susan Schultz, MD – Member Kimberly Yonkers, MD – Member Glenn Martin, MD – Assembly Liaison Rebecca Rinehart – APP Liaison Wilson Compton, MD – Ex-officio/NIDA Bruce Cuthbert, PhD – Ex-officio/NIMH George Koob, PhD – Ex-officio/NIAAA Geoffrey Reed, PhD – Ex-officio/WHO	Chief Operating Officer • Association Governance
9.A.1	**Speaker's Report** The Board of Trustees voted to approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*.	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 on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.3	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Relationship between Treatment and Self Help*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
9.A.4	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.5	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Elder Abuse, Neglect and Exploitation*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.6	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Discriminatory Disability Insurance Coverage*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.7	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations.* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.8	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *State Mental Health Services* with a revised title: Position Statement on Leadership of State Mental Health Services. The position statement language is unchanged.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.9	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Universal Access to Healthcare*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.10	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion.* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
9.A.11	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Care*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.12	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Psychotherapy and Managed Care*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.13	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.14	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter.* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.15	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.16	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Abortion and Women's Reproductive Health Rights*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.17	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Xenophobia, Immigration and Mental Health*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
9.A.18	**Speaker's Report** The Board of Trustees approved the retirement of the Position Statement: *Juvenile Death Sentences*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.19	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Peer Review of Expert Testimony*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.20	**Speaker's Report** The Board of **[CC]** Trustees approved the retention of the Position Statement: *Joint Resolution against Torture*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.21	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Moratorium on Capital Punishment in the United States*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.22	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.23	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Insanity Defense*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.24	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
9.A.25	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury.* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.26	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Mentally Ill Prisoners on Death Row*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.27	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Diminished Responsibility in Capital Sentencing* **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.28	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Endorsement of the Patient-Physician Covenant*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.29	**Speaker's Report** The Board of Trustees approved the retention of the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*. **[CC]**	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.30	**Speaker's Report** The Board of Trustees 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.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.31	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
9.A.32	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.33	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.34	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.35	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.36	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.37	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library
9.A.38	**Speaker's Report** The Board of Trustees voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation.	Chief Operating Officer • Association Governance Chief of Membership & RFM-ECP • Library

Agenda Item #	Title/Action	Responsible Office/Component
11.D	**Ad Hoc Work Group on Real Estate** The APA Board of Trustees voted to approve the Work Group's recommendation that the APA purchase a new headquarters building in Washington, DC if a suitable deal can be found.	Office of the CEO & Medical Director
11.E.1	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Jack W. Bonner, M.D.	Chief Operating Officer • Association Governance
11.E.2	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Joseph T. English, M.D.	Chief Operating Officer • Association Governance
11.E.3	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Dilip V. Jeste, M.D.	Chief Operating Officer • Association Governance
11.E.4	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to, Wayne J. Katon, M.D.	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Responsible Office/Component
11.E.5	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Helen Mayberg, M.D.	Chief Operating Officer • Association Governance
11.E.6	**Distinguished Service Award Work Group** The Board of Trustees voted to approve the recommendation of the Distinguished Service Award Work Group to award the 2015 organization Distinguished Service Award to the *Academy of Psychosomatic Medicine*.	Chief Operating Officer • Association Governance

Agenda Item #	Title/Action	Responsible Office/Component
11.F	**Ad Hoc Work Group on APA Referendum Process** The Board of Trustees voted to approve option #2 of the report of the Ad Hoc Work Group on APA Referendum Process. **OPTION #2:** The Board could consider making a change to the APA Operations Manual to add a procedure concerning referenda that reach a minimum designated percentage of affirmative member votes. If this percentage (lower than the APA bylaws minimums) was reached, the Board Chair (APA President) would be instructed to place the item on the next Board agenda for appropriate discussion by the Board of Trustees. If the Board supports this option the following actions should also take place: a. Information concerning the referendum would be contained within the Tellers Report to the Board of Trustees so members may easily access the information. b. The Operations Manual would be amended to note the new process and requirement concerning the addition to the Board agenda and appropriate Board discussion. c. The CEO and Medical Director and the Chief of Communications and Public Affairs will address the member communication process. d. The General Counsel will provide any additional legal advice	Chief Operating Officer • Association Governance
New Business	**Replacement of APA Trustees if In-term Vacancies Occur** The Board of Trustees voted to ask the Bylaws Committee to draft language concerning replacement of Board Trustees should unforeseen in-term vacancies occur. Proposed changes should be consistent with the Bylaws and previous actions of the Board of Trustees. The language, if reviewed and approved by the Board of Trustees, will be placed in the APA Operations Manual.	Chief Operating Officer • Association Governance General Counsel

Agenda Item #	Title/Action	Responsible Office/Component
New Business	The Board of Trustees voted to commend CFO Therese V. Swetnam, PhD for her many years of outstanding service to the American Psychiatric Association and requested that the Board Minutes reflect this vote of thanks.	Chief Operating Officer • Association Governance Chief Financial Officer (for Information)

American Psychiatric Association
Board of Trustees
Westin Arlington Gateway Hotel
Arlington, VA

December 13-14, 2014

FINAL AGENDA

SATURDAY, DECEMBER 13TH

7:30 AM – 8:30 AM – Board of Trustees BREAKFAST *(Ernest Hemingway Salon)*

8:30 AM–5:00 PM - Board of Trustees Meeting (*F. Scott Fitzgerald A/B*)

8:30 am **1. Call to Order –** Paul Summergrad, MD

A. Introductions and Verbal Conflict of Interest Disclosures and Affiliations

8:35 am **2. Consent Calendar** – Paul Summergrad, MD

A. Requests to Remove Items from the Consent Calendar

B. Approval of Items on the Consent Calendar

ACTION:
Will the Board of Trustees vote to approve the Consent Calendar?

8:37 am **5. Report of the Secretary** – Maria A. Oquendo, MD

A. Minutes of the September 9-10, 2014 Board of Trustees Meeting

cc

ACTION:
Will the Board of Trustees vote to approve the minutes of its September 9-10, 2014 meeting?

8:38 am **6. Report of the Treasurer** – Frank Brown, MD

A. Treasurer's Report

B. Status of the Board Contingency Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the Board of Trustees Contingency Fund? (Please see item BOT 6.B.)

C. Presidents' New Initiative Funds

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the President's New Initiative Funds for Dr. Jeste, Dr. Lieberman, and Dr. Summergrad? (Please see item BOT 6.C.)

D. Assembly New Initiative Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the Assembly's New Initiative Fund? (Please see item BOT 6.C.)

8. Reports from Standing Committees and Councils

8:48 am **B. Finance and Budget Committee Report**
Alan F. Schatzberg, MD, Chair

ACTION 1:
Travel Policies: Will the Board of Trustees approve the proposed amendment to the travel policy to allow "an upgrade to the next class of service" when air time exceeds 12 hours, and to the Officers Reimbursement policy when air time is greater than 5 hours?

ACTION 2:
Travel Policy: Will the Board of Trustees approve the proposed amendment to the travel policy to allow reimbursement of costs associated with upgraded economy class seats when no other seat is available?

ACTION 3:
Lump Sum Dues: Will the Board of Trustees approve the establishment of a lump sum dues program for International Members, with rates as proposed?

ACTION 4:
Lump Sum Dues: Will the Board of Trustees approve the establishment of a lump sum dues program for Canadian Members, with rates as proposed?

ACTION 5:
Lump Sum Dues: Will the Board of Trustees approve the adjustment of the lump sum dues amounts for US Members, as proposed?

ACTION 6:
Reserve Spending Policy: Will the Board of Trustees approve the APA Reserve Spending Policy as proposed?

ACTION 7:
Reserve Spending Policy: Will the Board of Trustees allow the use of the June 30 balance of the prior year as the base for calculations for budget years 2015-2017, with the three year averaging to begin in 2018 budget year?

ACTION 8:
Capital Budget: Will the Board of Trustees approve the 2015 Capital budget as proposed?

ACTION 9:
American Psychiatric Foundation Operating Budget: Will the Board of Trustees approve the 2015 Foundation Operating Budget as proposed?

ACTION 10:
APA Operating Budget: Will the Board of Trustees approve the 2015 APA Operating Budget as proposed?

10:18 am **D.** **Report from the Nominating Committee**
Jeffrey A. Lieberman, MD, Chair

ACTION:
Will the Board of Trustees vote to accept the report of the Nominating Committee as presented?

11. Work Group and Task Force Reports

10:20 am **A.** **Ad Hoc Work Group on Education and Training**
Richard Summers, MD, Chair

10:50 am **B.** **Ad Hoc Work Group on Liability Insurance**
William Arroyo, MD, Chair **(skype)**

11:10 am **C.** **Ad Hoc Work Group on Strategic Planning**
Paul Summergrad, MD

12:00 Noon – 1:00 PM LUNCH *(Ernest Hemingway Salon)*

1:00 pm **D.** **Ad Hoc Work Group on Real Estate**
Frank Brown, MD, Chair

3:30 pm **EXECUTIVE SESSION**

5:00 pm **ADJOURNMENT FOR THE DAY** (Must end at 5 pm due to another event in the room.)

BOARD DINNER — NOPA Kitchen and Bar Restaurant, 800 F Street, NW, Washington, DC. (Meet in hotel lobby at 6:30 pm for shuttle to restaurant. Dinner will be at 7:00 pm.)

SUNDAY, DECEMBER 14TH

8:00 AM – 8:55 AM BREAKFAST (*Ernest Hemingway Salon*)

9:00 AM – BOARD OF TRUSTEES' ANNUAL PHOTOGRAPH (Gather in Hotel Lobby Promptly at 9:00 am)

9:10 AM – 1:30 PM BOARD OF TRUSTEES MEETING (*F. Scott Fitzgerald A/B*)

11. Work Group and Task Force Reports (Continued)

9:10 am

E. Distinguished Service Award Work Group
Paul Summergrad, MD, Chair

ACTION 1:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Jack W. Bonner, M.D.?

ACTION 2:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Joseph T. English, M.D.?

ACTION 3:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Dilip V. Jeste, M.D.?

ACTION 4:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to, Wayne J. Katon, M.D.?

ACTION 5:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Helen Mayberg, M.D.?

ACTION 6:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 organization Distinguished Service Award to Academy of Psychosomatic Medicine?

9:15 am

F. Ad Hoc Work Group on APA Referendum Process
Renée L. Binder, MD, Chair

8. Reports from Standing Committees and Councils (Continued)

9:25 am **A.** **Membership Committee Report**
Rahn K. Bailey, MD, Chair (speakerphone)

cc

ACTION 1:
Will the Board of Trustees approve the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report?

ACTION 2:
Will the Board of Trustees approve the recommendation of the Membership Committee to establish a new category of International Resident-Fellow Members for applicants who meet the following criteria?

- Physicians enrolled in an accredited residency training program in psychiatry or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, which is verified by the training program director. International Resident-Fellow Member status shall not exceed ten years, and upon completion of approved residency training, members shall be advanced to International Membership.

ACTION 3:
Will the Board of Trustees approve the recommendation of the Membership Committee to approve the concept of offering lump sum dues rates to International Members (Fellows and Distinguished Fellows) and request that the Finance & Budget Committee propose specific amounts to the BOT for approval?

ACTION 4:
Will the Board of Trustees approve the following recommendations of the Membership Committee to change the dues policies as outlined below, effective with the 2016 dues year (recommend approving all items below as a package since each idea is inter-reliant on all the other ideas together):

4.1. Change the payment deadline to March 31;
a. reaffirm that the current administrative reinstatement period of six months be continued (full year of dues must be paid to be administratively reinstated retroactive to March 31);
b. declare the first quarter of the year as a grace period; dropped members will not have any dues obligation in the first quarter in order to reinstate, unless they do so during the administrative reinstatement period; *after* the administrative reinstatement period, payment of future dues (only) will be required.

4.2. Require new and reinstating members to pay dues in advance, prior to enrollment (new members) or reinstatement (former members);

4.3. Offer final Dues Amnesty Program:
a) extend to the approximate 750 psychiatrists who have received it in the past;
b) extend to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty, and
c) allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in

a new DB jurisdiction), even if dues are owed to the former DB (i.e., because it doesn't offer amnesty).

cc **ACTION 5:**
Will the Board of Trustees vote that the Members listed in Attachment F be approved for Fellowship and Life Fellowship?

cc **ACTION 6:**
Will the Board of Trustees vote that the Members listed in Attachment G be approved for International Fellowship?

cc **ACTION 7:**
Will the Board of Trustees vote that the Members listed in Attachment H be advanced to Distinguished Fellow or Distinguished Life Fellow?

cc **ACTION 8:**
Will the Board of Trustees vote to approve the nomination listed in Attachment J for International Distinguished Fellow of the APA?

cc **ACTION 9:**
Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment M for failure to meet the requirements of membership?

cc **ACTION 10:**
Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment N, who have been dropped by their district branches?

cc **ACTION 11:**
Will the Board of Trustees vote to approve the applicants listed in Attachment O for International Membership?

cc **ACTION 12:**
Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment P?

9:45 am **C.** **<u>Investment Oversight Committee Report</u>** (*For Information Only*)

9:46 am **F.** **<u>Conflict of Interest Committee Report</u>**
Maria A. Oquendo, MD, Chair

ACTION:
Will the Board of Trustees approve the participation on the DSM Steering Committee of the following individuals, as recommended by the Conflict of Interest Committee?

Paul Appelbaum, MD – Chairperson
Kenneth Kendler, MD – Vice Chairperson
Renato Alarcon, MD – Member
Deanna Barch, PhD – Member
Pamela Collins, MD, MPH – Member

Michelle Craske, PhD – Member
Michael First, MD – Member
Dilip Jeste, MD – Member
Ellen Leibenluft, MD – Member
Susan Schultz, MD – Member
Kimberly Yonkers, MD – Member
Glenn Martin, MD – Assembly Liaison*
Rebecca Rinehart – APPI Liaison

Wilson Compton, MD – Ex-officio/NIDA
Bruce Cuthbert, PhD – Ex-officio/NIMH
George Koob, PhD – Ex-officio/NIAAA
Geoffrey Reed, PhD – Ex-officio/WHO

*The COI Committee notes that Dr. Martin has investments over the $10,000 limit that may give the appearance of conflict. However, in his role as Assembly Liaison, the committee recommends his appointment to the DSM-5 Steering Committee.

10:05 am **7. Reports of the Joint Reference Committee and President-Elect**
Renée L. Binder, MD, Chair

A. Joint Reference Committee Recommendations

ACTION 1:
Will the Board of Trustees approve, as a pilot program, that each ABPN subspecialty identify one individual to hold an ex-officio, non-voting position on its corresponding APA council?

ACTION 2:
Will the Board of Trustees form a work group to review and revise the 2008 Task Force Report to Update the Ethics Annotations?

cc **ACTION 3:**
Will the Board of Trustees approve the 2015 nominee for the Jacob Javits Award, Dave Jones - California State Insurance Commissioner?

cc **ACTION 4:**
Will the Board of Trustees approve the 2015 nominee for the Human Rights Award nominee, Chester Pierce, MD?

cc **ACTION 5:**
Will the Board of Trustees approve the 2014 Jack Weinberg Memorial Award in Geriatric Psychiatry nominee, Robert G. Robinson, MD?

cc **ACTION 6:**
Will the Board of Trustees approve the nominees for the 2014 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society?

cc **ACTION 7:**
Will the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award, Dr. Karl Deisseroth?

cc **ACTION 8:**
Will the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award, Patrick J. Kennedy?

cc **ACTION 9:**
Will the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Awards?

Gold Award for Academically or Institutional Sponsored Programs:
Alliance Health Project
Dept. of Psychiatry, University of California, San Francisco, San Francisco, CA
Gold Award for Community-based Programs:
Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, MA
Silver:
Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, PA
Bronze:
Shared Psychiatric Services, LifeWorks, Austin, TX
Certificate of Significant Achievement:

- The Mental Health Crisis Alliance, St. Paul MN
- GATE-Utah (Giving Access to Everyone) Salt Lake City UT

Behavioral Health Integration Program, University of Washington, Seattle WA

cc **ACTION 10:**
Will the Board of Trustees approve the 2015 John Fryer Award nominee, Laverne Cox?

cc **ACTION 11:**
Will the Board of Trustees approve the 2014 Bruno Lima Award nominees, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD?

cc **ACTION 12:**
Will the Board of Trustees approve the revision to the charge to the Council on Communications to include the entirety of the APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies?

ACTION 13:
Will the Board of Trustees approve the Council on Communications recommendation and support the APA's branding initiative to help brand the APA consistently and demonstrate its value?

cc **ACTION 14:**
Will the Board of Trustees approve the revision of the charge to the Council on Research?

cc **ACTION 15:**
Will the Board of Trustees approve the APA signing onto the AllTrials registry?

cc **ACTION 16:**
Will the Board of Trustees approve transferring the administration of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry with the requisite changes to each council's charge editorially revised?

cc **ACTION 17:**
Will the Board of Trustees approve allowing the Council on Medical Education and Lifelong Learning to seek publication of the resource document entitled *Training Psychiatrists for Integrated Behavioral Health Care: A Report of the American Psychiatric Association* outside of the American Psychiatric Association?

The Council on Medical Education and Lifelong Learning has approached *Academic Psychiatry* regarding potential publication. APP, Inc.

B. Report of the President-Elect

ACTION:
Will the Board of Trustees vote to approve the revised composition and charge to the Scientific Program Committee of the Institute of Psychiatric Services?

10:35 am **9. Report of the Speaker** – Jenny Boyer, MD, PhD, JD

A. Executive Summary

ACTION 1:
Will the Board of Trustees approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*?

ACTION 2:
Will the Board of Trustees approve the Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*?

cc **ACTION 3:**
Will the Board of Trustees approve the retention of the Position Statement: *Relationship between Treatment and Self Help*?

cc **ACTION 4:**
Will the Board of Trustees approve the retirement of the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*?

cc **ACTION 5:**
Will the Board of Trustees approve the retention of the Position Statement: *Elder Abuse, Neglect and Exploitation*?

cc **ACTION 6:**
Will the Board of Trustees approve the retention of the Position Statement: *Discriminatory Disability Insurance Coverage*?

cc **ACTION 7:**
Will the Board of Trustees approve the retention of the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations*?

cc **ACTION 8:**
Will the Board of Trustees approve the retention of the Position Statement: *State Mental Health Services*?

cc **ACTION 9:**
Will the Board of Trustees approve the retention of the Position Statement: *Universal Access to Healthcare*?

cc **ACTION 10:**
Will the Board of Trustees approve the retention of the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*?

cc **ACTION 11:**
Will the Board of Trustees approve the retirement of the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Care*?

cc **ACTION 12:**
Will the Board of Trustees approve the retirement of the Position Statement: *Psychotherapy and Managed Care*?

cc **ACTION 13:**
Will the Board of Trustees approve the retirement of the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*?

cc **ACTION 14:**
Will the Board of Trustees approve the retirement of the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter*?

cc **ACTION 15:**
Will the Board of Trustees approve the retirement of the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded*?

cc **ACTION 16:**
Will the Board of Trustees approve the retention of the Position Statement: *Abortion and Women's Reproductive Health Rights*?

cc **ACTION 17:**
Will the Board of Trustees approve the retention of the Position Statement: *Xenophobia, Immigration and Mental Health*?

cc **ACTION 18:**
Will the Board of Trustees approve the retirement of the Position Statement: *Juvenile Death Sentences*?

cc **ACTION 19:**
Will the Board of Trustees approve the retention of the Position Statement: *Peer Review of Expert Testimony*?

cc **ACTION 20:**
Will the Board of Trustees approve the retention of the Position Statement: *Joint Resolution against Torture*?

cc **ACTION 21:**
Will the Board of Trustees approve the retention of the Position Statement: *Moratorium on Capital Punishment in the United States*?

cc **ACTION 22:**
Will the Board of Trustees approve the retention of the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*?

cc **ACTION 23:**
Will the Board of Trustees approve the retention of the Position Statement: *Insanity Defense*?

cc **ACTION 24:**
Will the Board of Trustees approve the retention of the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*?

cc **ACTION 25:**
Will the Board of Trustees approve the retention of the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury?*

cc **ACTION 26:**
Will the Board of Trustees approve the retention of the Position Statement: *Mentally Ill Prisoners on Death Row*?

cc **ACTION 27:**
Will the Board of Trustees approve the retention of the Position Statement: *Diminished Responsibility in Capital Sentencing*?

cc **ACTION 28:**
Will the Board of Trustees approve the retention of the Position Statement: *Endorsement of the Patient-Physician Covenant*?

cc **ACTION 29:**
Will the Board of Trustees approve the retention of the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*?

ACTION 30:
Will the Board of Trustees 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?

ACTION 31:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment?

ACTION 32:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk?

ACTION 33:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors?

ACTION 34:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors?

ACTION 35:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health?

ACTION 36:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment?

ACTION 37:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making?

ACTION 38:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation?

10:45 am **3. Report of the President** – Paul Summergrad, MD

A. Discussions
Paul Summergrad, MD

B. Executive Committee Report (*For Review and Appropriate Action*)

11:05 am **4. Report of the CEO/Medical Director**– Saul Levin, MD, MPA

A. CEO/MDO Presentation

11:25 pm **10. Report of the American Psychiatric Foundation** – Saul Levin, MD, MPA Chairperson and Paul Burke, Executive Director

A. Report from American Psychiatric Foundation

8. Reports from Standing Committees and Councils (Continued)

11:45 pm **E. APA/AMA Delegation Report**
Carolyn B. Robinowitz, MD, Senior Delegate

12:00 Noon – 1:00 PM LUNCH *(Ernest Hemingway Salon)*

12. Informational Items

13. Unfinished Business

14. New Business

1:00 pm **EXECUTIVE SESSION**

15. Adjournment
Note: Dr. Summergrad plans to conclude the meeting by 1:30 pm.

Future Meetings

2015

March 14-15, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
May 17, 2015, Board of Trustees Meeting, Convention Center, Toronto, Canada
June12-14, 2015, Executive Committee Retreat, The Inn Above Tide, Sausalito, CA
July 11-12, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA
October 11-12, 2015, Board of Trustees Meeting, (w/Institute on Psychiatric Services), New York, NY
December 12-13, 2015, Board of Trustees Meeting, Westin Arlington Gateway Hotel, Arlington, VA

BOARD OF TRUSTEES
DECEMBER 2014 MEETING

ALL ACTIONS BEING PRESENTED FOR CONSIDERATION
(**As of December 2, 2014**)

Consent Calendar Items Notated by "cc"

5. Report of the Secretary – Maria A. Oquendo, MD

A. Minutes of the September 9-10, 2014 Board of Trustees Meeting

cc **ACTION:**
Will the Board of Trustees approve the minutes of its September 9-10, 2014 Meeting?

6. Report of the Treasurer – Frank Brown, MD

B. Status of the Board Contingency Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the Board Contingency Fund?

C. Presidents' New Initiative Funds

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status of the Presidents' New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder?

D. Assembly New Initiative Fund

cc **ACTION:**
Will the Board of Trustees vote to accept the report of the status for the Assembly's New Initiative Fund?

7. Report of the Joint Reference Committee Report and President-Elect

A. Joint Reference Committee Recommendations – Renée Binder, MD

ACTION 1:
Will the Board of Trustees approve, as a pilot program, that each ABPN subspecialty identify one individual to hold an ex-officio, non-voting position on its corresponding APA council?

ACTION 2:
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cc **ACTION 3:**
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Department of Psychiatry, University of California, San Francisco, San Francisco, CA

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Silver:
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Bronze:
Shared Psychiatric Services, LifeWorks, Austin, TX

Certificate of Significant Achievement:
- The Mental Health Crisis Alliance, St. Paul MN
- GATE-Utah (Giving Access to Everyone) Salt Lake City UT
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B. <u>Report of the President-Elect</u>

ACTION:
Will the Board of Trustees vote to approve the revised composition and charge to the Scientific Program Committee of the Institute of Psychiatric Services?

8. Reports from Standing Committees and Councils

A. **Membership Committee Report** – Rahn Bailey, MD, Chair

cc **ACTION 1:**
Will the Board of Trustees approve the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report?

ACTION 2:
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ACTION 3:
Will the Board of Trustees approve the recommendation of the Membership Committee to approve the concept of offering lump sum dues rates to International Members (Fellows and Distinguished Fellows) and request that the Finance & Budget Committee propose specific amounts to the BOT for approval?

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4.2. Require new and reinstating members to pay dues in advance, prior to enrollment (new members) or reinstatement (former members);

4.3. Offer final Dues Amnesty Program:
a) extend to the approximate 750 psychiatrists who have received it in the past;

b) extend to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty, and
c) allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in a new DB jurisdiction), even if dues are owed to the former DB (i.e., because it doesn't offer amnesty).

cc **ACTION 5:**
Will the Board of Trustees vote that the Members listed in Attachment F be approved for Fellowship and Life Fellowship?

cc **ACTION 6:**
Will the Board of Trustees vote that the Members listed in Attachment G be approved for International Fellowship?

cc **ACTION 7:**
Will the Board of Trustees vote that the Members listed in Attachment H be advanced to Distinguished Fellow or Distinguished Life Fellow?

cc **ACTION 8:**
Will the Board of Trustees vote to approve the nomination listed in Attachment J for International Distinguished Fellow of the APA?

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Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment M for failure to meet the requirements of membership?

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Will the Board of Trustees vote to approve the applicants listed in Attachment O for International Membership?

cc **ACTION 12:**
Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment P?

B. **Finance and Budget Committee Report** – Alan F. Schatzberg, MD, Chair

ACTION 1:
Travel Policies: Will the APA Board of Trustees approve the proposed amendment to the travel policy to allow "an upgrade to the next class of service" when air time exceeds 12 hours, and to the Officers Reimbursement policy when air time is greater than 5 hours?

ACTION 2:
Travel Policy: Will the APA Board of Trustees approve the proposed amendment to the travel policy to allow reimbursement of costs associated with upgraded economy class seats when no other seat is available?

ACTION 3:
Lump Sum Dues: Will the APA Board of Trustees approve the establishment of a lump sum dues program for International Members, with rates as proposed?

ACTION 4:
Lump Sum Dues: Will the APA Board of Trustees approve the establishment of a lump sum dues program for Canadian Members, with rates as proposed?

ACTION 5:
Lump Sum Dues: Will the APA Board of Trustees approve the adjustment of the lump sum dues amounts for US Members, as proposed?

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ACTION 7:
Reserve Spending Policy: Will the APA Board of Trustees allow the use of the June 30 balance of the prior year as the base for calculations for budget years 2015-2017, with the three year averaging to begin in 2018 budget year?

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ACTION 9:
American Psychiatric Foundation Operating Budget: Will the Board of Trustees approve the 2015 Foundation Operating Budget as proposed?

ACTION 10:
APA Operating Budget: Will the Board of Trustees approve the 2015 APA Operating Budget as proposed?

D. **Report from the Nominating Committee** – Jeffrey A. Lieberman, MD, Chair

ACTION:
Will the Board of Trustees vote to accept the report of the Nominating Committee as presented?

F. **Conflict of Interest Committee Report** – Maria A. Oquendo, MD, Chair

ACTION:
Will the Board of Trustees approve the participation on the DSM Steering Committee of the following individuals, as recommended by the Conflict of Interest Committee?

Paul Appelbaum, MD – Chairperson
Kenneth Kendler, MD – Vice Chairperson
Renato Alarcon, MD – Member
Deanna Barch, PhD – Member
Patricia Collins, MD, PhD – Member
Michelle Craske, PhD – Member
Michael First, MD – Member
Dilip Jeste, MD – Member
Ellen Leibenluft, MD – Member
Susan Schultz, MD – Member
Kimberly Yonkers, MD – Member
Glenn Martin, MD – Assembly Liaison*
Rebecca Rinehart – APPI Liaison
Wilson Compton, MD – Ex-officio/NIDA
Bruce Cuthbert, PhD – Ex-officio/NIMH
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Geoffrey Reed, PhD – Ex-officio/WHO

*The COI Committee notes that Dr. Martin has investments over the $10,000 limit that may give the appearance of conflict. However, in his role as Assembly Liaison, the committee recommends his appointment to the DSM-5 Steering Committee.

9. **Report of the Speaker** – Jenny Boyer, MD, PhD, JD

A. **Executive Summary**

ACTION 1:
Will the Board of Trustees approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*?

ACTION 2:
Will the Board of Trustees approve the Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*?

cc **ACTION 3:**
Will the Board of Trustees approve the retention of the Position Statement: *Relationship between Treatment and Self Help*?

cc **ACTION 4:**
Will the Board of Trustees approve the retirement of the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*?

cc **ACTION 5:**
Will the Board of Trustees approve the retention of the Position Statement: *Elder Abuse, Neglect and Exploitation*?

cc **ACTION 6:**
Will the Board of Trustees approve the retention of the Position Statement: *Discriminatory Disability Insurance Coverage*?

cc **ACTION 7:**
Will the Board of Trustees approve the retention of the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations*?

cc **ACTION 8:**
Will the Board of Trustees approve the retention of the Position Statement: *State Mental Health Services*?

cc **ACTION 9:**
Will the Board of Trustees approve the retention of the Position Statement: *Universal Access to Healthcare*?

cc **ACTION 10:**
Will the Board of Trustees approve the retention of the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*?

cc **ACTION 11:**
Will the Board of Trustees approve the retirement of the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Care*?

cc **ACTION 12:**
Will the Board of Trustees approve the retirement of the Position Statement: *Psychotherapy and Managed Care*?

cc **ACTION 13:**
Will the Board of Trustees approve the retirement of the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*?

cc **ACTION 14:**
Will the Board of Trustees approve the retirement of the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter*?

cc **ACTION 15:**
Will the Board of Trustees approve the retirement of the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded*?

cc **ACTION 16:**
Will the Board of Trustees approve the retention of the Position Statement: *Abortion and Women's Reproductive Health Rights*?

cc **ACTION 17:**
Will the Board of Trustees approve the retention of the Position Statement: *Xenophobia, Immigration and Mental Health*?

cc **ACTION 18:**
Will the Board of Trustees approve the retirement of the Position Statement: *Juvenile Death Sentences*?

cc **ACTION 19:**
Will the Board of Trustees approve the retention of the Position Statement: *Peer Review of Expert Testimony*?

cc **ACTION 20:**
Will the Board of Trustees approve the retention of the Position Statement: *Joint Resolution against Torture*?

cc **ACTION 21:**
Will the Board of Trustees approve the retention of the Position Statement: *Moratorium on Capital Punishment in the United States*?

cc **ACTION 22:**
Will the Board of Trustees approve the retention of the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*?

cc **ACTION 23:**
Will the Board of Trustees approve the retention of the Position Statement: *Insanity Defense*?

cc **ACTION 24:**
Will the Board of Trustees approve the retention of the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*?

cc **ACTION 25:**
Will the Board of Trustees approve the retention of the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*?

cc **ACTION 26:**
Will the Board of Trustees approve the retention of the Position Statement: *Mentally Ill Prisoners on Death Row*?

cc **ACTION 27:**
Will the Board of Trustees approve the retention of the Position Statement: *Diminished Responsibility in Capital Sentencing*?

cc **ACTION 28:**
Will the Board of Trustees approve the retention of the Position Statement: *Endorsement of the Patient-Physician Covenant*?

cc **ACTION 29:**
Will the Board of Trustees approve the retention of the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*?

ACTION 30:
Will the Board of Trustees 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?

ACTION 31:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment?

ACTION 32:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk?

ACTION 33:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors?

ACTION 34:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors?

ACTION 35:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health?

ACTION 36:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment?

ACTION 37:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making?

ACTION 38:
Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation?

11. Work Group and Task Force Reports

E **<u>Distinguished Service Award Work Group</u> —** Paul Summergrad, MD

ACTION 1:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Jack W. Bonner, M.D.?

ACTION 2:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Joseph T. English, M.D.?

ACTION 3:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Dilip V. Jeste, M.D.?

ACTION 4:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to, Wayne J. Katon, M.D.?

ACTION 5:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Helen Mayberg, M.D.?

ACTION 6:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 organization Distinguished Service Award to Academy of Psychosomatic Medicine?

Item 3.B
Board of Trustees
December 13-14, 2014

Executive Committee
Conference Call Report
October 7, 2014

Executive Committee:
Chair: Paul Summergrad, MD; Members: Renée Binder, MD; Jenny Boyer, MD, JD, PHD; Frank Brown, MD; Saul M. Levin, MD, MPA; Jeffrey Lieberman, MD; Maria Oquendo, MD

Parliamentarian: Carol A. Bernstein, MD

Administration:
Colleen Coyle, JD; Rodger Currie, JD; Yoshie Davison; Margaret Dewar; Jon Fanning; Ian Hedges; Kristin Kroeger; Ardell Lockerman; Dr. Annelle Primm; Shaun Snyder, JD; Terri Swetnam, PhD; Jason Young

The following actions were approved during the Executive Committee Conference Call:

ACTION:
The Executive Committee voted to support the nomination of Michael Botticelli as Director of the White House Office of National Drug Control Policy (ONDCP).

ACTION:
The Executive Committee voted to approve having the Nominating Committee oversee a new vote to determine the three individuals who will run as candidates and alternate for the 2015 APA Election.

It is understood that this is a one-time exception to the submission deadline for M/UR Trustee position. The final results of this vote will be conveyed to the Nominating Committee as part of the normal nomination process.

Information Item

Strategic Planning: Next steps
APA leadership and staff will work to finalize an all-member survey to gather input on APA member concerns. The survey will be developed with the help of CFAR and the Division of Communications and Public Affairs. It was noted that the survey should be designed to encourage broad member feedback and a high response rate.

Report of the
CEO and Medical Director
to the
APA Board of Trustees

December 13-14, 2014

Westin Arlington Gateway
Arlington, VA

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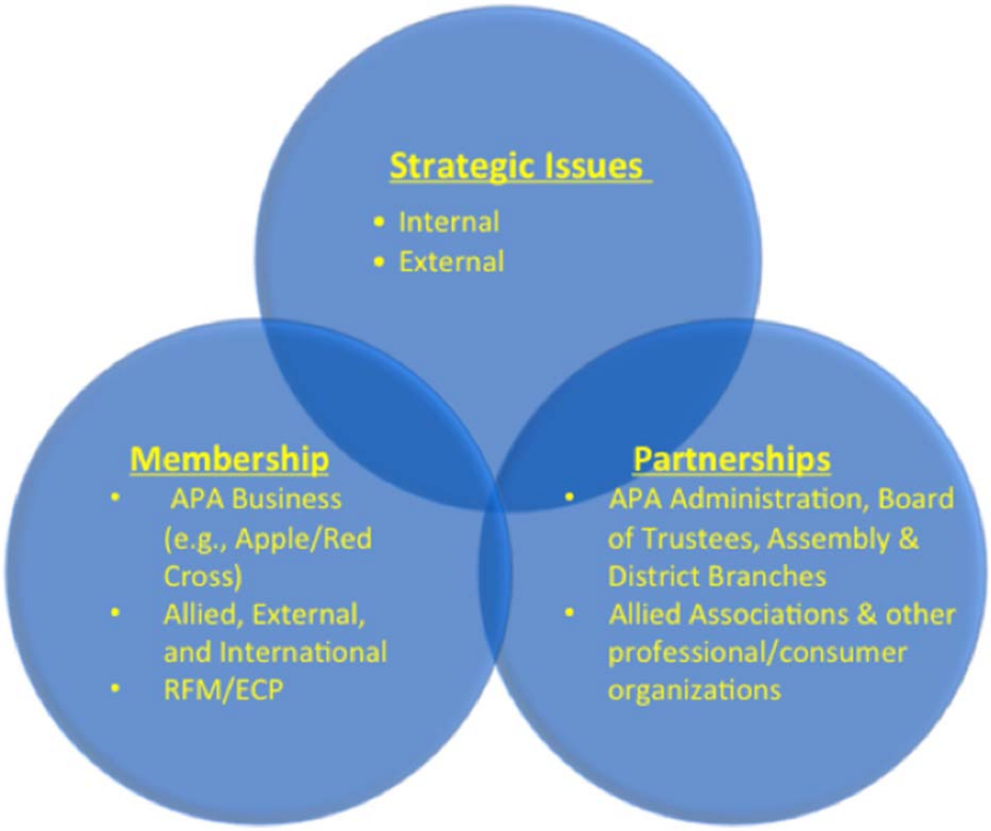
EXECUTIVE SUMMARY



As the APA Administration implements this vision, the Association's governing bodies have begun to see robust successes for the association in these areas.

To further carry out this vision, APA recently hired Ranna Parekh, M.D., M.P.H. as Director Division of Diversity and Health Equity (DDHE) beginning in January 2015. Dr. Parekh, a practicing child, adolescent and adult psychiatrist, has been at Massachusetts General Hospital (MGH) for the last seven years, building diversity initiatives within the department of psychiatry. At MGH, she leads the thousand-member psychiatry department's Diversity Center and is a member of the hospital's executive diversity committee. Additionally, at McLean Hospital, Dr. Parekh is the medical director for the adolescent dual diagnoses residential programs and is an active member of the hospital-wide diversity task force.

We are also pleased to announce that Caterina Luppi is the new Chief Information Officer (CIO) for the APA. Prior to her appointment at the APA, Caterina served as the IT Director and Chief Information Officer at the Pan American Health Organization (PAHO). In that role, Caterina provided leadership and strategic direction for the technology of this $500M, 2,500+ employees United Nations agency. In that role she directed all day-to-day operations, including planning, budgeting, development and expansion of the infrastructure, data center, system

integration and architecture, application development, and business intelligence. She managed staff at headquarters as well as in PAHO's 36 locations, distributed in North, Central and South America with a $40M operating/capital budget.

As the association moves into 1Q2015, 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 4Q2014.

Strategic Issues

The 2014 Elections and Preparing for the 114th Congress

The 2014 elections swung heavily in favor of Republicans. The GOP gained 12 seats in the House to strengthen its majority (currently 244 to 186), 8 seats in the Senate to take the majority (currently 53 to 44), and at least 3 governorships to increase its majority to 36 states.

Having taken control of the 114th Congress, Republicans face significant challenges around developing and successfully executing a unifying legislative agenda and strategy. First, there is a growing rift between the GOP establishment, led by House Speaker John Boehner (OH) and incoming Senate Majority Leader Mitch McConnell (KY), and tea party-inclined groups, led by Senator Ted Cruz (TX) and Representative Louie Gohmert (TX), over major issues important to the party, such as tax and entitlement reform.

One potential major game changer is the Supreme Court's November 7 decision to hear the most serious challenge to the ACA since the justices found it constitutional more than two years ago: a lawsuit targeting the federal subsidies that help millions of Americans buy health insurance in the federal exchanges. The court's acceptance of *King v. Burwell* raises the possibility that federal subsidies would not be available in the 36 states that are using the federal exchanges. A seismic decision by the court in mid-2015 would likely lead to Congressional Republicans being forced to come up with a substitute plan to cover millions of Americans and the President will have to negotiate with them on that. This doesn't mean that a Republican bill would get signed into law, but such a bill would likely move via the so-called "Budget Reconciliation" shortcut procedures that only require 51 votes in the Senate and could include a Medicare SGR fix among other Medicare or Medicaid provisions.

The 113th Congress has convened a lame duck session, which is expected to last through December. Several smaller items may be considered by both chambers, including a bicameral veterans' suicide reduction measure (H.R. 5059) which includes the APA-supported Ensuring Veterans' Resiliency Act language. One potential big-ticket item is a controversial package of tax extenders, onto which a permanent repeal of the flawed Sustainable Growth Rate (SGR) formula may be attached, although its prospects for passage are dim. It's worth noting that the tone set by the lame duck may be an indicator of how conciliatory or hostile the environment of the 114th Congress becomes.

When the 114th Congress convenes on January 3, 2015, the biggest hurdle for Republicans will be adopting a budget resolution that will be used to pass various partisan measures utilizing special budget reconciliation rules that only require 51 votes in the Senate. Depending on the scale of the GOP's ambitions (i.e., whether Republicans seek $1 trillion in cuts or they return to the 2011 "Grand Bargain" talk of $4+ trillion in spending reductions), debt ceiling negotiations may represent a major threat to federal healthcare spending – including physician reimbursement – and could include GOP reforms to the Medicaid program.

Finally, the latest SGR "patch" expires on March 31. Given that the current cost of repeal ranges between $140 and $180 billion, and assuming Congress fails to act in the lame duck, two scenarios are possible. The more likely scenario is that Congress will enact another costly $20 billion patch that kicks the can until the end of 2015 or beyond. The less likely scenario is that SGR repeal gets wrapped into larger debt ceiling and debt reduction negotiations.

The Department of Government Relations will be aggressively advancing APA's policy agenda, which currently centers on promoting meaningful reforms to the way the Federal government finances and manages mental health and substance use disorder programs – particularly to the SMI population, fair physician reimbursement under Medicare, full implementation and proper enforcement of MHPAEA, a robust and diverse psychiatric physician workforce, and the preservation of Federally-supported mental health research.

Enhancing Partnerships

The APA collaborated with the National Association of Social Workers (NASW) in offering a "Social Workers" track during the Institute on Psychiatric Services. The presentations were taped and will be promoted on both APA and NASW websites. We are looking to continue this collaboration at next year's IPS meeting and expand it to include other mid-level mental health professionals.

Additionally, APA Administration has recently reached out to our consumer advocacy groups to review and provide feedback on APA's "Consumer Guide to the DSM5". We conducted two focus groups with parents of children with mental illness, caretakers, peer counselors, and persons with lived experience and they provided feedback on the content and usefulness of the book. A majority of the feedback was positive and the participants felt that the book would be useful to both individuals and families affected by mental illness as well as those who are new to the illness and looking for information. The National Alliance on Mental Illness (NAMI) and Mental Health America (MHA) have provided us with testimonials for the book at this time, with more agreeing to add their testimonials.

The Administration has also met with American Association of Community Psychiatrists (AACP), American Academy of Child and Adolescent Psychiatry (AACAP), Academy of Psychosomatic Medicine (APM), American Academy of Pediatrics (AAP) and The National Council for Behavioral Health about future collaborative initiatives.

Membership

Total membership is 36,306 as of October 2014. This is an increase of 4.9% compared to the same time last year and dues paying members increased by 3.5%.

Vision: Strategic Issues and Membership

Item: **APA Real Estate Workgroup**

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

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

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. will be delivered at the December 2014 Board of Trustees meeting.

E. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Vision: Strategic Issues and Membership

Item: **APA Liability Insurance Workgroup**

Chief: **Terri Swetnam, Chief Financial Officer and Jon Fanning, Chief Membership & RFM-ECP 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.

E. <u>Recommendations for Major Policy Issues for Action or Discussion</u>: This is for information only.

Item: **Final Rule re 2015 Medicare Physician Fee Schedule**

Chief: **Kristin Kroeger, Chief of Policy, Programs and Partnerships**
Rodger Currie, Chief of Government Relations

A. **Division/Department Head:** Irvin (Sam) Muszynski, Director of Office of Healthcare Systems and Financing (OSHF), Director of Quality Improvement and Psychiatric Services (QIPS), Director of Regulatory Affairs (DGR)

B. **Division/Offices Involved**: Government Relations, OHSF, QIPS

C. **Front-Burner Issue Background:** CMS finalized a number of proposals of interest to psychiatry in its Final Rule for the 2015 Medicare Physician Fee Schedule. These include:

a. Telehealth: The addition of Family Therapy (90846 and 90847), Psychoanalysis (90845) and prolonged evaluation and management services (99354 and 99355) to the list of services eligible for telehealth payment.

b. Chronic Care Management: Finalization of the CPT code, payment and requirements for chronic care management services. These are non-face to face services furnished to Medicare beneficiaries with two or more chronic conditions that to date has not been covered by CMS. CMS states that this is one of the ways they are working to support primary care. CMS has come to "recognize care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth". Beginning in 2015 CMS will pay CPT code 99490 at $40.60 per month for 20 minutes or more of non-face to face care coordination services performed by clinical staff (or the physician) for the benefit of the Medicare beneficiary. Payment will be made to only one physician (the first to have met the 20 minute threshold and bill the service) per patient per month and the patient must give written consent to have the services provided. There are a number of other specific requirements that must be met including the development of a comprehensive patient-centered care plan, enhanced access to the physician (such as by phone or email), coordination of home/community-based services and the use of certified EMR.

We recognize that the average physician would not be billing for this service. It is clear from the statements made by CMS in the rule, the values assigned and the requirements put forward that CMS envision these services to be billed primarily by physicians who serve as primary care providers. This service would also most likely be only viable in those practices that staff already performing care management functions. For psychiatry, this change could mean a

small increase in dollars coming in to a primary care practice with an established care management protocol which may help pay for some of the costs of collaborative care. APA has been and will continue to work with a number of other physician and healthcare related organizations to identify work that is either not currently captured in the CPT coding structure or not appropriately valued to support evidence-based care. We see this as the first step in that process.

c. PQRS, Value-Based Modifier, EMR: As has been reported by the AMA and medical specialty societies, there are an increasing number of requirements, that if not met, impose a financial penalty. In the Final Rule for the 2015 Medicare Physician Fee Schedule, CMS finalized several initiatives that, in combination with already existing programs, will affect the reimbursement physicians will receive from Medicare for the services they provide. There are initiatives related to the ongoing 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 and solo practices in 2017; and the issuance of Quality Resource Use Reports (QRUR). All of these are interrelated and could impose penalties as high as 11% or practices of 10 or more in 2017. Those practices with less than 10 physicians could face penalties as high as 9%. For instance, changes in the rule to fulfill PQRS reporting requirements and the reduction of psychiatric specific measures presents potential problems for psychiatrists to successfully report.

D. **Staff Action/Response:** Further analysis of the impact of the proposals finalized in this rule will occur. APA's Office of Government Relations, OHSF, and QIPS will collaborate on a response back to CMS on issues of concern. Finally a discussion and development of an agenda of quality measure refinements for the PQRS and an advocacy strategy with the agency (CMS) will need to occur.

E. **Recommendations for Major Policy Issues for Action or Discussion:** This is for information only and making the Board of Trustees aware that we will need to have a substantive discussion as to what should be APA's quality measure agenda as part of pay for performance methodologies.

Vision: Strategic Issues and Membership

Item: **Medicaid Pay Parity for Evaluation and Management Codes (i.e. Medicaid Bump)**

Chief: **Rodger Currie, Chief of Government Relations**

A. Division/Department Head: Rodger Currie, Chief of Government Relations

B. Division/Offices Involved: Government Relations

C. Front-Burner Issue Background: 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.

D. Staff Action/Response: APA has teamed up with the American Academy of Neurology, and to a lesser extent, the American College of Obstetrics and Gynecology, to advocate for the inclusion of our specialties in any extension of the Medicaid Bump. Meetings were held with Senate Majority Leader Reid, Senate Minority Leader McConnell, Finance Committee Chair Ron Wyden, Finance Committee Ranking Member Orrin Hatch, Senators Sherrod Brown, Amy Klobuchar, and Patty Murray, Speaker John Boehner, and Energy and Commerce Committee Chair Fred Upton.

Despite DGR gaining a generally favorable response from Congress to the arguments around why psychiatry should be included in the Bump, the current overall outlook for any extension of the Bump beyond December 31, 2014, is problematic. The current cost of the Bump is estimated to be nearly $11 billion over two years, Congressional Republicans have very little desire to extend any provision in the Affordable Care Act, and Congressional Democrats appear more inclined to study the Bump's effectiveness before renewing it and/or expanding it. DGR will continue targeted advocacy work as appropriate and will advise BOT and administration leadership of any developments when warranted.

E. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Vision: Strategic Issues and Partnership

Item: **Recovery-Oriented Care in Psychiatry**

Chief: **Kristin Kroeger, Chief of Policy, Programs and Partnerships**

A. Division/Department Head: Annelle Primm, MD, MPH, Deputy Medical Director and Director of Division of Diversity and Health Equity

B. Division/Offices Involved: Division of Diversity and Health Equity

C. Front-Burner Issue Background: In 2009, SAMHSA implemented the five-year Recovery to Practice initiative to help mental health professionals better understand and implement recovery-oriented practices and to facilitate the system transformation envisioned by the President's New Freedom Commission report in 2003. APA was one of six disciplines to receive SAMHSA funding to carry out this undertaking and set out to create a set of materials designed to increase awareness, acceptance, and adoption of recovery principles and practices among psychiatrists.

D. Staff Action/Response: The APA Division of Diversity and Health Equity and Division of Education in collaboration with the American Association of Community Psychiatrists has created a curriculum consisting of nine modules that address specific aspects of recovery-oriented practice. The goal of the curriculum is to equip psychiatrists with the knowledge and tools to provide care in a manner that respects the person, engages them in decision making, and engenders hope. In September 2014, marking the official end of the five-year effort, the curriculum was uploaded to APA's online learning website **apaeducation.org** whereby learners can earn a maximum of 1 AMA PRA Category 1 credit per curriculum module. The course is also designed to be presented to live audiences, and as part of the effort, cadres of specially trained facilitator teams of psychiatrists and persons with lived experience have been assembled to present the course around the country.

E. Recommendations for Major Policy Issues for Action or Discussion:
This is for information only and making the Board of Trustees aware that recovery-oriented practice modules are on APA's learning management system (LMS) and members can access free CME.

Vision: Strategic Issues and Partnership

Item: **Mental Health Substance Use Parity Education and Enforcement**

Chief: **Colleen Coyle, General Counsel**
Kristin Kroeger, Chief of Policy, Programs and Partnerships
Rodger Currie, Chief of Government Relations
Jason Young, Chief of Communications

A. Division/Department Head: Irvin (Sam) Muszynski, Director of OHSF

B. Division/Offices Involved: OHSF, Government Relations, Communications

C. Front-Burner Issue Background: With the challenges of enforcing the Mental Health Parity and Addiction Equity Act violations are frequent. Many patients do not know their rights under the law and it takes education and awareness to help patients and providers to be able to identify practices that restrict mental health coverage beyond that of medical coverage.

D. Staff Action/Response: APA Administration has created a parity enforcement poster titled "Fair Insurance Coverage: It's the Law." The poster is written for lay people, with an explanation of what to expect under the law and what concrete steps to take when they suspect a parity violation. The poster was printed in the December 5 edition of Psych News as a pull out for members to post in their offices. It was also emailed out to members, with a link to a downloadable poster online to share with their patients. APA Administration is devising a communications and outreach plan to circulate the poster to various partners such as consumer groups, primary care organizations, employers, human resource management associations, and Congressional offices. Draft legislation requiring employers to post the notice in their work place, similar to the OSHA posters, will be shared with targeted Members of Congress.

E. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Vision: Strategic Issues and Membership

Item: **PsychiatryOnline Platform Migration**

Chief: **Shaun Snyder, Esq., COO**

A. Division/Department Head: Rebecca Rinehart, Publisher

B. Division/Offices Involved: Publishing

C. Front-Burner Issue Background: On October 29, PsychiatryOnline was launched on Atypon's hosting platform, Literatum. The migration took place following 4 months of intense preparation to ensure continuity of service, quality of content, and integrity of functionality. Concurrent with this migration, all CME products were consolidated in the existing learning management system (LMS) in anticipation of a transition to a new system.

D. Staff Action/Response: A content archive was created to aid the migration and create standards for content ingestion. The team was able to successfully self-load new book content, and 3 new titles were available at launch. All customer usage data was moved from Silverchair and, with the aid of the IT Department, coded to create a link between APA Publishing and Atypon systems. The Customer Service Department was briefed and FAQs were developed to allow timely responses that were processed through a dedicated line. There was no lapse in service or functionality and calls were only moderately increased. Issues remain to be resolved to fix bugs and content display and remote/mobile access. The platform is fully functional, however, and offers promise for future updating and product development. It provides flexibility in creating new features, such as consolidations of related content in landing pages, and real-time revisions of information and formatting. Literatum also allows self-loading of new content, allowing us to add books and related products quickly and cost-effectively.

E. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Vision: Strategic Initiatives - Meetings

Item: **Journal Redesign**

Chief: **Shaun Snyder, Chief Operating Officer**

F. Division/Department Head: Rebecca Rinehart, Publisher

G. Division/Offices Involved: Publishing

H. Front-Burner Issue Background: The January issues of *The American Journal of Psychiatry, Psychiatric Services, Journal of Neuropsychiatry and Clinical Neurosciences,* and *FOCUS* will feature a new design that will begin to reinforce the cohesive brand of both the print and online publications.

I. Staff Action/Response: For the past year, Publishing staff has been working with a professional design firm on a comprehensive redesign of APA journals to enhance the readership experience with bold new looks and engaging features. Unifying our journals with a consistent design signifies the relatedness of the titles, both stylistically and functionally, as well as the collective breadth of content, which is immediately apparent in a search on PsychiatryOnline and lends value to the product. Design elements, both covers and inside text, will also be similar across titles. The Table of Contents (TOC) has been redesigned to become more informative and mirror our online efforts to help readers quickly determine items to click to or store for later reading. Viewers of the online TOC will be able to click an arrow next to the title for a short summary of what the article presents. This same summary will be featured on the print TOC. The TOC also will feature symbols that identify content that conforms with ACGME core competencies of Patient Care, Medical Knowledge, Interpersonal and Communications Skills, Practice-Based Learning and Improvement, Professionalism, and Systems-Based Practice. This design provides improved readability, increased emphasis on the relatedness of our titles, and more informed rapid review of content.

J. Recommendations for Major Policy Issues for Action or Discussion: This is for information only.

Vision: Membership

Item: **Membership Update**

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

A. Division/Department Head: Susan Kuper

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

C. Front-Burner Issue Background:

Total membership is 36,306 as of October 2014. This is an increase of 4.9% compared to the same time last year. The following are the specifics by segment:

- Medical Student membership has increased by 35.1% compared to the same time last year.
- Resident and Fellow membership has increased by 6.4% compared to the same time last year.
- Early Career physician membership has increased by 3.9% compared to the same time last year.
- International membership has increased by 27.8% compared to same time last year.
- Members in dues paying categories have increased by 3.5% 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 IPS meeting, that can be delivered online to increase membership value for both domestic and international psychiatrists.

E. <u>Recommendations for Major Policy Issues for Action or Discussion</u>: This is for information only.

DRAFT

MINUTES OF A MEETING
OF THE
APA BOARD OF TRUSTEES

SEPTEMBER 9-10, 2014

Minutes of a Meeting

APA Board of Trustees

September 9-10, 2014

Arlington, VA

SECTION 1. CALL TO ORDER

Dr. Paul Summergrad, APA President, called the July meeting of the Board of Trustees to order at 9:00 a.m., Tuesday, September 9, 2014, at the Hilton Crystal City Hotel in Arlington, Virginia. Dr. Summergrad welcomed Board members, guests, and the administration to the meeting.

A. Introductions and Verbal Conflict of Interest Disclosures

Board of Trustees

Dr. Summergrad asked each Board member to state his or her name and then disclose their source(s) of income as well as any potential conflicts of interest.

Paul Summergrad, MD, President – receives income from Tufts University School of Medicine through Tufts Medical Center Physicians Organization; Past President of the American Association of Chairs of Departments of Psychiatry; receives modest stipend in forensic work; receives an APA stipend as President.

Renée Binder, MD, President-Elect – receives income from the University of California; Professor of Psychiatry at the University of California San Francisco; receives an APA stipend as President-Elect.

Carol A. Bernstein, MD, Parliamentarian and APA Past-President – receives income as Vice-Chair for Education and Director of Residency Training at NYU; serves on the Board of Regents of the American College of Psychiatrists and the Board of Directors of the ACGME.

Frank Brown, MD, Treasurer – receives income from the Emory Clinic in Atlanta, Georgia; serves as Vice President of the American College of Psychiatrists.

Maria A. Oquendo, MD, Secretary – receives income from New York State Psychiatric Institute and Columbia University; receives income from private practice; receives royalties for a suicide rating scale; receives unrestricted educational grants for training; husband is an employee of Bristol-Myers-Squibb.

Jenny L. Boyer, MD, Ph.D., J.D., Speaker – receives income from the Veterans Administration; receives income from pensions, one from the State of Oklahoma and one from the Federal government; receives an APA stipend as Speaker.

Glenn A. Martin, MD, Speaker-Elect – receives income from the Icahn School of Medicine at Mt. Sinai; receives income from private practice; receives an APA stipend as Speaker-Elect; Medical Director of Information Exchange in Queens.

Dilip Jeste, MD, Trustee– receives income as full time faculty at University of California San Diego; receives honorarium as Editor of *American Journal of Geriatric Psychiatry*; Board of Regents of the American College of Psychiatrists.

Jeffrey L. Geller, MD, MPH, Area 1 Trustee – receives income from the University of Massachusetts Medical School; receives income from the Carson Community Mental Health Center; receives income from some forensic work.

Vivian B. Pender, MD, Area 2 Trustee – receives income from private practice; consulting for the United Nations; on the voluntary faculty at Cornell.

Brian Crowley, MD, Area 3 Trustee – receives income from private practice.

Judith F. Kashtan, MD, Area 4 Trustee – receives income from private practice; on the clinical faculty of the University of Minnesota.

R. Scott Benson, MD, Area 5 Trustee – receives income from private practice in child and adolescent psychiatry; forensic psychiatry in Pensacola, Florida.

Melinda Young, MD, Area 6 Trustee – receives income from private practice.

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 APAPAC Board; chair of the Hawaii Psychiatric PAC; co-chair of the Hawaii Medical Association PAC.

Anita Everett, MD, Trustee-at-Large – receives income from Johns Hopkins Hospital; President of the American Association of Community Psychiatrists.

Molly K. McVoy, MD, ECP Trustee-at-Large – receives income from Case Western and University Hospitals of Cleveland; royalties from book sales with APA Publishing; serves on APP Editorial Board.

Lara J. Cox, MD, Resident-Fellow Member Trustee – receives income from NYU; receives income from moonlighting through NYU Gracie Square Hospital and Lennox Hill Hospital.

Ravi N. Shah, MD, Resident-Fellow Member Trustee-Elect – receives income from New York Presbyterian Columbia, New York State Psychiatric Institute.

Desiree Shapiro, MD, APA/Leadership Fellow – receives income from University of California San Diego and moonlighting at Fallbrook Family Health Centers.

Adeniyi O. Adelakun, MD, APA/SAMHSA/Diversity Leadership Fellow – receives income from Thomas Jefferson University Hospital; receives income as a minority partner at a community outpatient agency.

Christina Arredondo, MD, APA/Public Psychiatry Fellow – receives income from the state of Connecticut and Yale University.

Administration:

Saul Levin, MD, MPA, APA CEO and Medical Director – receives income from the APA.

SECTION 2. CONSENT CALENDAR

A. Requests to Remove Items from the Consent Calendar

There were no items removed from the Consent Calendar.

B. Approval of Items on the Consent Calendar

Dr. Summergrad presented the Consent Calendar to the Board.

The Board of Trustees voted to approve the Consent Calendar.

SECTION 3. REPORT OF THE PRESIDENT

Paul Summergrad, MD

A. Brief Update

Dr. Summergrad began with a moment of silence in memory of Linda Hughes, who passed away on Saturday, August 30, 2014. Linda held the position of Director, Office

of Ethics and District Branch/State Association Relations. She had recently retired from this position after 30 years of service at the APA. She was highly respected by many, particularly DB/SA executive staff and leaders, and credited with the creation of the DB/SA Executive Staff Leadership Conferences, Model DB document, and the DB grant process.

Dr. Summergrad informed the Board of Wednesday's agenda, which he said would be entirely focused on APA's strategic planning with CFAR, the management consulting firm, who developed a set of strategic areas for APA to explore, using input from interviews with individuals from different areas in the field and the pulse poll survey of the leadership. He noted that CFAR attended the Executive Committee Retreat, July 18-19, 2014 in Boston, which served as a kickoff to APA's strategic planning activities.

Dr. Summergrad summarized an action passed at the July Board Meeting, which approved a series of rate adjustments for the Annual Meeting registration fees for non-physician attendees. He told the Board that there were further discussions with the Executive Committee and the administration around the potential financial consequences of this action. After considering the financial and operational impact during its conference call in August, the Executive Committee felt it should be reconsidered and asks the Board to rescind the action passed at the July Board Meeting.

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.

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.

B. <u>Executive Committee Report</u>

This report was presented for Board review and appropriate action.

Executive Committee Report
August 14, 2014

<u>Executive Committee</u>
Chair: Paul Summergrad, MD; Members: Renée Binder, MD; Jenny Boyer, MD, JD, PHD; Frank Brown, MD; Saul Levin, MD, MPA; Jeffrey Lieberman, MD; Maria Oquendo, MD

In August 2014, an issue arose with respect to nominations for the Area IV Trustee position.

In 2013, Area IV designated Shastri Swaminathan, MD as the Area IV Representative to the Nominating Committee for a 2 year-term from 2013-2015. He has served 15 months of his two-year appointment. Recently, the Area IV Trustee Nominating Committee nominated Dr. Swaminathan as one of two candidates (with a third member serving as an alternate) for the Area IV Trustee position.

Initially, the Administration informed Dr. Swaminathan that he could not resign from the Nominating Committee in order to run for the Area IV Trustee position because the *APA Operations Manual* prohibits this action.

The *APA Operations Manual* includes the following language: "Acceptance of an appointment to the APA Nominating Committee will preclude consideration for any elected APA position (e.g., APA Officer, Trustee, Area Trustee, etc.) during the committee member's appointment tenure."

Individuals within Area IV noted that two former members of the APA Nominating Committee have not followed that rule, resigning from the Committee to accept nominations as Area Trustees. It is unlikely that people were aware of this rule when this occurred.

On August 14th, in response to the request, the Executive Committee passed the following Motion with respect to Dr. Swaminathan:

ACTION:
The Executive Committee waived the restriction on accepting nomination as the Area Trustee for members of the Nominating Committee if the nominee resigns from the Nominating Committee before accepting the nomination.

Going forward, the Administration will include language within future appointment letters for the Nominating Committee to note the restriction and ensure that all Area Councils and all Nominating Committee Members are fully aware that sitting Nominating Committee members may NOT accept nominations for APA national office during their two-year term.

Executive Committee
Conference Call Report
August 5, 2014

Executive Committee
Chair: Paul Summergrad, MD; Members: Renée Binder, MD; Jenny Boyer, MD, JD, PHD; Frank Brown, MD; Saul Levin, MD, MPA; Jeffrey Lieberman, MD
Member Excused: Maria Oquendo, MD
Parliamentarian: Carol A. Bernstein, MD

Administration:
Colleen Coyle, JD; Yoshie Davison; Margaret Dewar; Jon Fanning; Ian Hedges; Kristin Kroeger; Ardell Lockerman; Shaun Snyder, JD; Therese Swetnam, PHD; Jason Young

Information Items

1. APA Budget Update
The Executive Committee received an update from CFO Terri Swetnam on APA finances. APA has budgeted to use $258K of its Reserves (a net deficit). It does, however, expect to end the year with positive net income of $2.4M. The favorable variance is due to sales of DSM5 and the New York Annual Meeting.

2. Ad Hoc Work Group on Real Estate

The Executive Committee received a brief update on the real estate process. The Ad Hoc Work Group on Real Estate held an initial meeting to consider their timeline of 24-30 months, noting that the time frame to conclude either a lease or a purchase will not differ appreciably. The real estate consultants have informed APA that, given the healthy real estate market in the Washington area, APA may need to move expeditiously if a suitable site (whether for lease or purchase) is identified. At the September Board meeting, the AHWG on Real Estate will bring forward a request to establish a rapid decision-making process to allow the APA Executive Committee to authorize the CEO to sign a non-binding letter of intent, allowing 30-60 days for standard due diligence.

The Executive Committee was also informed that a separate American Psychiatric Foundation Work Group would be established to review the real estate issue. The APF work group will consider real estate issues relevant to that entity and report back to the APF Board.

3. APA Strategic Planning

The Executive Committee discussed the next steps of the strategic planning process. CFAR Consultants have been invited to the September Board Meeting to participate in an in-depth discussion on all aspects of the strategic planning initiative. The initial meeting of the Strategic Planning Steering Committee will take place immediately following the Board of Trustees meeting.

4. CEO and Medical Director Update

Dr. Levin provided a status report on a number of pending issues and will bring a comprehensive CEO Report to the Board of Trustees in September.

Open Position—Director of Education

The APA has hired a search firm (Grant Cooper) to identify candidates for the next Director of Education. APA has solicited and received input on the position description and individual qualifications/characteristics of candidates from members of the Board of Trustees and the Council on Medical Education and Lifelong Learning. A potential slate of candidates should be developed by the end of September.

Open Position—Director of Research

The Grant Cooper search firm will also be used to fill the Director of Research Position. The administration is currently updating the position description to align with the Division of Research Review Committee's Report. Once complete, the position description will be shared with leadership and the research-related components, mirroring the process used for the Division of Education.

Open Position—Director of Diversity and Health Equity

Eleven Skype candidate interviews took place during the week of August 4-8, 2014 using an interview committee comprised of 6 staff members: Annelle Primm, MD; Kristin Kroeger; William Narrow, MD; Shaun Snyder; Jason Young and Alison Bondurant. As a result of these interviews, four candidates have been asked to return for second round interviews.

Open Position—Chief of Government Affairs

The process is nearing completion. Dr. Levin will make the final selection between the two top candidates in the near future.

Open Position—Director of Quality
The position of Director of Quality remains unfilled at this time. The administration is considering further outreach and research regarding the types of candidate similar medical groups or associations selected when they went through this process.

Open Physician Payments
As many members know, CMS has begun to allow physicians to look at the information pharmaceutical companies have reported to the government under the Sunshine Act. To assist our members, APA immediately sent out information about how to log-in, how to look at the information, and how to appeal to CMS if the information was incorrect. To date, 7,752 members opened the email and 365 members have clicked the link to check their record on the web. Dr. Levin has received positive member feedback about the instructions. He noted that APA staff assists any member who is enduring complications and directed them to the appropriate individual to walk them through the process.

DSM–5 Sales
Dr. Levin informed the EC that, as of July 31, APA has received $48,796,636 in revenue for the DSM. As of August 5th, the DSM was ranked #40 on the Amazon best sellers list.

IPS Meeting in San Francisco: October 30th - November 2nd
As of August 5th, 418 people have registered for IPS, making it the highest amount for IPS registration in five years, apart from the New York City meetings.

5. Board Action on Annual Meeting Registration Rates for Non-physician Attendees

The Executive Committee received an update on registration rates for non-physician attendees at the Annual Meeting. At the July Board Meeting, the Board voted to approve a series of rate adjustments for the Annual Meeting registration fees beginning in 2015. Dr. Levin requested an administration review of the action to clarify the ramifications of these changes. The resulting input showed that the action could result in dramatically increased registration fees for the non-member categories. This could have the unwanted side-effect of discouraging their attendance resulting in a loss in APA revenue. The Executive Committee discussed the potential financial and operational impact of this action and agreed to bring this item back to the September Board meeting for reconsideration.

C. Executive Session Actions

1. ***The American Journal of Psychiatry*** **Editorial Board**
The following action was approved on the Consent Calendar.

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.

2. ***The American Journal of Psychiatry*** **Editorial Board**
The following action was approved on the Consent Calendar.

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.

3. ***The American Journal of Psychiatry* Editorial Board**
The following action was approved on the Consent Calendar.

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.

4. ***The American Journal of Psychiatry* Editorial Board**
The following action was approved on the Consent Calendar.

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.

5. ***The American Journal of Psychiatry* Editorial Board**
The following action was approved on the Consent Calendar.

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.

SECTION 4. REPORT OF THE CEO AND MEDICAL DIRECTOR

Saul Levin, MD, MPA

A. Presentation by the CEO and Medical Director

Dr. Levin told the Board as of last week, the *DSM-5* was number six on the Amazon's top 100 Books list, which he said is a rare occurrence for a medical book. As of August 31, 2014, the APA has sold 9.86 million *DSM-5* books, which brings the total sales up to $48,796,636.

Dr. Levin discussed the APA Grassroots Campaign, which started in August. The campaign was designed to increase membership participation in grassroots efforts and encourage members to advocate on behalf of mental health communities by meeting with their representative(s) in their home district and by calling and writing their representatives and senators and attending hall meetings or political fund raisers. He told the Board that over 100 members have signed up for information on local events.

Jason Young, Chief of Communications, discussed APA's family of brands. He noted the likeness of Dr. Benjamin Rush as an emblem of Psychiatry dates back 85+ years, and appears to pre-date even the name change to "American Psychiatric Association." It exists within a wider APA family of brands, which APA has displayed at its Annual Meetings, websites, and on emails. He noted that, with multiple brands, it can be very hard for our members to make sense of who our organization is and the real value that it adds to their practice.

SECTION 5. REPORT OF THE SECRETARY

Maria A. Oquendo, MD

A. Minutes of the July 12-13, 2014 Board of Trustees Meeting

The following action was approved on the Consent Calendar.

The Board of Trustees voted to approve the minutes of its July 12-13, 2014 meeting.

SECTION 6. REPORT OF THE TREASURER

Frank Brown, MD

A. Treasurer's Report

Dr. Brown provided the Treasurer's Report to the Board of Trustees.

B. Status of the Board of Trustees Contingency Fund

A written status report of the Board Contingency Fund was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Board of Trustees Contingency Fund.

C. Status of the Presidential New Initiative Funds

A written status report of the Presidential New Initiative Funds was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Presidential New Initiative Funds for Dr. Jeffrey Lieberman, Dr. Paul Summergrad, and Dr. Renée Binder.

D. Status of the Assembly New Initiative Fund

A written status report of the Assembly New Initiative Fund was approved on the Consent Calendar.

The Board of Trustees voted to accept the report of the status of the Assembly's New Initiative Fund.

SECTION 8. REPORTS FROM STANDING COMMITTEES AND COUNCILS

A. Report from the Membership Committee

The Board of Trustees received a report from the Membership Committee and the following actions were approved on the Consent Calendar.

1. Membership Requirements Drops

The Board of Trustees authorized dropping from APA membership the Members listed in Attachment F for failure to meet the requirements of membership.

2. International Membership

The Board of Trustees voted to approve the applicants listed in Attachment G for International Membership.

3. Membership Dues Relief

The Board of Trustees voted to approve the Membership Committee's recommendations on the dues relief requests as listed in Attachment H.

B. Report from the Finance and Budget Committee

Alan F. Schatzberg, MD, Chair

Dr. Schatzberg discussed establishing an APA reserves spending plan with the Board. He informed the Board that most spending policies are developed to preserve the corpus of the reserve, and, typically nonprofit organizations set a spending level at 4 percent of a rolling (3-year) average reserve balance. In some organizations, this represents a floor; the amount may be adjusted upward if the average earnings over the rolling time frame exceeds the long term investment target (for APA, it is 8% annually). He asked the Board to consider using reserve payout in the budgeting process for initiatives that the organization wishes to pursue.

C. Report from the Investment Oversight Committee

A written report was presented to the Board of Trustees about the investment performance and current Investment Oversight Committee activities, for information only.

SECTION 9. REPORT OF THE SPEAKER

Jenny Boyer, MD, PhD, JD

Dr. Boyer discussed the Assembly Executive Committee meeting held on July 25-26, 2014. At this meeting the focus was on the Assembly reorganization and long range planning. She told the Board that in 2015, the Assembly plans to revert back to its old structure and member representation. Because of this fact, the AEC (through Dr. Boyer) presented the Budget Committee with a request to increase its 2015 budget. If approved by the Board, this increase will be used to support full attendance to the November Assembly, along with funding for a small new initiative fund and possible funding for the Assembly Allied Organizations' Representatives' participation in the November Assembly.

SECTION 10. APA c/3 SUBSIDIARY

A. Report of the American Psychiatric Foundation

Saul Levin, MD, MPA, Chair and Paul Burke, Executive Director

Dr. Levin highlighted three major APF programs: *Typical or Troubled Program*, Partnership for Workplace Mental Health Programs, and Judicial Leadership Initiative. Over 1,100 schools are now enrolled in *Typical or Troubled Program* and 80,000 teachers have gone through the training. In the coming year, he said, APF will aggressively lobby Congress to be included when they provide funding to other

organizations for overarching programs around mental health and mental illness at schools and children.

Dr. Levin said the Partnership for Workplace Mental Health Programs continues to grow larger. Currently, there are 40,000 subscribers. With the depression programs, 73% show a positive impact in actually reaching out proactively to the employers and employees. He said the APA also serves its own staff through a similar program, asking staff who feel depressed or in need of help to seek assistance through APA's employee assistance program, managed by CIGNA.

Dr. Levin said the Judicial Leadership Initiative provides judges with training on mental illness and mental health. This program has conducted 11 training sessions so far with two additional regional meetings with judges to come. He noted there is a demand for more training so APF is currently looking to host a conference in 2016.

SECTION 11. WORK GROUP AND TASK FORCE REPORTS

A. International Psychiatrists Work Group

The Board of Trustees received a report from the International Psychiatrists Work Group and the following action was approved on the Consent Calendar.

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.

B. Update from the Ad Hoc Work Group on Liability

William Arroyo, MD, Chair (speakerphone)

Dr. Arroyo provided the Board with an update on the activities of the Ad Hoc Work Group on Liability. He told the Board that their charge is to help the Board select a liability insurance company for APA endorsement. He said the work group met on August 4, 2014 and has held email exchanges since that time related to its charge. The work group has been in consultation with ALS Group, the independent insurance and risk management consultants that have assisted APA on previous liability insurance endorsement agreement. The work group has not concluded its effort to identify a company to receive APA endorsement but is working closely with the work group and ALS Group to finalize this process.

C. Report of the Ad Hoc Work Group on Real Estate

Frank Brown, MD, Chair

Dr. Brown discussed the pros and cons of purchasing and leasing a building for the APA. Some possible benefits to purchasing mentioned were potential asset appreciation, ability to sell/mortgage property to raise cash and, (over time) an occupancy cost that is usually less than that for leasing. Some of the benefits to leasing were lower upfront costs, lease flexibility, ability to pay for only the space used, and limited office management responsibilities. Dr. Brown said that, based on preliminary financial analysis, the Work

Group indicated an initial preference for purchasing over leasing, without precluding particularly compelling opportunities that may arise in the Lease Market.

Dr. Brown said the Work Group has met with the consultant team and members of the administration to review options, identify key assumptions, and set parameters. The brokers have advised that the Association needs to be ready to explore options as they become available. Because the timing may not coincide with a scheduled Board meeting, the Work Group recommends a rapid decision making process.

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 office location provided the opportunity meets the agreed-upon parameters.

SECTION 12. INFORMATIONAL ITEMS

There were no informational items.

SECTION 13. UNFINISHED BUSINESS

There were no unfinished business items.

SECTION 14. NEW BUSINESS

A. Endorsement of Mental Health Goals Developed by WHO
Paul Summergrad, MD

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.'

Professors Thornicroft and Patel also propose that this is directly supported by two 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.'

SECTION 15. ADJOURNMENT

Dr. Summergrad thanked the Board and the Association Governance administration for their excellent work. Dr. Summergrad adjourned the meeting of the Board of Trustees at 12:00 pm, Wednesday, September 10, 2014. The next Board of Trustees meeting will be December 13-14, 2014 at the Westin Gateway Hotel in Arlington, Virginia.

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

Agenda Item #	Title/Action	Responsible Office/Component
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
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

AMERICAN PSYCHIATRIC ASSOCIATION
REPORT OF THE TREASURER
TO THE
Board of Trustees
Frank Brown, MD, Treasurer

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

APA Unrestricted Revenue is lower than prior year by $21.2M but above budget by $5.1M due primarily to sales of DSM.

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

Non-DSM Publishing – Publishing revenues are $1.2M above budget due to advertising sales in Psych News.

DSM – Sales for DSM are above budget by $2.3M.

Continuing Medical Education – Annual Meeting revenue is $11M 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 and budget by $3.1M and $1M, respectively, 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 $129M, of which $71.6M 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 $3.2M.

Statement of Financial Position

APA Assets increased $3.9M over December 2013 balances, primarily due to the increase in the portfolio. APA's share of the long term investment portfolio is $71.6M, which is 56% of the total portfolio. APF holds $57M. Total investments are $129M.

APA's liabilities decreased approximately $8.9M, due primarily to the recognition of deferred membership dues and subscription revenue.

Audit Committee

The Audit Committee met on November 19, 2014 to discuss the Audit Plan for year ending December 31, 2014. Our auditors, Gelman Rosenberg & Freedman, presented the plan, which was approved by the committee. The next meeting is tentatively scheduled for May 2015, in conjunction with the Spring Finance & Budget Meeting.

American Psychiatric Association
Summary Financial Review

January 1, 2014 to October 31, 2014

Prepared by the Office of the Chief Financial Officer
November 17, 2014

Distribution:

P. Burke	M. Hunte	A. Schatzberg
C. Coyle	K. Kroeger	S. Snyder
R. Currie	S. Levin	T. Swetnam
Y Davison	A. Porfiri	J. Young
M. Dewar	A. Primm	Executive Committee
J. Fanning	R. Rinehart	

American Psychiatric Association and Affiliates
For the Nine Months Ended October 30, 2014

Unrestricted Net Income **APA - Operating**	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Revenue	72,091	50,939	45,870	5,069	51,069	55,023	3,954	81,053
Expense	44,279	41,198	41,953	755	51,327	50,575	752	54,523
APA Net Unadjusted	27,812	9,741	3,917	5,824	(258)	4,448	4,706	26,530
APF - Operating								
Revenue	1,056	2,115	1,375	(740)	1,678	2,437	759	1,288
Expense	3,975	4,404	4,009	(395)	5,236	5,988	(752)	5,345
APF Net Unadjusted	(2,919)	(2,289)	(2,634)	(1,135)	(3,558)	(3,551)	7	(4,057)
Consolidated - NonOperating								
Investment Income - LT	9,131	6,059	71	5,988	85			14,384
Investment Income - ST	4	4	0	4	0			4
Less: Portfolio Management Fees	(171)	(122)	(87)	(35)	(105)			(223)
Net Consolidated - Non Operating	8,964	5,941	(16)	5,957	(20)			14,165

Comments:

APA:

Revenue is above budget YTD by $5M, primarily due to an increase in membership revenue by $375k, publishing by $1.2M, DSM sales $2.3M, and Annual Meeting Registration (meeting and CME courses) by $1.2M compared with the annual budget.

Expenses are below budget YTD by $755k. DSM expenses are $466k greater than budgeted YTD. Publishing overhead costs are above YTD budget by $725k, and CME and meetings expenses are $1.2M above YTD budget. This is offset by Advocacy---expenses are down by $492k, Division of Communications by $365k, Division of Policy, Programs and Partnerships by $953k and Division of Operations by $215k.

APA adjusted net income is expected to be above budget by $4.7M, due primarily to DSM Sales and Annual Meeting registration.

APF:

Revenue (unrestricted) is above YTD budget by $740k.

Expenses are above YTD budget by $395k, due to timing.

The Foundation is projected to end the year with a deficit of $3.6M.

APA - Operating	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
DSM Revenue	37,466	12,097	9,787	2,310	11,622	13,953	2,331	42,091
DSM Expenses	9,984	3,621	3,155	(466)	3,789	4,842	(1,053)	12,982
Net, DSM	27,482	8,476	6,632	1,844	7,833	9,111	1,278	29,109

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
UNRESTRICTED REVENUE:								
Membership								
Membership Dues	$9,362	$9,494	$9,366	$128	$9,690	$9,690		$9,713
Insurance Program	1,500	1,375	1,375		1,500	1,500		1,625
Membership Affinity Programs	84	76	79	(3)	81	81		110
APA Job Bank	537	695	542	153	650	700	50	660
APA Store	12	6	10	(4)	11	11		11
List Sales	25	57	66	(9)	80	67	(13)	50
Board Funds		110		110		110	110	
Membership Subtotal	***11,520***	***11,813***	***11,438***	***375***	***12,012***	***12,159***	***147***	***12,169***
Advocacy								
PAC	4	4	6	(2)	7	7		6
Advocacy Leadership Conference	15	10	12	(2)	15	22	7	19
Healthcare Systems & Financing								53
Advocacy Subtotal	***19***	***14***	***18***	***(4)***	***22***	***29***	***7***	***78***
Communications								
OCPA	34							38
Let's Talk Facts		29	38	(9)	46	46		
Communications Subtotal	***34***	***29***	***38***	***(9)***	***46***	***46***		***38***
Publishing								
American Journal of Psychiatry	3,826	4,364	4,393	(29)	5,272	5,283	11	5,118
Journal of Psychiatric Services	577	821	750	71	900	938	38	806
Psychiatric News	2,726	3,653	2,656	997	3,187	4,034	847	3,344
Books	3,669	4,328	4,790	(462)	5,684	4,949	(735)	4,803
Specialty Journals	443	233	292	(59)	351	351		564
Psychiatry Online	332	473		473				6
Electronic Publishing	11	62		62				8
Legacy content	23	162	42	120	50	165	115	23
Publishing Subtotal	***11,607***	***14,096***	***12,923***	***1,173***	***15,444***	***15,720***	***276***	***14,672***
DSM								
DSM IV	485	27	15	12	20	28	8	707
DSM 5	36,981	12,070	9,772	2,298	11,602	13,925	2,323	41,384
DSM Subtotal	***37,466***	***12,097***	***9,787***	***2,310***	***11,622***	***13,953***	***2,331***	***42,091***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Continuing Medical Education								
Annual Meeting	9,315	10,977	10,126	851	10,126	10,979	853	9,414
CME Products and Accreditation	457	318	215	103	230	330	100	795
Institute on Psychiatric Services	362	390	312	78	350	446	96	393
Focus Journal	1,130	1,117	943	174	1,132	1,240	108	1,272
Continuing Medical Education Subtotal	***11,264***	***12,802***	***11,596***	***1,206***	***11,838***	***12,995***	***1,157***	***11,874***
Research								
Practice Guidelines	60	83	66	17	80	116	36	84
Research Subtotal	***60***	***83***	***66***	***17***	***80***	***116***	***36***	***84***
Other Income								
Miscellaneous Income	121	5	4	1	5	5		47
Other Income Subtotal	***121***	***5***	***4***	***1***	***5***	***5***		***47***
Total Unrestricted Revenue	***72,091***	***50,939***	***45,870***	***5,069***	***51,069***	***55,023***	***3,954***	***81,053***
UNRESTRICTED EXPENSES:								
Membership Direct Expenses								
Membership Services	1,318	1,470	1,488	18	1,797	1,797		1,709
Division of Membership		243	229	(14)	279	285	(6)	
Membership Recruitment	120	127	124	(3)	174	174		126
Insurance Program		13		(13)		50	(50)	
Membership Affinity Programs			11	11	14	14		13
APA Job Bank (membership)	4	24	18	(6)	19	19		4
APA Store	18	12	13	1	13	13		18
Ethics/DB Relations	201	178	206	28	250	250		248
Library & Archives	76	112	117	5	140	140		96
International Programs	3	86	86		128	128		28
Membership Direct Expenses Subtotal	***1,740***	***2,265***	***2,292***	***27***	***2,814***	***2,870***	***(56)***	***2,242***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Advocacy								
APA PAC Operating Expenses	128	145	128	(17)	148	148		159
Division of Advocacy	307	3	3		3	3		367
Government Relations	1,357	1,003	1,536	533	1,871	1,859	12	1,643
Leadership Conference	32	177	202	25	202	180	22	163
CALF	50	195	146	(49)	175	195	(20)	85
Advocacy Subtotal	***1,874***	***1,523***	***2,015***	***492***	***2,399***	***2,385***	***14***	***2,417***
Communications								
Communications & Public Affairs	811	957	1,203	246	1,442	1,502	(60)	992
Association Marketing	91	190	306	116	370	370		121
Let's Talk Facts		3	6	3	7	7		
Communications Subtotal	***902***	***1,150***	***1,515***	***365***	***1,819***	***1,879***	***(60)***	***1,113***
Publishing								
American Journal of Psychiatry	1,539	1,631	1,745	114	2,104	2,127	(23)	1,959
Journal of Psychiatric Services	537	526	574	48	694	694		700
Psych News	1,883	1,881	1,729	(152)	2,088	2,381	(293)	2,391
Unrelated Business Income Tax	417	167	167		200	200		88
Books	440	952	1,187	235	1,598	1,483	115	1,163
Specialty Journals	196	178	110	(68)	131	131		247
Psychiatry Online	20	13		(13)				
Electronic Publishing	14	4		(4)				(67)
Legacy content		3		(3)				
Publishing Subtotal	***5,046***	***5,355***	***5,512***	***157***	***6,815***	***7,016***	***(201)***	***6,481***
Publishing Overhead								
Publishing Administration	550	602	520	(82)	632	632		657
Publishing Overhead	(629)	(167)	(423)	(256)	(507)	(507)		(745)
Sales & Marketing	807	814	724	(90)	879	1,029	(150)	1,152
Customer Service	997	990	853	(137)	1,028	1,028		1,276
Advertising Sales	650	758	542	(216)	650	800	(150)	787
Periodical Services	19	6		(6)		6	(6)	27
Editorial Development	814	967	1,033	66	1,248	1,278	(30)	1,220
Editorial Production	670	795	791	(4)	965	819	146	843
Publishing Overhead Subtotal	***3,878***	***4,765***	***4,040***	***(725)***	***4,895***	***5,085***	***(190)***	***5,217***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
DSM								
DSM IV	240	3	15	12	20	2	18	268
DSM 5 Publishing Costs	2,348	1,204	1,333	129	1,601	1,637	(36)	2,714
DSM 5 Development	7,396	2,414	1,807	(607)	2,168	3,203	(1,035)	10,000
DSM Subtotal	***9,984***	***3,621***	***3,155***	***(466)***	***3,789***	***4,842***	***(1,053)***	***12,982***
Continuing Medical Education								
Annual Meeting	3,136	4,715	3,561	(1,154)	3,611	4,712	(1,101)	3,176
CME Products & Accreditation	395	386	243	(143)	296	325	(29)	509
Department of Meetings & Conventions	672	579	607	28	740	740		730
Office of Scientific Programs	265	364	443	79	537	537		427
Institute on Psychiatric Services	85	98	92	(6)	416	416		355
Focus Journal	135	197	193	(4)	231	231		181
Continuing Medical Education Subtotal	***4,688***	***6,339***	***5,139***	***(1,200)***	***5,831***	***6,961***	***(1,130)***	***5,378***
Policy, Programs, and Partnerships								
Division of Policy, Programs, & Partnerships		284	259	(25)	315	315		
Division of Education	729	742	913	171	1,099	1,099		877
Healthcare Systems and Financing	899	1,104	1,350	246	1,611	1,566	45	1,201
Office of Diversity & Health Equity	481	412	461	49	605	605		610
Research - Director's Office	511	762	969	207	736	736		638
Office of QIPS	395	237	452	215	551	551		461
Practice Guidelines	165	191	270	79	358	358		209
DSM Other	1,391	(11)		11				1,630
Policy, Programs, and Partnerships Subtotal	***4,571***	***3,721***	***4,674***	***953***	***5,275***	***5,230***	***45***	***5,626***
Operations								
Division of Operations		284	315	31	385	385		
APA Answer Center	246	115	267	152	323	323		301
Human Resources	308	744	495	(249)	636	863	(227)	445
Information Technology	2,355	2,509	2,828	319	3,444	3,444		3,235
Association Mgmt System	313	282	242	(40)	323	323		363
Association Governance Office	660	669	671	2	821	821		810
Operations Subtotal	***3,882***	***4,603***	***4,818***	***215***	***5,932***	***6,159***	***(227)***	***5,154***
Foundation								
Foundation Operating	327	362	362		435	435		312
Foundation Subtotal	***327***	***362***	***362***		***435***	***435***		***312***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Administration								
Office of the CEO	1,727	1,578	1,798	220	2,133	2,161	(28)	2,350
Staff Strategic Planning		8	104	96	200	15	185	15
Finance and Administrative Services	1,986	2,017	1,991	(26)	2,470	2,470		2,488
Building Operations	2,301	2,380	2,569	189	3,083	3,089	(6)	2,774
Employee Benefits	4,283	4,121	4,309	188	5,360	5,385	(25)	1,579
Fringe Benefits Allocation	(4,220)	(4,227)	(4,833)	(606)	(5,900)	(5,900)		(5,197)
Legal Office	454	464	1,015	551	1,248	848	400	752
Budget Reallocation			175	175	578	(2,180)	(2,758)	
Administration Subtotal	***6,531***	***6,341***	***7,128***	***787***	***9,172***	***5,888***	***3,284***	***4,761***
Organization-Wide Expenses								
General	555	665	688	23	809	759	50	2,553
APA Overhead	(1,243)	(1,467)	(1,469)	(2)	(1,763)	(1,794)	31	(1,926)
Recovered OH Costs	(40)	(35)	(38)	(3)	(45)	(45)		(41)
Organization-Wide Expenses Subtotal	***(728)***	***(837)***	***(819)***	***18***	***(999)***	***(1,080)***	***81***	***586***
Governance & Components Expenses								
Assembly	535	659	588	(71)	879	879		830
Board, Operating	482	616	686	70	836	836		613
Standing Committees	137	179	262	83	334	334		205
Direct DB Support								
DB Leadership	62	247	58	(189)	293	293		191
DB StateAssociation Funds	120							120
BD DB Infrastructure Grants	28	14	29	15	61	61		48
Components	184	209	334	125	422	422		204
Board Funds	36	18		(18)		25	(25)	43
Board Strategic Planning		48	165	117	325	55	270	
Governance & Components Expenses Subtotal	***1,584***	***1,990***	***2,122***	***132***	***3,150***	***2,905***	***245***	***2,254***
Total Unrestricted Expenses	***44,279***	***41,198***	***41,953***	***755***	***51,327***	***50,575***	***752***	***54,523***
Unrestricted Operating Net Income/(Loss)	***27,812***	***9,741***	***3,917***	***5,824***	***(258)***	***4,448***	***4,706***	***26,530***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
Statement of Activities

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
TEMPORARILY RESTRICTED REVENUE:								
APA	91	106	113	(7)	122	122		104
Total Temp Restricted Revenue	***91***	***106***	***113***	***(7)***	***122***	***122***		***104***
TEMPORARILY RESTRICTED EXPENSES:								
APA	213	199	187	(12)	217	217		221
Total Temp Restricted Expenses	***213***	***199***	***187***	***(12)***	***217***	***217***		***221***
Temp Restricted Net Income/(Loss)	***(122)***	***(93)***	***(74)***	***19***	***(95)***	***(95)***		***(117)***
NON-OPERATING ACTIVITY:								
Investment Income - LT	3,075	3,135	71	3,064	85	85		5,709
Investment Income - ST	4	4		4				4
Less: Portfolio Management Fees	(54)	(59)	(71)	12	(85)	(85)		(78)
Non-Operating Income/(Loss)	***3,025***	***3,080***		***3,080***				***5,635***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Membership								
Membership Dues Revenue	$9,362	$9,494	$9,366	$128	$9,690	$9,690		$9,713
Insurance Program Revenue	1,500	1,375	1,375		1,500	1,500		1,625
List Sales Revenue	25	57	66	(9)	80	67	(13)	50
Membership Revenue	10,887	10,926	10,807	119	11,270	11,257	(13)	11,388
Membership Services Expense	1,318	1,470	1,488	18	1,797	1,797		1,709
Insurance Program		13		(13)		50	(50)	
Division of Membership		243	229	(14)	279	285	(6)	
Membership Recruitment	120	127	124	(3)	174	174		126
Ethics/DB Relations	201	178	206	28	250	250		248
Library & Archives	76	112	117	5	140	140		96
International Programs	3	86	86		128	128		28
Membership Expense	1,718	2,229	2,250	21	2,768	2,824	(56)	2,207
Contribution	***9,169***	***8,697***	***8,557***	***140***	***8,502***	***8,433***	***(69)***	***9,181***
Membership Affinity Programs Revenue	84	76	79	(3)	81	81		110
Direct Expense			11	11	14	14		13
Contribution	***84***	***76***	***68***	***8***	***67***	***67***		***97***
APA Job Bank Revenue	537	695	542	153	650	700	50	660
Direct Expense	4	24	18	(6)	19	19		4
Contribution	***533***	***671***	***524***	***147***	***631***	***681***	***50***	***656***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
APA Store Revenue	12	6	10	(4)	11	11		11
Direct Expense	18	12	13	1	13	13		18
Contribution	***(6)***	***(6)***	***(3)***	***(3)***	***(2)***	***(2)***		***(7)***
Board Funds Revenue		***110***				***110***	***110***	
Membership Subtotal	***9,780***	***9,548***	***9,146***	***292***	***9,198***	***9,289***	***91***	***9,927***
Advocacy								
PAC	4	4	6	(2)	7	7		6
APA PAC Operating Expenses	128	145	128	(17)	148	148		159
Contribution	***(124)***	***(141)***	***(122)***	***(19)***	***(141)***	***(141)***		***(153)***
Advocacy Leadership Conference	15	10	12	(2)	15	22	7	19
Expense	32	177	202	25	202	180	22	163
Contribution	***(17)***	***(167)***	***(190)***	***23***	***(187)***	***(158)***	***29***	***(144)***
Advocacy Subtotal	***(141)***	***(308)***	***(312)***	***4***	***(328)***	***(299)***	***29***	***(297)***
Communications								
OCPA & Let's Talk Facts	34	29	38	(9)	46	46		38
Expense		3	6	3	7	7		
Communications Subtotal	***34***	***26***	***32***	***(6)***	***39***	***39***		***38***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Publishing								
American Journal of Psychiatry	3,826	4,364	4,393	(29)	5,272	5,283	11	5,118
Direct Expense	1,539	1,631	1,745	114	2,104	2,127	(23)	1,959
Contribution	***2,287***	***2,733***	***2,648***	***85***	***3,168***	***3,156***	***(12)***	***3,159***
Journal of Psychiatric Services	577	821	750	71	900	938	38	806
Direct Expense	537	526	574	48	694	694		700
Contribution	***40***	***295***	***176***	***119***	***206***	***244***	***38***	***106***
Psychiatric News	2,726	3,653	2,656	997	3,187	4,034	847	3,344
Direct Expense	1,883	1,881	1,729	(152)	2,088	2,381	(293)	2,391
Unrelated Business Income Tax	417	167	167		200	200		88
Contribution	***426***	***1,605***	***760***	***845***	***899***	***1,453***	***554***	***865***
Books	3,669	4,328	4,790	(462)	5,684	4,949	(735)	4,803
Direct Expense	440	952	1,187	235	1,598	1,483	115	1,163
Contribution	***3,229***	***3,376***	***3,603***	***(227)***	***4,086***	***3,466***	***(620)***	***3,640***
Specialty Journals	443	233	292	(59)	351	351		564
Direct Expense	196	178	110	(68)	131	131		247
Contribution	***247***	***55***	***182***	***(127)***	***220***	***220***		***317***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Psychiatry Online	332	473		473				6
Direct Expense	20	13		(13)				
Contribution	***312***	***460***		***460***				***6***
Electronic Publishing	11	62		62				8
Direct Expense	14	4		(4)				(67)
Contribution	***(3)***	***58***		***58***				***75***
Legacy content Revenue	***23***	***162***	***42***	***120***	***50***	***165***	***115***	***23***
Publishing Administration	550	602	520	(82)	632	632		657
Publishing Overhead	(629)	(167)	(423)	(256)	(507)	(507)		(745)
Sales & Marketing	807	814	724	(90)	879	1,029	(150)	1,152
Customer Service	997	990	853	(137)	1,028	1,028		1,276
Advertising Sales	650	758	542	(216)	650	800	(150)	787
Periodical Services	19	6		(6)		6	(6)	27
Editorial Development	814	967	1,033	66	1,248	1,278	(30)	1,220
Editorial Production	670	795	791	(4)	965	819	146	843
Publishing Overhead Subtotal	***3,878***	***4,765***	***4,040***	***(725)***	***4,895***	***5,085***	***(190)***	***5,217***
Publishing Contribution	***2,683***	***3,979***	***3,371***	***608***	***3,734***	***3,619***	***(115)***	***2,974***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
DSM								
DSM IV	485	27	15	12	20	28	8	707
DSM 5	36,981	12,070	9,772	2,298	11,602	13,925	2,323	41,384
DSM IV Direct Expense	240	3	15	12	20	2	18	268
DSM 5 Publishing Costs	2,348	1,204	1,333	129	1,601	1,637	(36)	2,714
DSM 5 Development	7,396	2,414	1,807	(607)	2,168	3,203	(1,035)	10,000
DSM Contribution	***27,482***	***8,476***	***6,632***	***1,844***	***7,833***	***9,111***	***1,278***	***29,109***
Continuing Medical Education								
Annual Meeting	9,315	10,977	10,126	851	10,126	10,979	853	9,414
Direct Expense	3,136	4,715	3,561	(1,154)	3,611	4,712	(1,101)	3,176
Department of Meetings & Conventions	672	579	607	28	740	740		730
Office of Scientific Programs	265	364	443	79	537	537		427
Contribution	***5,242***	***5,319***	***5,515***	***(196)***	***5,238***	***4,990***	***(248)***	***5,081***
CME Products and Accredition	457	318	215	103	230	330	100	795
Direct Expense	395	386	243	(143)	296	325	(29)	509
Contribution	***62***	***(68)***	***(28)***	***(40)***	***(66)***	***5***	***71***	***286***
Institute on Psychiatric Services	362	390	312	78	350	446	96	393
Direct Expense	85	98	92	(6)	416	416		355
Contribution	***277***	***292***	***220***	***72***	***(66)***	***30***	***96***	***38***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Focus Journal	1,130	1,117	943	174	1,132	1,240	108	1,272
Direct Expense	135	197	193	(4)	231	231		181
Contribution	***995***	***920***	***750***	***170***	***901***	***1,009***	***108***	***1,091***
Continuing Medical Education Contribution	***6,576***	***6,463***	***6,457***	***6***	***6,007***	***6,034***	***27***	***6,496***
Practice Guidelines								
Practice Guidelines	60	83	66	17	80	116	36	84
Direct Expense	165	191	270	79	358	358		209
Contribution	***(105)***	***(108)***	***(204)***	***96***	***(278)***	***(242)***	***36***	***(125)***
Other Income	***121***	***5***	***4***	***1***	***5***	***5***		***100***
Foundation Expense	***327***	***362***	***362***		***435***	***435***		***312***
Total Contribution	***46,103***	***27,609***	***24,764***	***2,845***	***25,775***	***27,011***	***1,236***	***47,910***
Association Initiatives:								
Advocacy Subtotal	1,714	1,201	1,685	484	2,049	2,057	(8)	2,095
Communications Subtotal	902	1,147	1,509	362	1,812	1,872	(60)	1,113
Policy Programs Partnerships Subtotal	4,406	3,530	4,404	874	4,917	4,872	45	5,412
Governance & Components Expenses Subtotal	1,584	1,990	2,122	132	3,150	2,905	245	2,254
Association Initiatives	***8,606***	***7,868***	***9,720***	***1,852***	***11,928***	***11,706***	***222***	***10,874***

American Psychiatric Association
For the Ten Months Ending October 31, 2014
APA Contribution Margin Report

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection Vs. Annual Budget Fav (Unfav)	2013 Annual Actual
Overhead Costs:								
Operations Subtotal	3,882	4,603	4,818	215	5,932	6,159	(227)	5,154
Administration Subtotal	6,531	6,341	7,128	787	9,172	4,888	4,284	4,761
Organization-Wide Expenses Subtotal	(728)	(837)	(819)	18	(999)	(1,080)	81	586
Overhead costs	***9,685***	***10,107***	***11,127***	***1,020***	***14,105***	***9,967***	***4,138***	***10,501***
Unrestricted Operating Income (Loss)	***27,812***	***9,744***	***3,917***	***5,827***	***(258)***	***5,448***	***5,706***	***26,535***

American Psychiatric Association
Statement of Financial Position

	10/31/13	12/31/13	10/31/14
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$11,455	$11,236	$5,715
Accounts Receivable, Net	9,187	10,227	5,040
Advances to Affiliates	521	1,373	487
Publications Inventory, Net	1,558	1,567	1,362
Prepaid Expenses and Other Current Assets	1,032	1,147	810
Total Current Assets	*23,753*	*25,550*	*13,414*
Investments in Marketable Securities	43,678	52,908	71,630
Property and Equipment, Net	2,130	2,234	2,122
Intangible	5,788	3,900	3,705
Development Costs	14,544	11,843	9,430
TOTAL ASSETS	***89,893***	***96,435***	***100,301***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	8,896	7,762	5,598
Dues Payable (DB & Other)	1,137	1,341	1,172
Deferred Revenue:			
Membership Dues	1,904	5,057	2,142
Other	4,758	7,690	4,272
Total Current Liabilities	*16,695*	*21,850*	*13,184*
Deferred Rent Liability	1,372	1,425	1,233
TOTAL LIABILITIES	***18,067***	***23,275***	***14,417***
NET ASSETS			
Beginning Balance			
Unrestricted, Undesignated	33,882	23,125	35,852
Unrestricted, Designated	37,097	49,184	49,274
Temporarily Restricted	847	851	758
ENDING BALANCE, NET ASSETS	***71,826***	***73,160***	***85,884***
TOTAL LIABILITIES AND EQUITY	***89,893***	***96,435***	***100,301***

Statement of Activities - APF

For the Ten Months Ending October 31, 2014

	October 2013 Actual YTD	October 2014 Actual YTD	October 2014 Budget YTD	YTD Variance Fav (Unfav)	2014 Annual Budget	2014 Annual Projection	Projection /s. Annual Budge Fav (Unfav)	2013 Annual Actual
UNRESTRICTED REVENUE:								
D&HE Federal Awards	$492	$1,233	$671	$562	$805	$1,439	$634	$594
Research Federal Awards	291	380	394	(14)	473	473		363
General Unrestricted	273	502	310	192	400	525	125	331
Total Unrestricted Revenue	***1,056***	***2,115***	***1,375***	***(740)***	***1,678***	***2,437***	***759***	***1,288***
UNRESTRICTED EXPENSES:								
Research Federal Awards	370	402	391	(11)	473	473		442
D&HE Federal Awards	523	1,260	681	(579)	805	1,439	(634)	631
Office of Diversity & Health Equity	327	326	367	41	413	480	(67)	387
Institute on Research & Educ	211	217	265	48	251	251		265
Practice Research Network	523	379	385	6	465	465		647
Office of HIV Psychiatry	88	99	126	27	173	173		116
Programs	85	35	12	(23)	14	41	(27)	105
National Partnership	185	157	156	(1)	186	186		203
Library & Archives	79	65	73	8	93	93		95
Board Funds	3	45	1	(44)	397	308	89	3
Subtotal, Program	***2,394***	***2,985***	***2,457***	***(528)***	***3,270***	***3,909***	***(639)***	***2,894***
New Initiatives Fund					100	65	35	
Division of Education	100							
Foundation Grants	58	46	114	68	150	194	(44)	170
Subtotal, Grants and Other	***158***	***46***	***114***	***68***	***250***	***259***	***(9)***	***170***
Foundation Operating	211	194	154	(40)	182	182		364
Fund Raising	252	216	274	58	335	335		310
Subsidiary Boards	59	41	63	22	63	63		79
Old C3 Administration								20
Subtotal, Administration	***522***	***451***	***491***	***40***	***580***	***580***		***773***
APA Overhead	1,243	1,467	1,469	2	1,763	1,794	(31)	1,926
Recovered OH Costs	(342)	(545)	(522)	23	(627)	(554)	(73)	(418)
Subtotal, Overhead	***901***	***922***	***947***	***25***	***1,136***	***1,240***	***(104)***	***1,508***
Total Unrestricted Expenses	***3,975***	***4,404***	***4,009***	***(395)***	***5,236***	***5,988***	***(752)***	***5,345***
Unrestricted Operating Net Income/(Loss)	***(2,919)***	***(2,289)***	***(2,634)***	***345***	***(3,558)***	***(3,551)***	***7***	***(4,057)***
TEMPORARILY RESTRICTED ACTIVITY:								
Temp Restricted Revenue	990	698	1,623	(925)	1,945	1,509	(436)	2,193
Temp Restricted Expenses	1,933	1,683	2,045	362	2,367	2,011	356	2,199
Temp Restricted Net Income/(Loss)	***(943)***	***(985)***	***(422)***	***(563)***	***(422)***	***(502)***	***(80)***	***(6)***
NON-OPERATING ACTIVITY:								
Investment Income - LT	6,056	2,923		2,923				8,675
Less: Portfolio Management Fees	(117)	(63)	(17)	(46)	(20)	(20)		(144)
Non-Operating Grant								(2)
Non-Operating Income/(Loss)	***5,939***	***2,860***	***(17)***	***2,877***	***(20)***	***(20)***		***8,529***

American Psychiatric Foundation
Statement of Financial Position

	10/31/13	12/31/13	10/31/14
ASSETS			
Current Assets:			
Cash and Cash Equivalents	$3,075	$8,704	$3,548
Accounts Receivable, Net	4		
Pledges Receivable	5	207	6
Grant Receivable, Net	200	122	99
Prepaid Expenses and Other Current Assets	6		
Total Current Assets	*3,290*	*9,033*	*3,653*
Investments in Marketable Securities	54,929	52,466	56,602
Property and Equipment, Net	83	75	38
TOTAL ASSETS	***58,302***	***61,574***	***60,293***
LIABILITIES			
Current Liabilities:			
Accounts Payable and Accrued Expenses	178	224	238
Advances to Affiliates	510	1,352	471
TOTAL LIABILITIES	***688***	***1,576***	***709***
NET ASSETS			
Beginning Balance			
Unrestricted, Undesignated	21,785	13,741	14,350
Unrestricted, Designated	31,186	40,593	40,548
Temporarily Restricted	3,658	4,570	3,550
Permanently Restricted	985	1,094	1,129
ENDING BALANCE, NET ASSETS	***57,614***	***59,998***	***59,577***
TOTAL LIABILITIES AND EQUITY	***58,302***	***61,574***	***60,286***

INVESTMENTS

APA and Subsidiaries
Investment Balances as of September, 2014
Use in October 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	$9,092	$ 9,092
APA c6 ST Invest Account	SunTrust	179	179
TOTAL CASH & CASH EQUIVALENTS		**$ 9,271**	**$ 9,271**

INVESTMENTS IN MARKETABLE SECURITIES

		COST	Market VALUE	APA Sep 2014 YTD Returns *	Benchmark 09-14 YTD Returns *	Index Name	Current Portfolio Allocation	Target Allocation +/- 10%
EQUITIES								
All Cap Equities - Core	Vanguard Total Stock Fnd	26,059	34,693	7.0%	7.0%	CRSFB Leveraged Loan	27.5%	
All Cap Equities	Fidelity Spartan Total Mkt	13,500	13,441		7.1%	Wilshire 5000 Total Mkt	10.6%	
Int'l All-Cap Core	Vanguard Int'l Stock	8,139	8,583	0.0%	0.6%	FTSE Global All Cap ex US	6.8%	
Small Cap Int'l Equities	Brandes Intl Small Cap	6,014	5,648		-2.7%	MSCI EAFE Small Cap	4.5%	
Int'l Equity Mutual Fund	Dodge & Cox	7,146	9,135	5.0%	0.0%	MSCI ACWI ex US	7.2%	
SUBTOTAL EQUITIES		**$ 60,858**	**$ 71,500**				56.7%	70%
MUTUAL & FIXED INCOME FUNDS								
Intermediate Term Bond	Baird FDS Inc	13,021	12,895	5.0%	4.1%	Barclay's Aggregate	10.2%	
High Yield Bonds	Delaware Pooled	2,372	2,547	3.6%	3.5%	Barclay's High Yield	2.0%	
Floating Rt CL I Mutual Fund	Eaton Vance	6,526	6,846	0.9%	2.4%	CSFB Leverated	5.4%	
Bond Index Mutual Fund	Vanguard Bond Fund	9,572	9,711	4.1%	4.1%	Barclay's Aggregate	7.7%	
SUBTOTAL MUTUAL FUNDS		**31,491**	**31,999**				25.4%	30%
Liquidity								
SunTrust Money Market		618	618				0.5%	
SUBTOTAL CASH		**$ 618**	**$ 618**				0.5%	0%
TOTAL PORTFOLIO IN SUNTRUST CUSTODY		**$ 92,967**	**$ 104,117**				82.5%	
HEDGE & Real Estate Funds								
Common Sense Long **		135	151		1.1%	HFRX Equity Hedge Indx	0.1%	
Pinehurst	May	9,400	10,758	5.2%	1.1%	HFRX Global Hedge Indx	8.5%	
Prime Property LT Real Estate		9,416	11,186	9.5%	5.0%	NFI	8.9%	
SUBTOTAL HEDGE & RE FUNDS		**18,951**	**22,095**				17.5%	
LONG TERM POOLED APA, APF Total		**$ 111,918**	**$ 126,212**	5.1%	3.9%	Composite Benchmark	100.0%	
OTHER LT INVESTMENT ACCOUNTS								
CRUT and Pooled Income Trusts	MS, SunTrust	105	130					
Rabbi Trust/Def. Exec. Comp. Accts	NY Life/State Street	1,891	1,891					
Insurance Trust	Wilmington Trust	521	521					
TOTAL INVESTMENTS IN MARKETABLE SECURITIES		**$ 114,435**	**$ 128,754**					
TOTAL CASH AND INVESTMENTS		**$ 123,706**	**$ 138,025**					

* 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.

Item BOT 6.B
Board of Trustees
December 13-14, 2014

Status of the Board Contingency Fund

ACTION:

Will the Board of Trustees vote to accept the report of the status for the Board Contingency Fund?

Status of Board of Trustee's Contingency Fund
as of October 31, 2014

2014 Approved Budget	$ 25,000.00
Less: Expenses paid as of October 31, 2014	-
Unspent Budget as of October 31, 2014	$ 25,000.00

Status of the President's New Initiative Funds

A President's New Initiative Fund is established for each President-Elect in the amount of $25,000. This amount is available for a three year period starting with the term as President-Elect and ending with the completion of the term as Immediate Past President. Any spending requires the approval of the Executive Committee of the Board.

ACTION:

Will the Board of Trustees vote to accept the report of the status for the President's New Initiative Funds for Dr. Lieberman, Dr. Summergrad, and Dr. Binder?

Status of the President's New Initiative for Dr. Lieberman's Fund
as of October 31, 2014

Approved Budget	$	25,000.00
Less: Expenses paid as of October 31, 2014		25,000.00
Unspent Budget as of October 31, 2014	$	-

Status of the President's New Initiative for Dr. Summergrad's Fund
as of October 31, 2014

Approved Budget	$	25,000.00
Less: Expenses paid as of October 31, 2014		-
Unspent Budget as of October 31, 2014	$	25,000.00

Status of the President's New Initiative for Dr. Binder's Fund
as of October 31, 2014

Approved Budget	$	25,000.00
Less: Expenses paid as of October 31, 2014		-
Unspent Budget as of October 31, 2014	$	25,000.00

Status of the Assembly's New Initiative Fund

The Assembly's New Initiative Fund is established with no carry over of unspent amounts. Any spending requires the approval of the Assembly.

ACTION:

Will the Board of Trustees vote to accept the report of the status for the Assembly's New Initiative Fund?

Status of the Assembly's New Initiative Fund
as of October 31, 2014

2014 Approved Budget	$	25,000.00
Less: Expenses paid as of October 31, 2014		(11,003.88)
Unspent Budget as of October 31, 2014	$	13,996.12

Report of the Joint Reference Committee to the Board of Trustees

The Joint Reference Committee (JRC) forwards the following actions to the Board of Trustees for consideration. The draft summary of actions from the October 2014 JRC meeting may be found as attachment #16 (a separate document). The full reports from the Councils to the Joint Reference Committee are located on the APA website in the Association Governance section under Joint Reference Committee:
http://apps.psychiatry.org/staticfiles/governance/jrc/JRCPortfolioOctober2014.pdf

ACTION ITEMS

Item 7.A.1 Subspecialty Ex-officio Member of the Councils (JRCOCT143.1)

Will the Board of Trustees approve, as a pilot program, that each ABPN subspecialty identify one individual to hold an ex-officio, non-voting position on its corresponding APA council?

The cost of this position will be shared between the APA and the subspecialty. The individual chosen must be an APA member. There is no requirement that the council fill such a position each year.

Council on Geriatric Psychiatry (AAGP)
Council on Children, Adolescents & Their Families (AACAP)
Council on Psychiatry and Law (AAPL)
Council on Psychosomatic Medicine (APM)
Council on Addiction Psychiatry (AAAP)

Note: The cost of a representative [travel to the September Components Meetings and conference calls] would be shared between the APA and the subspecialty. The estimated total cost per person per year is $1,043 (2014 dollars) per Council. The APA total = $2,607.50 [5 subspecialty reps/2]

Item 7.A.2 Task Force Report – Ethics Annotations (JRCOCT143.2)
(Please see attachment #2 – *a separate document*)

Will the Board of Trustees form a work group to review and revise the 2008 Task Force Report to Update the Ethics Annotations?

The work group would bring recommendations to the Board of Trustees with regard to whether a revised document might replace the current ethics annotations or be approved as a separate resource document of the APA. The JRC recommended that the work group have representatives from the BOT, Assembly, Ethics Committee, Council on Psychiatry and Law, and also include the APA General Counsel. In addition, the JRC recommended that Drs. Paul Appelbaum and Laura Roberts be appointed as consultants. Names of members recommended by the JRC can be given to Dr. Summergrad who will appoint the workgroup.

Item 7.A.3 2015 Jacob Javits Award (JRCOCT147.A)
(Please see attachment #3)

Will the Board of Trustees approve the 2015 nominee for the Jacob Javits Award, Dave Jones - California State Insurance Commissioner?

Item 7.A.4 2015 Human Rights Award (JRCOCT147.B)
(Please see attachment #4)

Will the Board of Trustees approve the 2015 nominee for the Human Rights Award nominee, Chester Pierce, MD?

Item 7.A.5 2014 Jack Weinberg Memorial Award in Geriatric Psychiatry (JRCOCT147.C)
(Please see attachment #5)

Will the Board of Trustees approve the 2014 Jack Weinberg Memorial Award in Geriatric Psychiatry nominee, Robert G. Robinson, MD?

Item 7.A.6 2014 Member Communications Award (JRCOCT147.D)
(Please see attachment #6)

Will the Board of Trustees approve the nominees for the 2014 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society?

Item 7.A.7 2015 Adolf Meyer Award (JRCOCT147.E)
(Please see attachment #7)

Will the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award, Dr. Karl Deisseroth?

Item 7.A.8 2015 Patient Advocacy Award Lecture (JRCOCT147.F)
(Please see attachment #8)

Will the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award, Patrick J. Kennedy?

Item 7.A.9 2014 Psychiatric Services Achievement Awards (JRCOCT147.G)
(Please see attachment #9)

Will the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Awards?

Gold Award for Academically or Institutional Sponsored Programs:
Alliance Health Project
Department of Psychiatry, University of California, San Francisco, San Francisco, CA

Gold Award for Community-based Programs:
Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, MA

Silver:
Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, PA

Bronze:
Shared Psychiatric Services, LifeWorks, Austin, TX

Certificate of Significant Achievement:

- The Mental Health Crisis Alliance, St. Paul MN
- GATE-Utah (Giving Access to Everyone) Salt Lake City UT

Behavioral Health Integration Program, University of Washington, Seattle WA

Item 7.A.10 2015 John Fryer Award (JRCOCT147.H)
(Please see attachment #10)

Will the Board of Trustees approve the 2015 John Fryer Award nominee, Laverne Cox?

Item 7.A.11 2014 Bruno Lima Award (JRCOCT147.I)
(Please see attachment #11)

Will the Board of Trustees approve the 2014 Bruno Lima Award nominees, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD?

Item 7.A.12 Revision of Charge to the Council on Communications (JRCOCT148.D.1)
(Please see attachment #12)

Will the Board of Trustees approve the revision to the charge to the Council on Communications to include the entirety of the APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies?

Item 7.A.13 APA Branding Initiative (JRCOCT148.D.2)
(Please see attachment #13)

Will the Board of Trustees approve the Council on Communications recommendation and support the APA's branding initiative to help brand the APA consistently and demonstrate its value?

Item 7.A.14 Revision of Charge to Council on Research (JRCOCT148.M.1)
(Please see attachment #14)

Will the Board of Trustees approve the revision of the charge to the Council on Research?

Item 7.A.15 APA Signing onto the AllTrials Registry (JRCOCT148.M.3)
(Please see attachment #15 – a separate document)

Will the Board of Trustees approve the APA signing onto the AllTrials registry?

Item 7.A.16 Transfer of Administration of the Human Rights Award (JRCOCT138.J.15)

Will the Board of Trustees approve transferring the administration of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry with the requisite changes to each council's charge editorially revised?

Note: If the transfer is approved, it will result in a revision to the Human Rights/Isaac Ray Award Committee's name to the Isaac Ray Award Committee and a revision to the charge.

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24, 2014

Foundation instructions:

If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24, 2014

AWARD NAME: Jacob Javits Award for Public Service

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Advocacy and Government Relations

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CHAIRPERSON: Barry Perlman, M.D.

STAFF LIAISON: Deana McRae

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
The Council on Advocacy and Government Relations presents the Jacob K. Javits Public Service Award annually to a public servant who has made a significant contribution to the mental health community and patients suffering from mentally disorders. This is the highest award conferred upon a public servant by the APA. Presenting the Javits Award gives APA the opportunity to showcase the work honorees provide on behalf of consumers and the fields of health care and mental health care.

Description of Selection Criteria for Award:
The award is given annually, alternately, between a state public servant and a federal public servant.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: **$200.00**
Cost of Cash Award:
Cost of Lectureship:
Other (please list):

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s): Dave Jones (California State Insurance Commissioner)

(*Please find attach a biosketch and all letters submitted on behalf of the nomination of this individual*)

Description of the Committee's Selection Process:

The Committee on Advocacy and Government Relations received six nominations from APA leadership and Council members for this award and determined that California State Insurance Commissioner Dave Jones would receive the award, by a majority vote. The vote took place during the CAGR meeting at the September Component Meeting on September 12, 2014.

CALIFORNIA PSYCHIATRIC ASSOCIATION
1029 K STREET, SUITE 28, SACRAMENTO, CA 95814
(916) 442-5196 FAX (916) 442-6515 calpsych@calpsych.org

CPA NOMINATION FOR THE 2015 JACOB K. JAVITS AWARD

MR. DAVE JONES
CALIFORNIA STATE INSURANCE COMMISSIONER

Dave Jones is a former legal aid attorney with Legal Aid Services of Northern California; former Sacramento City Councilman; former White House Fellow in the Clinton administration (in 1995 Jones was one of 13 Americans awarded a White House Fellowship, first serving as a special assistant to Janet Reno and later as her counsel); and former California State Assemblymember. He is currently the Insurance Commissioner of the California Department of Insurance. As a public servant, and in more than one position in public service, Mr. Jones has made significant contributions to the welfare of mentally ill persons in the State of California.

The California Department of Insurance is the largest consumer protection agency in the United States, which regulates the $123 billion insurance industry in California. As Insurance Commissioner, Mr. Jones has recognized that monitoring and enforcement of parity legislation is as important as the legislation itself. He has led California and the California Department of Insurance to identify, implement, and at times compel, insurance industry compliance with both the language and the intent of mental health parity laws.

California's Mental Health Parity Act predates the federal Mental Health Parity and Addiction Equity Act by almost a decade. In CA, as in other jurisdictions, the insurance industry has misinterpreted parity legislation to mean less than full parity coverage by falling back on the specific wording of parity laws rather than their intent. Insurers are arguing parity requires coverage for services *equal to* (defined as the same as) services offered for medical and surgical treatments rather than services *equivalent* to those covered for medical and surgical treatment. This excludes many mental health interventions for which there are not corollary, typical medical or surgical interventions. Insurers also argue that the list of parity services written into parity legislation is an exhaustive list of covered services rather than a list illustrating typical mental health interventions, thereby excluding those mental health services that have not been specifically identified in legislation.

Mr. Jones has seen through these misrepresentations. In *Harlick v. Blue Shield*, coverage for residential treatment for a patient with severe, recurrent anorexia was denied because the California Mental Health Act did not specify residential treatment as a covered parity service and the patient's policy did not include residential treatment for medical and surgical disorders. Mr. Jones submitted amicus briefs in all case proceedings of the U.S. Ninth Circuit Court of Appeals (argued in federal court because it was a case that fell under ERISA law) for *Harlick*. He argued that the CA Mental Health Parity Act required health service plans to provide all *medically necessary* care even when not specifically enumerated in the Act or not appearing in a beneficiary's evidence of coverage – a conclusion the court subsequently adopted.

Dave Jones

A Brief Biography

Dave Jones, JD, is currently the Insurance Commissioner of California, administering the California State Department of Insurance. He was first elected in November 2012 to lead the largest consumer protection agency in the state, regulating the nation's largest insurance market and an insurance industry that annually collects $123 billion in premiums.

Commissioner Jones took immediate action to protect consumers the moment he was sworn in to office by signing an emergency regulation to require health insurers to begin spending at least 80 cents of every premium dollar on health care, rather than profits and administrative costs. This was the first action of many taken by Commissioner Jones to implement the Affordable Care Act in a way that is best for California consumers, which has been a top priority over the last three years.

Daily Journal, the state's largest legal newspaper, named him one of California's Top 100 Lawyers. The Greenlining Institute gave Jones their "Big Heart Award" for his work promoting insurance industry diversity. Jones received the Distinguished Advocate Award from Autism Speaks.

Jones served in the California State Assembly from 2004 through 2010, where he chaired the Assembly Health Committee, the Assembly Judiciary Committee and the Budget Subcommittee on Health and Human Services. Named "Consumer Champion" by the California Consumer Federation, Jones was also awarded the "Leadership Award" by the Western Center on Law and Poverty. Planned Parenthood, Environment California, the Urban League, Preschool California and CalPIRG have all honored his work. Capitol Weekly named Jones California's "most effective legislator" other than the Assembly Speaker and the Senate President Pro Tempore.

Prior to his election to the State Assembly, Jones was a member of the Sacramento City Council where he served from 1999-2004.

Jones began his career as a legal aid attorney, providing free legal assistance to the poor with Legal Services of Northern California from 1988 to 1995. In 1995, Jones was one of 13 Americans awarded a prestigious White House Fellowship. He served in the Clinton Administration for three years, first serving as special assistant to Janet Reno and later as her counsel.

Jones graduated with honors from DePauw University, Harvard Law School and Harvard's Kennedy School of Government.

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION
AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24, 2014

Foundation instructions:
If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24, 2014

AWARD NAME: Human Rights Award_____

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Psychiatry and Law

CHAIRPERSON: Mardoche Sidor, MD

STAFF LIAISON: Lori Klinedinst
[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
An individual and/or an organization whose efforts exemplify the capacity of human beings to act courageously and effectively to prevent human rights violations, to protect others from human rights violations and their psychiatric consequences, and to help victims recover from human rights abuses.

Description of Selection Criteria for Award:
This award is given to an individual or organization exemplifying the capacity of human beings to protect others from damage at the hands of other human beings. If possible, this damage should be related to the professional, scientific, and clinical dimensions of mental health.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: under $100
Cost of Cash Award: $0
Cost of Lectureship: $0
Other (please list):
Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s): Chester Pierce
Dr. Pierce is Emeritus Professor of Psychiatry at Harvard Medical School and Emeritus Professor of Education at the Harvard College of Arts and Sciences. He has had an amazing academic career, publishing more than 180 books, articles, and reviews. He wrote about the psychological effects of extreme environments, even doing some research on the latter while in the Navy. He also wrote about the effects of racism, first proposing the concept of racial microagressions in the 1970.

His work mostly surrounds areas of racism, societal tensions, sports medicine, and the media. He is a member of the Institute of Medicine at the National Academy of Sciences as well as at the American Academy of Arts and Science. He frequently offers his time as a guest lecturer and has given talks at over 100 universities in the United States alone. Although Pierce retired as a psychiatrist in 1997, one of his most recent accomplishments came in 2002 when he organized an “African Diaspora” conference that brought psychiatrists from all around the globe to discuss issues and problems we face today. Because of his efforts, the MGH Division of International Psychiatry was founded in 2003.

His numerous awards include those from the National Medical Association, American Psychiatric Association, Black Psychiatrists of America, and the World Psychiatric Association. In addition, he has won national and international awards for film production. He was also the subject of a book entitled "Race and Excellence: My Dialogue with Chester Pierce" by Ezra E.H. Griffith published in 1998.

Description of the Committee's Selection Process:
Initially, there were no nominations for the 2015 Human Rights Award. Committee members met in person at the 2014 APA Annual Meeting held in New York to discuss strategy for soliciting more applicants. The committee discussed several possible applicants and collected further information. The Committee then met by conference call in June and selected the nominee. The Council on Psychiatry and Law approved the committee's recommendation at the September component meeting.

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24, 2014

Foundation instructions:

If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24, 2014

AWARD NAME: **Jack Weinberg Memorial Award in Geriatric Psychiatry**

NAME OF AWARD ADMINISTRATIVE COMPONENT:
Council on Geriatric Psychiatry

CHAIRPERSON: Robert Paul Roca, MD

STAFF LIAISON: Sejal Patel

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

Candidates for the award must be psychiatrists who are nominated by an APA member.

Description of Selection Criteria for Award:

A psychiatrist, who, over the course of his/her career, has demonstrated special leadership or who has done outstanding work in clinical practice, training, or research into geriatric psychiatry.

Award Funding Information: [Please complete the following if applicable]

Cost for Plaque: $200 (Approx)
Cost of Cash Award: $500.00
Cost of Lectureship:
Other (please list):

Award Account Balance: $3042(as reported by APA Online Financials)
Date Balance Determined: August 31, 2014

Award Nominee(s): Robert G. Robinson, M.D

(Please attach a biosketch and any letters of nomination or support for this individual)

Description of the Committee's Selection Process:

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24th.

Foundation instructions:

If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24th.

AWARD NAME: Member Communications Award
NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Communications (COC) -Award Sub-Committee

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CHAIRPERSON: J. Raymond DePaulo, MD
STAFF LIAISON: Lisa Fields

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
Solicitations for the award can be received from District Branch/State Associations or other APA constituent groups such as Resident-Fellow Members (RFM); Early Career Psychiatrists (ECP); Assembly Allied Organization Liaisons (AAOL); and Minority Under-Represented (MUR). Each APA Member Group has an opportunity to select from only one of the four categories and submit the entry form accordingly. An award can be won in successive years.

Description of Selection Criteria for Award:
The Member Communications Award (formerly known as the Newsletter of the Year Award) recognizes e-newsletters, Innovative & Emerging Technology, Websites, and an Overall Communications Plan that facilitates effective communication with members and/or external audiences on matters of importance to psychiatry, the District Branch/State Association, or an APA constituent group. Judging criteria include how the award category achieve the goals of the format used including but not limited to the; frequency of content distributed; originality; general layout and design; available resources; creative solutions for member & non-member outreach; timeliness; and overall impression.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: $21.00
Cost of Cash Award:
Cost of Lectureship:
Other (please list):

Award Account Balance: COC budget (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s):

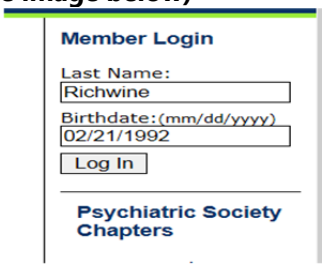
1. **North Carolina Psychiatric Association – Innovative & Emerging Technology**
   https://guidebook.com/guide/23750/

   To Download NCPA's Guidebook app, follow these steps:

   1. **Scan the QR Code at right with your device QR Reader/Scanner OR search within your device's app store for "Guidebook"**
   2. **Once Guidebook is on your device, search for "NC Psychiatric Association" within the app to load our event.**

2. **OHIO PSYCHIATRIC ASSOCIATION – Website Category**
   Website: www.ohiopsychiatry.org

3. **PENNSYLVANIA PSYCHIATRIC SOCIETY – e-Newsletter Category**
   Website: www.papsych.org
   URL: http://www.papsych.org/index.aspx?ReturnUrl=%2fSecure%2fNewsletter%2fNewsletter_toc.aspx
   Login on right side of the screen: (see image below)



Last Name: Richwine
DOB: 02/21/1992

<u>Description of the Committee's Selection Process</u>:

Survey Monkey facilitated an easier review process. Criteria ranked via a rating scale of 1-5 (1 good, 5 not so good) - tally dictates the winner(s).

AMERICAN PSYCHIATRIC ASSOCIATION

AWARD REVIEW FORM (CONFIDENTIAL)

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation on to the Joint Reference Committee.

AWARD NAME: **Adolf Meyer Award Lecture**

NAME OF AWARD ADMINISTRATIVE COMPONENT:
Annual Meeting Scientific Program Committee under Council on Medical Education and Lifelong Learning

CHAIRPERSON: **Philip R. Muskin, M.D.**
STAFF LIAISON: **Joy Raether, M.B.A.**

Description of Eligibility for Award: The Adolf Meyer Lectureship (Established 1957)
This lectureship series at the Annual Meeting is intended to advance psychiatric research by enabling psychiatrists to hear from leading scientists and to exchange new research information with outstanding colleagues. Winner presents a lecture at the APA Annual Meeting. Eligibility: Researchers in the U.S. and abroad. Component: Annual Meeting Scientific Program Committee.

Description of Selection Criteria for Award: The awardee is nationally or internationally recognized as a leading scientist in an area of psychiatric research.

Award Funding Information:
Cost for Plaque: $200
Cost of Honorarium: $3,000.
Other (please list): Up to $500 in travel reimbursement for nonmember winner(s).

Award Account Balance: *N/A* [Funded from the Annual Meeting lecturers honoraria budget.]

Award Nominee(s): Karl Deisseroth, M.D.

Description of the Committee's Selection Process:
The APA President and the Chairman of the Scientific Program Committee reviewed the list of past recipients and identified a renowned researcher who has yet to receive the award.

Karl Deisseroth, M.D., Ph.D.

D.H. Chen Professor of Bioengineering and of Psychiatry And Behavioral Sciences, Stanford University Howard Hughes Medical Institute
318 Campus Drive West, Clark Center W083
Department of Bioengineering, Stanford University
Stanford, CA 94305

Biographical Sketch

Karl Deisseroth, M.D., Ph.D., is the D.H. Chen Professor of Bioengineering and Psychiatry at Stanford University and an Investigator and Early Career Scientist at the Howard Hughes Medical Institute. He received his Ph.D. (neuroscience, 1998) and M.D. (2000) from Stanford University. He also completed an internship and his residency there. Dr. Deisseroth's research efforts have resulted in the development of high-resolution optical methods for investigating intact biological systems. His group has pioneered optogenetics, a technology that uses light for controlling activity patterns in the brains of freely moving mammals, and CLARITY, a chemical engineering technology that enables high-resolution structural and molecular access to intact brains. Among his numerous honors and awards for his work in optogenetics are the McKnight Foundation Scholar Award, the BRAIN Prize (Lundbeck Research Foundation), and an award from Premio Citta' di Firenze for Molecular Sciences for his work in optogenetics and CLARITY. He has been elected to both the Institute of Medicine (IOM) and the National Academy of Sciences (NAS). A practicing psychiatrist, Dr. Deisseroth has applied his technologies to study parkinsonian motor behaviors, anxiety, depression, and social dysfunction and has used CLARITY for mapping the nervous system.

Education

1988-1992	A.B., Biochemical Sciences, *summa cum laude*, Harvard University
1992-2000	M.D., Stanford University Medical School (MSTP Program)
1994-1998	Ph.D. Stanford University (Neuroscience)

Postgraduate Training

2000-2001	MD internship/licensure, Stanford
2000-2004	Psychiatry Residency, Stanford

Specialty Board Certification

2006 Diplomate, American Board of Neurology and Psychiatry

Previous Academic and Administrative Appointments

2004-2005	Principal Investigator and Clinical Educator, Department of Psychiatry, Stanford University School of Medicine
2005-2008	Assistant Professor of Bioengineering and Psychiatry, Stanford

2009-2012	Associate Professor of Bioengineering and Psychiatry, Stanford
2009-2013	HHMI Early Career Investigator
2012-pres	Professor of Bioengineering and Psychiatry, Stanford University
2012-pres	D.H. Chen Professorship and Chair, Stanford University
2013-pres	Foreign Adjunct Professor, Karolinska Institutet
2014-pres	Investigator, HHMI

Service

National and International

2005-2007	Scientific advisor, nonprofit: Michael J Fox Foundation for Parkinson's Research
2007-2009	Member, NIH Molecular Neurogenetics chartered study section (MNG)
2007-	*Ad hoc* member, NIH study sections
2007-	Scientific advisor, nonprofit: Kinetics Foundation for Parkinson's Research
2008-	Woods Hole and Cold Spring Harbor couses; yearly optogenetics teaching
2008-	Stanford, optogenetics course for visiting students
2009-	NARSAD Council (Brain and Behavior Research Foundation)
2010-	Elected to the Institute of Medicine
2011-	Elected to the National Academy of Sciences

University

2010-	Chair of Undergraduate Education in Bioengineering
2004-	Inpatient and outpatient care: attending physician, inpatient and outpatient service, interventional psychiatry

Honors and Awards

1990-1992	John Harvard Scholarship: Academic Achievement of the Highest Distinction, Harvard
1992	Phi Beta Kappa, Harvard
1992	*Summa cum laude*, Harvard
1992	Highest Honors, Department of Biochemistry and Molecular Biology, Harvard
1997	Stanford Yanofsky Graduate Research Award
2002	NIMH Outstanding Resident Award
2004	American Psychiatric Association Resident Research Award
2004	Charles E. Culpeper Scholarship in Medical Science Award
2005	Klingenstein Fellowship Award and Robert H. Ebert Clinical Scholar Award
2005	Whitehall Foundation Award
2005	NARSAD Young Investigator Award
2005	American Psychiatric Institute for Research and Education Young Faculty Award
2005	McKnight Foundation Technological Innovations in Neuroscience Award
2005	Coulter Foundation Early Career Translational Research Award in Biomedical Engineering
2005	NIH Director's Pioneer Award
2006	Presidential Early Career Award in Science and Engineering (PECASE)

2007	McKnight Foundation Scholar Award
2007	*Top 10 Technologies* Award, MIT Technology Review
2008	*Brilliant 10* Award, Popular Science
2008	World Economic Forum Lecturer, Davos Switzerland
2008	William M. Keck Foundation Medical Research Award
2008	Lawrence C. Katz Prize, Duke University, for optogenetics
2008	Schuetze Prize, Columbia University, for optogenetics
2009	Society for Neuroscience YIA Award, for optogenetics
2009	Society for Neuroscience Special Lecture: "*Optogenetics: Development and Application*"
2010	Gill YIA Award, Indiana University, for optogenetics
2010	Koetser Prize laureate, Zurich Switzerland, for optogenetics
2010	Nakasone Prize laureate, International Human Frontier Science Program/HFSP, for optogenetics
2010	Institute of Medicine (IOM) Election
2011	Alden Spencer Prize, Columbia, for optogenetics
2012	Perl/UNC Prize, for optogenetics
2012	Record Prize, Baylor, for optogenetics
2012	National Academy of Sciences (NAS)
2012	Zuelch Prize, Max-Planck Society, for optogenetics
2013	Richard Lounsbery Prize from the National Academy of Sciences, for optogenetics
2014	Dickson Prize in Science

Publications

1. Warden MR, Cardin JA, Deisseroth K. **Optical Neural Interfaces.** Annu. Rev. Biomed. Eng. 2014. 16:103-29. [PDF]

2. Gunaydin LA, Grosenick L, Finkelstein JC, Kauvar IV, Fenno LE, Adhikari A, Lammel S, Mirzabekov JJ, Airan RD, Zalocusky KA, Tye KM, Anikeeva P, Malenka RC, Deisseroth K. **Natural Neural Projection Dynamics Underlying Social Behavior.** Cell. June 2014. [PDF | VTA-NAc social behavior video | VTA-NAc novel objects video | VTA social behavior video | VTA novel object video | Stanford Medicine | Scope Blog | Nature]

3. Fenno LE, Mattis J, Ramakrishnan C, Hyun M, Lee SY, He M, Tucciarone J, Selimbeyoglu A, Berndt A, Grosenick L, Zalocusky KA, Bernstein H, Swanson H, Perry C, Diester I, Boyce FM, Bass CE, Neve R, Huang ZJ, Deisseroth K. **Targeting cells with single vectors using multiple-feature Boolean logic** Nature Methods. June 2014. 11, 763-772. [PDF | Supplement]

4. Tomer R, Ye L, Hsueh B, Deisseroth K. **Advanced CLARITY for rapid and high-resolution imaging of intact tissues.** Nature Protocols. June 2014. [PDF | COLM resources and hi-res figures/movies | Stanford News | DARPA]

5. Berndt A, Lee SY, Ramakrishnan C, Deisseroth K **Structure-guided transformation of a channelrhodopsin into a light-activated chloride channel.** Science. April 2014. 344(6182):420-4 [PDF | Supplement | Perspective]

6. Deisseroth K. **Circuit dynamics of adaptive and maladaptive behavior.** Nature. January 2014. 505(7483):309-17 [PDF | Fig 1 (hi-res) | Fig 2 (hi-res)]

7. Williams SCP and Deisseroth K. **Optogenetics.** PNAS. October 2013. [PDF]

8. Kim SY, Chung K, and Deisseroth K. **Light microscopy mapping of connections in the intact brain.** Trends in Cognitive Sciences. November 2013. 17(12):596-9 [PDF]

9. Stamatakis AM, Jennings JH, Ung RL, Blair GA, Weinberg RJ, Neve RL, Boyce F, Mattis J, Ramakrishnan C, Deisseroth K, Stuber GD. **A unique population of ventral tegmental area neurons inhibits the lateral habenula to promote reward.** Neuron. November 2013. 80(4):1039-53 [PDF]

10. Deisseroth K and Schnitzer MJ. **Engineering approaches to illuminating brain structure and dynamics.** Neuron. October 2013. 80(3):568-77 [PDF]

11. Chen AC, Oathes DJ, Chang C, Bradley T, Zhou ZW, Williams LM, Glover GH, Deisseroth K, Etkin A. **Causal interactions between fronto-parietal central executive and default-mode networks in humans. 110(49):19944-9** PNAS. October 2013. [PDF]

12. Hamilton LS, Sohl-Dickstein J, Huth AG, Carels VM, Deisseroth K, Bao S. **Optogenetic activation of an inhibitory network enhances feedforward functional connectivity in auditory cortex.** Neuron. November 2013. 80(4):1066-76 [PDF]

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AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24th.

AWARD NAME: Patient Advocacy Award Lecture

NAME OF AWARD ADMINISTRATIVE COMPONENT:

Annual Meeting Scientific Program Committee under Council on Medical Education and Lifelong Learning.

CHAIRPERSON: _Philip R. Muskin, M.D.

STAFF LIAISON: _Joy Raether, M.B.A.

Description of Eligibility for Award: APA Award for Patient Advocacy**,** established in 1987, recognizes a public figure respected for personal accomplishments and beliefs, who has promoted the improvement of services for people coping with mental disorders and substance abuse, and who has fought stigma by speaking out about experiences with mental illness and psychiatric treatment.

Description of Selection Criteria for Award: Selection is made by the Annual Meeting Scientific Program Committee in conjunction with the APA President.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: $100
Cost of Cash Award: $2000
Cost of Lectureship:
Other (please list):

Award Account Balance: *N/A* [Funded from the Annual Meeting lecturers honoraria budget.]

Award Nominee(s): Patrick J. Kennedy

Biosketch attached

Description of the Committee's Selection Process:

The APA President and the Chairman of the Scientific Program Committee reviewed the list of past recipients and identified an exceptional and prominent advocate for mental health to receive this distinguished award.

The Honorable Patrick J. Kennedy
Former United States Representative, Rhode Island
Co-Founder, One Mind for Research
Founder, Kennedy Forum

Representative Patrick Kennedy served 16 years in the U.S. House of Representatives, and is predominantly known as author and lead sponsor of the Mental Health Parity and Addiction Equity Act of 2008. This dramatic piece of legislation provides tens of millions of Americans who were previously denied care with access to mental health treatment.

Now, Rep. Kennedy is the co-founder of One Mind for Research, a national coalition seeking new treatments and cures for neurologic and psychiatric diseases of the brain afflicting one in every three Americans. One Mind for Research is dedicated to dramatic enhancements in funding and collaboration in research across all brain disorders in the next decade. This historic grassroots endeavor unites efforts of scientists, research universities, government agencies, and industry and advocacy organizations not only across the country, but throughout the world. Rep. Kennedy is bringing everyone together to design the first blueprint of basic neuroscience, to guide efforts in seeking cures for neurological disorders affecting Americans.

Rep. Kennedy is the founder of the Kennedy Forum on Community Mental Health which served as a vehicle to celebrate the 50th anniversary of President Kennedy's signing of the Community Mental Health Act, the landmark bill that laid the foundation of contemporary mental health policy and provided Rep. Kennedy with the platform to launch a bold, ongoing effort to advance the work President Kennedy began. The Kennedy Forum continues to advocate for mental health parity.

Rep. Kennedy has authored and co-sponsored dozens of bills to increase the understanding and treatment of neurological and psychiatric disorders, including the National Neurotechnology Initiative Act, the Genomics and Personalized Medicine Act, the COMBAT PTSD Act, and the Alzheimer's Treatment and Caregiver Support Act.

Rep. Kennedy is a winner of the American College of Neuropsychopharmacology Distinguished Service Award, the Society for Neuroscience Public Service Award, the Peter C. Alderman Foundation Humanitarian Award, Centennial Award from the Clifford Beers Foundation, the Autism Society of America Congressional Leadership Award, the Depression and BiPolar Support Paul Wellstone Mental Health Award, the Epilepsy Foundation Public Service Award and has been recognized by many organizations for his mental health advocacy. In 2014, he is being recognized by the Society of Biological Psychiatry, The Samaritan Institute, and The Association for Medical Education and Research in Substance Abuse (AMERSA).

He is also founder of the Congressional Down Syndrome Caucus and the 21st Century Healthcare Caucus, as well as an honorary board member of SAM-Smart Approaches to Marijuana.

Rep. Kennedy lives in Brigantine, NJ, with his wife, Amy, and their three children.

Ref: http://www.patrickjkennedy.net/about-patrick-j-kennedy

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24th.

Foundation instructions:

If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24th.

AWARD NAME: Psychiatric Services Achievement Awards

NAME OF AWARD ADMINISTRATIVE COMPONENT: Psychiatric Services Achievement Awards Selection Committee

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CHAIRPERSON: Gerard Gallucci, MD

STAFF LIAISON: Samantha Hawkins

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

Any hospital, clinic, school, or community program is eligible if it has been in full operation for at least two years.

Description of Selection Criteria for Award:

These awards recognize outstanding programs that deliver services to the mentally ill or disabled, have overcome obstacles, and can serve as models for other programs, from both academically or institutionally sponsored programs as well as community-based programs.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque:
Cost of Cash Award: Total of 10,000 (3500 to each gold award; 2000 for silver; 1000 for bronze; no money is given if the committee chooses programs for a Certificate of Significant Achievement).
Cost of Lectureship:
Other (please list): IPS expenses

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s):

Gold Award for Academically or Institutional Sponsored Programs: Alliance Health Project
Department of Psychiatry, University of California, San Francisco, San Francisco, California

Gold Award for Community-based Programs: Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, Massachusetts
Silver: Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, Pennsylvania
Bronze: Shared Psychiatric Services, LifeWorks, Austin, Texas

Certificate of Significant Achievement:

- The Mental Health Crisis Alliance, St. Paul MN
- GATE-Utah (Giving Access to Everyone) Salt Lake City UT
- Behavioral Health Integration Program, University of Washington, Seattle WA

(Please attach a biosketch and any letters of nomination or support for this individual)

The application packet and site review is attached for each of the programs.

Description of the Committee's Selection Process:

Online e-application form, program description, and supporting materials. The Committee reviews applications, ranks and selects programs to receive site visits. Appropriate district branches are asked to make site visits to the top ranked programs and submit an evaluation to the Awards Committee. Committee convenes by phone to review site evaluations and choses awardees.

AMERICAN PSYCHIATRIC ASSOCIATION

AWARD REVIEW FORM

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation on to the Joint Reference Committee.

AWARD NAME: *John Fryer*

NAME OF AWARD ADMINISTRATIVE COMPONENT: *C. on Minority Mental Health/Health Disparities*

CHAIRPERSON: *Sandy Walker, MD*

STAFF LIAISON: *Alison Bondurant*

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

Honors an individual whose work has contributed to the improvement of the mental health of sexual minority communities. Individuals need not be gay, lesbian, bisexual or psychiatrists .

Description of Selection Criteria for Award:

See above.

Award Funding Information: [Please complete the following if applicable]

Cost for Plaque:	*<$300*
Cost of Cash Award:	*$1,000*
Cost of Lectureship:	
Other (please list):	*Travel expenses for non-APA member awardee: @ $1,500 if applicable*
	Travel expenses for APA member awardee: $0

Award Account Balance: *Per special arrangement in June 2013 between APF and the award's co-sponsor Association of Gay & Lesbian Psychiatrists, expenses for the 2015 award will be covered via a Board account.*

Date Balance Determined:

Award Nominee(s): Laverne Cox

(Please attach a biosketch and any letters of nomination or support for this individual)

Other individuals considered for the award:

Description of the Committee's Selection Process:

Nominations are sought annually and include self-nominations or nominations by groups, institutions, or individuals. Selection is made by a work group of the Council on Minority Mental Health and Health Disparities, which includes representatives from the Association of Gay and Lesbian Psychiatrists (the award's co-sponsor) and APA Caucus of GLB Psychiatrists. The work group evaluates nominations and selects a finalist via email or conference call.

Laverne Cox is a critically Emmy Award-nominated actress and LGBT advocate. She currently appears in the Netflix original series Orange is the New Black as Sophia Burset, an incarcerated African American transgender woman. Ms. Cox is the first trans woman of color to have a leading role on a mainstream scripted television show. Time Magazine named Cox's role on Orange as one of the most influential fictional characters of 2013 and put her on their cover, the first ever openly transgender person to appear.

Laverne Cox is the first trans woman of color to produce and star in her own television show, VH1's TRANSForm Me. Laverne is also the first trans woman of color to appear on an American reality television program, VH1's I Wanna Work for Diddy. Both these shows were nominated for GLAAD media awards, the latter winning the award for Outstanding Reality Program.

Cox is a frequent writer, speaker and commentator on trans issues, highlighting the stories of trans people that are outside the media's eye, and encouraging us all toward moving beyond gender expectations to live more authentically. Her writing has appeared in The Advocate and The Huffington Post. Cox was born in Alabama and holds a degree in Fine Arts from Marymount Manhattan College.

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION
AWARD REVIEW FORM

APA Board instructions:
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Foundation instructions:
If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24, 2014

AWARD NAME: Bruno Lima Award

NAME OF AWARD ADMINISTRATIVE COMPONENT: Committee on Psychiatric Dimensions of Disaster

CHAIRPERSON: Charles Marmar, MD

STAFF LIAISON: Ricardo A. Juarez
[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
• Providing direct service delivery and consultation in times of disaster
• Designing disaster response plans
• Providing key contributions in the areas of research and education

Description of Selection Criteria for Award:
The Bruno Lima Award recognizes excellence in Disaster Psychiatry which includes outstanding contributions of APA members to the care and understanding of the victims of disasters. Nominations must be submitted by a district branch or state association.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: $0
Cost of Cash Award: $0
Cost of Lectureship: $0
Other (please list): Certificate Cost Negligible
Award Account Balance: $0 (as reported by APA Online Financials)
Date Balance Determined: -

Award Nominee(s):
- Charles P. Ciolino, MD (Nominated by the New Jersey Psychiatric Association)
- Jagannathan Srinivasaraghavan, MD (Nominated by the Illinois Psychiatric Society)

(Please attach a biosketch and any letters of nomination or support for this individual)

Description of the Committee's Selection Process:
Members of the Committee on Psychiatric Dimensions of Disaster individually review submitted nomination materials, including a letter of recommendation from the nominating district branch or state association, and report their support or non-support of each nominee to the Committee.

Council on Communications Charge

History: Established as a council in May 2009, subsuming duties of the sunsetted Committee on Public Affairs (CPA) and District Branch Newsletter Corresponding Subcommittee. Established in 1979 as the Joint Commission on Public Affairs, replacing the Committee on Public Information originally established in 1948; restructured as committee under Council on Advocacy & Public Policy May 2002; charge revised June 2003.

Composition: Standard council composition.

Charge: Transform public attitudes towards psychiatry by

- Connecting the public emotionally to psychiatrists,
- Creating excitement about psychiatrists' ability to prevent and treat mental illness,
- Branding psychiatrists as the mental health and physician specialists with the most knowledge, training, and experience in the field.

To achieve the Council's goals, the Council will carry out the following strategies:

- Advise and assist the Office of Communications and Public Affairs in the development, implementation, and promotion of its advocacy initiatives and strategies, as they relate to public affairs.
- Understand the many diverse attitudes toward psychiatry among all cultural groups, and work to create approaches to improve attitudes about psychiatry.
- Review, advise, and cooperate with other Association components regarding issues affecting the public image of psychiatry and public understanding of mental illnesses and advocacy issues.
- Expand the Public Affairs Network both within and outside the APA and ensure bi-directional communications.
- Build coalitions at the local and national level.
- Develop recommendations for the Board and the Assembly on public affairs implications of psychiatric practices, policies, communications, and developing public attitudes and trends.
- Recommend ways to achieve a uniform, exciting and culturally relevant image of the APA through a new branding effort.
- Contribute consumer-oriented materials to Healthy Minds Web site and campaign, providing a caring and diverse "public face" to psychiatry in order to reduce stereotypes about psychiatrists.
- Collaborate and work constructively with the Assembly Committee on Communications.
- Identify and plan responses to 'teachable moments' that occur during and after crises, news stories, and other psychiatrically-relevant public situations.
- Media toolkit to help the APA DB/SAs address the problem of the vast state mental health budget cuts. The toolkit will be designed to help the DB/SAs lobby their state policy makers about the importance of state mental health programs, and educate them about the financial impact of cutting the funding for state mental health programs.
- Collaborate with OCPA to gain national distribution of the "Healthy Minds" public television series hosted by Dr. Jeffrey Borenstein and produced by WLIW in association with WNET.ORG. The series aims to humanize specific mental health conditions through inspiring personal stories and interviews with leading researchers and experts, who provide the latest

information on diagnosis and treatment.

Awards administered by the Council on Communications:

Newsletter of the Year Awards - Established: 1968 & amended in December 2011

Member Communications Award – Established in 2011

The Member Communications Award (formerly known as the Newsletter of the Year Award) recognizes e-Newsletters, Websites, a Communications Plan, or Innovative & Emerging Technology that facilitates effective communication with members and/or external audiences on matters of importance to psychiatry, the District Branch/State Association, or an APA constituent group. Judging criteria include how the award category achieve the goals of the format used including but not limited to the; frequency of content distributed; originality; general layout and design; available resources; creative solutions for member & non-member outreach; timeliness; and overall impression.

Solicitations for the award can be received from District Branch/State Associations or other APA constituent groups such as Members in Training (MIT); Early Career Psychiatrists (ECP); Assembly Allied Organization Liaisons (AAOL); and Minority Under-Represented (MUR). A District Branch/State Association or an APA Constituent Group can submit for only one of the four categories below.
The four award categories are:

1. The **Innovative & Emerging Technology** category encompasses the use of a blog, Podcast, e-Messaging, webinar, or video to share and express issues and ideas important to psychiatry. This new award category utilizes a social media or new technology format to bring change and novelty to message efficiency and engage follower's on an ongoing basis. Entries are judged for eloquence, creativity, graphic design & layout, writing quality and style, timeliness, significance of the issue, and its relevance to members. Innovation is progress!

2. The **e-Newsletter** category is presented to a district branch/state association or a constituent group that produces a high quality, engaging, timely, & resourceful e-Newsletter that keeps members interested, informed, and involved. The E-Newsletter must display the archive frequency setting.

3. The **Website** category is judged on the following award criteria:
   - Website include links that facilitate action;
   - Fresh and timely news that keeps site visitors engaged;
   - Includes headshots, graphic elements or photos;
   - Stays in touch with current issues about psychiatry and patients;
   - Directs people to useful events; webinars, conferences, workshops, etc.;
   - Is visually appealing;
   - Includes opinions or feedback on other topics; and
   - Easy navigation.

4. **Overall Communications Plan** award category establishes and executes a communication outreach plan that tackles a specific issue important to the profession or patients. Examples of an ideal communication plan include: raising awareness among the public and the press; organizing a grassroots advocacy outreach activity/ project/ or event; utilizing multi-media formats (webinars, video, social media) to educate the public or colleagues on a particular issue; or an advocacy outreach plan that engages other medical specialties, the public, or colleagues.

AMERICAN PSYCHIATRIC ASSOCIATION
DRAFT REQUEST FOR PROPOSAL (RFP) ELEMENTS:

DEMONSTRATING THE VALUE OF MEMBERSHIP THROUGH A CONSISTENT APA BRAND IDENTITY

DRAFT TECHNICAL REQUIREMENTS AS PRESENTED TO THE COUNCIL ON COMMUNICATIONS, SEPT. 2014:

The American Psychiatric Association seeks a creative team to create a new brand identify for the APA to include:

- Review of APA's internally conducted brand audit of the medical, mental health and patient advocacy spaces
- Review of APA's internally conducted needs assessment for branded assets
- A brand development process, to be implemented by the successful Offeror, that solicits and incorporates sufficient and appropriate input from APA's leadership, membership and District Branches/State Associations, as well as patients, families or other stakeholders required by your process
- Establishment of a brand strategy and architecture, to include the corporate APA brand and subordinate/programmatic assets, including APA's Annual Meeting, and also tone and language considerations
- Creation of a logo, logotype and tagline for the APA
- A mark for the APA Annual Meeting
- Brand guidelines, to include clear direction on the lock-up, color palette, fonts and the use of the existing Ben Rush seal
- All final files needed to launch the brand and to register/trademark, as appropriate
- Up to ten templates for common uses of the brand (e.g., letterhead, business cards, social media iconography, web masthead, PowerPoint Master, tradeshow pull-up banner or display)
- Regular check-ins to/progress updates to/approvals from the APA Chief Communications Officer or other points of contact as appropriate
- Presentation of the brand to the APA Board of Trustees (a presentation that is tentatively scheduled for XXX, 2015, in Arlington, VA)
- Service up to and including the kickoff of the new brand (Goal: XXX, 2015)
- OPTIONAL SERVICE (to be implemented at APA's discretion and to be provided as a separate, stand-alone service by the successful Offeror): A 2:00 brand video.

JRC
October 2014

Revised Charge to the Council on Research:

The Council on Research carries out activities to ensure that the substance and significance of research on mental health/illness remain integral parts of the APA mission and in the forefront of the national health agenda. The Council embodies the Association's commitment to advance evidence-based psychiatric knowledge ~~through the conduct of research by physician scientists~~ across a broad range of research fields and issues, which include, but are not limited to, basic science, clinical diagnosis and assessment, treatment research, research training, health services, ~~and~~ prevention research, and research ethics, and through the recognition of psychiatrist researchers who have made significant contributions to psychiatric knowledge and practice. These areas ~~are~~ may be represented by the Committees and Task Forces under the Council's jurisdiction, and others may be established in response to emerging needs relevant to the Council.

Principles of ethics in psychiatry

Section 1. Introduction

Psychiatric illness affects millions of persons throughout the world, regardless of age, gender, class, ethnicity, or nationality. One in five people will suffer a significant episode of mental illness over the course of his life. Psychiatric illnesses are some of the leading causes of disease burden in countries with established market economies and the third leading cause of disease burden across the globe. The immense suffering associated with mental illness is greatly increased by stigma, societal disadvantage, and coexisting physical disease or substance use disorders.

Psychiatrists are physicians with specialized knowledge of mental illness and its treatment. Psychiatrists share ethical ideals of physicians in general and are committed to compassion, fidelity, beneficence, trustworthiness, fairness, integrity, scientific rigor and clinical excellence, , and respect for persons. Psychiatrists endeavor to embody these principles in their diverse roles as diagnosticians, treating physicians, therapists, teachers, scientists, consultants, and colleagues.

The daily work of psychiatrists poses distinct ethical challenges. Mental illnesses directly affect thoughts, feelings, intentions, behaviors, and relationships – those attributes that help define people as individuals and as persons. The therapeutic alliance between psychiatrists and patients struggling with mental illness thus has a special ethical nature. Moreover, because of their unique clinical expertise psychiatrists are entrusted with a heightened professional obligation: to prevent patients from causing harm to themselves or others. Psychiatrists may also be called upon to assume duties of importance to society, such as legal or organizational consultation, that are beyond the scope of usual clinical activities. These features of psychiatric practice may therefore create greater asymmetry in interpersonal power than in other professional relationships and introduce ethical issues of broad social significance. For all these reasons, psychiatrists are called upon to be especially attentive to the ethical aspects of their work and, as with all physicians, to act with great professionalism.

Psychiatrists are entrusted to serve in a special role in the lives of ill persons and in society as a whole. Psychiatrists' ability to serve in this special role is predicated on the fulfillment of the ethical principles that ground the field. This is the cardinal feature of any profession: professionals apply specialized knowledge in the service of others, and are part of a distinct group that affirms a code of ethics and engages in self-governance. Members of the profession, by definition, must exercise strong self-discipline, accept responsibility for their actions, and must embrace a specific set of ethical standards. As a consequence, there are many who have a stake in the ethical commitments and conduct of psychiatrists. This is most apparent for patients and their families, but it is also true for colleagues, students, members of the profession of medicine as a whole, and society at large. All count on the profession's integrity in embodying the principles of ethical practice.

Ethical conduct by psychiatrists requires more than mere knowledge of ethics principles. It also requires certain moral skills and routine behaviors (or "habits"). These assure that ethically sound judgment is exercised and the actions that follow

fall within accepted ethical bounds. Examples of skills of importance to the ethical practice of psychiatry include: 1) the ability to recognize ethical aspects of a professional situation; 2) the ability to reflect on one's role, motives, potential "blind spots", and competing or conflicting interests; 3) the ability to seek out, critically appraise, and make use of additional knowledge and valuable resources, e.g., clinical, ethical, or legal information; 4) the ability to systematically evaluate the ethical aspects of a professional situation and identify possible courses of action; and 5) the ability to create appropriate safeguards in an ethically complex situation. Routine behaviors or habits include obtaining additional data, seeking appropriate consultation or supervision, maintaining clear professional boundaries, and separating roles that may pose conflicts. Together these skills and habits support ethical decision-making and minimize the likelihood of ethical breaches.

Suggestions: (1) maintain the difference between ethics (morality) and professionalism (competence) throughout the annotations. (2) justifications for the ethical psychiatrist should be in the document

This document provides guiding principles to assist psychiatrists in identifying and resolving ethical dilemmas. Ethics principles can also help define the boundaries of acceptable behavior, proscribing certain behaviors while supporting and encouraging others. Consequently, ethical principles are valuable in assessing the professional conduct of colleagues. Ethics principles are likewise an important tool for the educators who introduce students to the ethical foundations of the field.

To help fulfill these aims, this document has been organized into five sections.

Section 1 introduces the scope, spirit, and structure of the document.

Section 2 presents the Principles of Medical Ethics of the American Medical Association. These nine principles serve as the foundation for ethics and professionalism in medicine, including the specialty of psychiatry. The American Psychiatric Association conforms to these AMA principles in its Constitution and Bylaws.

Section 3 articulates ethics principles as applied to the morally complex aspects of psychiatric work. These aspects of professional practice are organized into four domains: the ethical basis of the physician-patient relationship; ethically important practices in psychiatric care; the ethical basis of relationships with colleagues; and other ethically important topics in psychiatric practice. Each domain covers several topics. For each topic, we provide a description of important ethics concepts, and seek to demonstrate their special relevance to psychiatric practice.

Section 4 discusses the uses of the document for educational, clinical, professional compliance, and related areas.

Section 5 outlines selected additional resources that may be of value to readers.

This document differs in two respects from prior APA guidelines of professional ethics (i.e., the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"). In addition to its regulatory purposes, this document has a much stronger educational emphasis. It is for this reason that the document gives

attention to the philosophical basis of ethical psychiatric practice, the concepts and terms of importance to ethics and professionalism, and the skills and habits of ethical professionals. Moreover, the document seeks to encompass more completely the multiplicity of roles and activities of psychiatrists, the diverse populations they serve, and the array of settings in which they work. It is our hope that this document will become a valuable resource for our profession.

Section 2. Principles of Medical Ethics of the American Medical Association

Preamble. The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician will uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted June 1957; revised June 1980; revised June 2001

Section 3. Ethical principles in the professional practices of psychiatrists

In this section, we illustrate how ethical principles find expression in the professional practice of psychiatrists in their various roles and activities. We have focused on four domains:

3.1 The ethical basis of the physician-patient relationship

3.2 Ethically important practices in psychiatric care

3.3 The ethical basis of relationships with colleagues

3.4 Other ethically important topics in psychiatric practice

We believe that ethical conduct is informed by knowledge of ethical principles and expectations but is best assured through the acquisition of ethically important skills and habits or behaviors. These skills and behaviors will allow a psychiatrist to respond to complex and novel situations with an understanding of their ethical implications and the ethically-sound decisions that should be undertaken.

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

Topic 3.1.1 The physician-patient relationship

The physician-patient relationship is the cornerstone of psychiatric practice, and its goal is to promote patient mental health and well-being, embodying the key ethical maxims of respect for persons, fairness, and beneficence. Most patients lack medical expertise and sometimes struggle with symptoms that adversely affect their autonomy and decision-making, particularly when their illness is severe. The psychiatrist therefore carries a heightened responsibility to render medical care in the best interests of his or her patient. Patients must also trust that their goals and values will also be considered.

The physician-patient relationship is a partnership between two autonomous individuals who establish the professional relationship for the benefit of the patient. The relationship can include a child's parent or guardian, next of kin, or an adult's legally recognized substitute decision-maker. The relationship may continue for as long as an illness persists or until a patient either transfers his or her care to another clinician or patient chooses to no longer seek treatment. Even then, there are important clinical remnants of the physician-patient relationship that endure.

The psychiatric encounter generally brings unique influences to the physician-patient relationship because of the sensitive and intimate nature of a patient's clinical history. In turn, the inherent asymmetry that already exists in the relationship will be magnified. Psychiatrists must therefore be vigilant in those clinical situations in which the patient is especially vulnerable to physical, sexual, psychological, or financial harm.

There may be times when the physician-patient relationship is difficult and when the sense of trust erodes. In most cases, the psychiatrist can find ways to improve the

relationship with mutually agreed upon parameters or with the help of a consultation. In fewer cases, the relationship can be terminated by a physician when the patient cannot abide by these conditions, and the physician can transfer the patient's care to another clinician so as not to abandon the patient.

Topic 3.1.2 Professionally competent care

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

In a rapidly evolving and diverse field such as psychiatry, competent practice is influenced by advances in behavioral and biological sciences and by complex social and economic contexts of practice. Obtaining and maintaining knowledge and skills sufficient for competent professional practice require attention throughout a psychiatrist's career.

Psychiatrists should maintain a sufficient level of professional competence through continuing education, supervision, consultation, or study. It is expected that psychiatrists will practice within the bounds of their competence as reflected in their training, education, and professional experience. Psychiatrists should make referrals or delegate care only to persons who are, in the psychiatrists' best judgment, competent to deliver the necessary treatment. Finally, it is expected that psychiatrists will obtain the relevant education, training, and supervised experience to implement effective new treatments or to treat conditions that are new to them.

Topic 3.1.3 Dual agency and overlapping roles

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

The primary obligation of psychiatrists is to their patients. Wherever possible, they should strive to eliminate potentially compromising dual roles by attending to the separation of their work as clinicians from their role as institutional or administrative representatives.

Informed consent "cautions" or "warnings" about overlapping roles should be commonplace in these settings. When dual or overlapping roles cannot be eliminated, it is especially important to inform the patient about the role issues and conflicting ethical obligations.

Practice Domain 3.2
Central ethical and professional practices in psychiatric care

Topic 3.2.1 Confidentiality

Medical confidentiality is the physician's obligation to his or her patient not to reveal a patient's personal information without that patient's explicit, informed permission. This obligation is an ethical duty distinct from and superseding the legal duty to protect patient privacy. The intensely personal, sometimes potentially compromising, and often unusually sensitive nature of the information we gather as psychiatrists, without which we could scarcely do our work, renders the patient unusually vulnerable.

Patients should be told of the limits to confidentiality at the beginning of the physician-patient relationship and again as necessary. Disclosures, even with informed consent, should be limited to the requirements of the situation, particularly when legal privacy rules provide a lower standard of protection than ethics require. Progress notes should record only the information necessary for good continuity of patient care. Psychotherapy notes may be specially protected and it may be beneficial to keep them separate from the medical record. Electronic medical records present special problems, but the ethical requirements for confidentiality do not change with the medium. Additional safeguards and precautions may be necessary, as well.

There are legally imposed limits on confidentiality. In general, when there is a reasonable probability that a patient may carry out the threat to harm him- or herself or another person, the physician should take reasonable precautions for the protection of the intended victim. Other limits to confidentiality may include the duty to report child and elder abuse. Every psychiatrist should know the legal constraints on confidentiality in his or her jurisdiction. There may also be a higher ethical duty to break confidentiality when the patient's life is in danger or when the patient is at risk of serious harm.

Topic 3.2.2 Honesty and Integrity

Honesty, derived from the core principles of trustworthiness, integrity, and respect, entails the positive duty to tell the truth as well as the negative obligation not to lie or intentionally mislead. Honesty is a fundamental expectation for the patient seeking psychiatric care. Patients are entitled to have complete information about their health and all aspects of their care, unless there are strong contravening cultural factors or overriding therapeutic factors that would make full disclosure medically harmful. Psychiatrists may be tempted on occasion to skirt or soften the truth in order to protect the patient from painful disclosure. In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between physician and patient and should be avoided.

During the course of patient care, psychiatrists are often asked to communicate with other individuals and agencies. Releasing inaccurate or misleading clinical information

to insurers, employers, or other third-party entities is a specific example of dishonesty and may constitute fraud.

Topic 3.2.3 Non-participation in fraud

Fraud is an action that is intended to deceive, and ordinarily arises in the context of behavior that seeks to secure unfair or unlawful gain. It is illegal, which violates a fundamental ethical principle for the profession of medicine (see Section 2). Moreover, because honest dealings are essential to the physician-patient relationship, any act of deception or misrepresentation compromises the psychiatrist's ability to provide care.

Psychiatrists communicate with numerous agencies and individuals during patient treatment. They are responsible for the usual physician contact with funding and reimbursement agencies, families, employers, and other third parties. However, because of their expertise in human behavior, psychiatrists are often asked, formally and informally, for information justifying or excusing patient actions. This offers numerous opportunities for ethical missteps.

Ideally, principles of trustworthiness and integrity will over-ride inappropriate attempts to benefit an individual patient or psychiatrist. Deceptive conduct of any kind cannot be generalized as a model for others, and, when it becomes known, undermines patient trust in the profession as a whole.

Specific examples of fraud in psychiatric practice include making false or intentionally misleading statements to patients, falsifying medical records, research, or reports, submitting false bills or claims for service, lying about credentials or qualifications, supporting inappropriate exemptions from work or school, practicing outside one's area of professional competence or beyond one's authorized scope, providing unnecessary treatment, and taking credit for another's work. Further illustrations of overt (and legally actionable) dishonesty include writing a prescription for a patient in a family member's name, or writing prescriptions for a larger number of pills than necessary in order to reduce insurance co-payments. These actions are not ethically acceptable in the practice of psychiatry.

Topic 3.2.4 Informed Consent

Informed consent for assessment or treatment is an ongoing process that involves disclosing information important to the patient or responsible caretaker, ensuring the patient has the capacity to decide, and avoiding coercive influences. Typical elements of disclosure include an accurate description of the proposed treatment, its potential risks and benefits, any relevant alternatives and their risks and benefits, and the risks and benefits of no treatment at all.

Physicians maintain the highest standards of informed consent when they honor the specific and enduring personal values of their patients. The requirement of voluntariness in informed consent specifically affirms autonomy and the values that influence distinct and personal individual decision-making. This is particularly important in psychiatry where, even if patients are seemingly capable of making rational decisions, there can be various factors (e.g., the patient's illness, stigma, or lack of resources) which can make them vulnerable to coercive influences.

Adults are presumed capable of making their own decisions. Assessments of decision-making capacity should follow clinical models of assessment and the legal standards of the jurisdiction.

Topic 3.2.5 Decision-making capacity

Decision-making capacity is the ability of an individual to reach an informed, reasoned, and free choice, when making a specific decision. Among patients and research participants, capacity is a consideration in psychiatric and non-psychiatric conditions that affect cognition or emotional regulation.

(comment: deleted because of its educational content which did not apply to all jurisdictions).

Topic 3.2.6 Involuntary psychiatric treatment

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

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

Topic 3.2.7 Therapeutic boundary keeping

Therapeutic boundaries are the limits on the conduct of the relationship between psychiatrists and their patients. They are required because of the special nature of that relationship. Psychiatrists must never exploit or otherwise take advantage of their patients, must avoid patient interactions that are aimed at gratifying the physician's needs and impulses, and must not use the unique position of power implicit in the therapeutic relationship to influence the patient in a manner that may undermine or threaten treatment goals.

Sexual behavior with patients is unethical. Further, even the possibility of future sexual or romantic relationship may contaminate current clinical treatment. Therefore, sexual activity not only with current, but also with known former, patients is unethical. Likewise, any occasion in which the physician interacts with a current or former patient in a way that may be a prelude to a more intimate relationship should be avoided. (comment: the language / content should provide for reasonable flexibility and judicisous consideration of cases involving minimal interactions, like temporally remote consultations or

medication refills; particularly when the document recognizes patient autonomy and competence).

While sexual contact is the most obvious form of unethical behavior, other non-sexual behaviors may also undermine the therapeutic relationship and cause harm to the patient. Because of the diverse array of treatments and treatment settings, it is impossible to create unambiguous rules of conduct for all areas of clinical practice. However, psychiatrists must maintain the awareness that their behavior should be directed toward the patient's therapeutic benefit, and behavior that is likely to conflict with that goal should be avoided.

Finally, rules guiding professional behavior are context sensitive. Because of this it is important to distinguish boundary violations from boundary crossings. Boundary violations are transgressions that are immediately harmful, are likely to cause future harm or are exploitive of the patient, and as such, are always unethical. Boundary crossings are deviations from customary behavior that do not harm the patient and that on occasion may facilitate the therapeutic process. (comment: the definitions are not universally accepted; these emenate from the APA) However, because of their potential to erode the therapeutic relationship, especially in the context of private long-term psychotherapy, boundary crossings should be undertaken in treatment only in an intentional manner and when the benefits clearly outweigh the risks. For instance, the appropriateness of accepting a small gift from a patient should be evaluated in light of the community context and the therapeutic impact. Psychiatrists are encouraged when in doubt to seek peer or other professional consultation in these matters.

3.2.8 Ethical philanthropy in psychiatry

Across all fields of medicine, organizational fundraising must be approached and conducted with great ethical sensitivity so as not to exploit the relative powerlessness of patients with serious illnesses. The ethical considerations for psychiatrists are oftentimes greater because of the severity of many mental disorders that lead to greater dependence on psychiatrists and mental health organizations across the course of illlness, because of the intimate nature of certain forms of treatment such as psychotherapy that introduce more intense power issues between psychiatrist and patient, and because of the characteristics of some psychiatric disorders that affect judgment and behavior (e.g., impulsive spending). Nevertheless, absolutely prohibiting philanthropic activities that may involve contributions from people living with mental illness is paternalistic and is not respectful of the strengths that they possess as individual people. To be ethically acceptable, fundraising in psychiatry must be based in trust and honesty and in the fulfillment of goals of shared importance to the organization and the donor. Most importantly, philanthropic activities must be non-exploitative. Fundraising practices should include safeguards that foster mutual understanding, clarify motivations and goals, and minimize the risk for exploiting the potential vulnerability of the donor. Individual psychiatrists must not approach their patients for funds, as this will adversely affect the therapeutic relationship and cannot be sufficiently safeguarded to protect the patient from exploitation. (comment: there is an inherent conundrum between philanthropy and a patient's vulnerability to financial harm).

Practice Domain 3.3
The ethical and professional basis of the relationship with colleagues

Topic 3.3.1 *Seeking professional consultation*

An important aspect of psychiatric practice is the ability to recognize when one needs consultation. Professional competence itself entails recognizing the limits of one's clinical skills. Consultation in the analysis of ethical dilemmas is encouraged as well.

Psychiatrists treat difficult illnesses, and psychiatric illnesses are influenced by complex social and cultural contexts, co-morbid conditions, and stigma. Because of this complexity, psychiatrists should carefully consider the need for consultation when patients are not doing well.

If psychiatrists receive referrals for conditions that are outside their expertise and more competent psychiatrists are available, they should make the referral to the more competent clinician. However, psychiatrists should not delegate care that requires the exercise of professional medical judgment to non-physicians.

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

Topic 3.3.2 Relations with Non-Psychiatrists on Multidisciplinary Teams

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

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

As teachers and supervisors, psychiatrists must model not only clinical expertise but also a high standard of professional ethics. They must foster a positive, respectful learning environment, mindful of the asymmetry in power between themselves and their trainees, with a resulting responsibility on teachers (for example, avoidance of sexual involvement with trainees). (comment: teaching / supervisory relationships are different than physician-patient ones and are not fiduciary).

Topic 3.3.4 Responding to the unethical conduct of colleagues

All physicians have an obligation to recognize and report the unethical behavior of colleagues, including a variety of behaviors that violate professional standards, such as exploitation of a patient, dishonesty, fraud, or behavior that appears to intentionally demean or humiliate others.

When psychiatrists act unethically and continue to practice, they not only harm patients and future patients who may be reluctant to seek care, but may also tarnish the profession as a whole

Physicians who engage in unethical behavior may be unaware of the ethical standards they are expected to observe. Alternatively, they may engage in unethical conduct because they believe the rules do not apply to their situation or believe they are "an exception". Finally, misconduct may occur because physicians intentionally choose not to abide by the rules and expectations of the profession. Irrespective of the reasons behind misconduct, however, psychiatrists have ethical obligations to learn and follow their profession's standards. In turn, colleagues are ethically obliged to report fellow practitioners who violate the profession's ethical code. In some instances reporting is also mandated by law.

In the clinical setting in particular there should be special practices (e.g., consultation, supervision) to safeguard against any behavior that could reasonably be expected to exploit a patient.

Unethical behavior which does not fit into the category of impairment or incompetence should be reported in the following manner: Unethical conduct which threatens patient safety or welfare should be reported to the appropriate authority. Unethical behavior which violates the provisions of the state licensing board should also be reported to the state licensing board. Unethical behavior which violates criminal statutes should be reported to the appropriate law enforcement authorities. Examples of unethical conduct which do not fall into the previous three categories, or which have not been addressed specifically by other institutional policies, should be reported to the local district branch of the APA, or to the county medical society. (comment: a change in behavior could be afforded by an initial approach / confrontation, before notifying authorities; also, a report (to authorities) after one failed intervention agrees with the next paragraph involving impaired colleagues).

Topic 3.3.5 Responding to impaired colleagues

Impairment among psychiatrists may arise from physical-, mental-, or substance-related disorders. Such impairment may compromise professional competence and pose a serious threat to patient welfare. An impaired psychiatrist who does not seek help and correct the problem fails the community of psychiatrists and its standards. Because psychiatrists often work with seriously ill persons who may have difficulty recognizing and reporting their psychiatrists' impaired behavior, some patients may consequently be unable to advocate for themselves or seek alternative treatment. This heightens the responsibility of psychiatrists to report impaired colleagues to the proper authorities.

A psychiatrist who is concerned about an impaired colleague's ability to care for patients safely may attempt to counsel or encourage the impaired colleague to seek

treatment and to refrain from patient care. However, if the impaired psychiatrist does not respond to a collegial approach, as is often the case, there is an ethical obligation to report the physician through appropriate channels. These channels might include the state's impaired physician program , the state medical board, the chief of the service, or the hospital medical staff.

Practice Domain 3.4
Other ethically important topics in psychiatric practice

Topic 3.4.1 Working within organized systems of care

An ethical managed care system should maintain the primacy of patient interests. Managed care systems prospectively, concurrently, or retrospectively review treatment in order to contain costs. They may emphasize preventive or primary care services, require specific approvals for specialty procedures or referral, encourage the use of specific treatment guidelines, or create economies of scale to streamline care within large systems. The fundamental tension of psychiatrists working in this setting is addressed by maintaining the primacy of patient benefit while recognizing the importance of resource stewardship. Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside it.

Use of appropriate standards of care, when available, is part of this obligation and supports efforts to maintain the primacy of patient care. (comment: evidenc based means different things in different practices).
(comment: this language puts psychiatrists in the role of attorneys) Further, psychiatrists should refrain from participating in such unethical strategies in their clinical and administrative activities.

Topic 3.4.2 *Clinically innovative practices*

Clinical decision-making when there is not established research evidence to guide practice requires informed clinical judgments drawing on the best available research, adherence to a "first do no harm" tradition, and sound theoretical reasoning. When usual treatments have failed, psychiatrists may offer non-standard or novel interventions using a shared decision-making approach grounded in the patient's informed consent and a thorough discussion of risks, benefits, and alternatives to the innovative treatment. Since innovative practice sometimes leads to important scientific advances, it should not be categorically discouraged; however, because it may prove either ineffective or even harmful, caution is recommended.

Topic 3.4.4 Relations with the Pharmaceutical Industry

Psychopharmacologic drugs are important elements of modern psychiatric practice. However, the pharmaceutical industry's goals of developing and promoting profitable products do not always coincide with the physician's primary goal of advancing the welfare of patients. Whether as researchers, teachers, administrators, or clinicians, psychiatrists must be aware of the conflicts that interactions with industry pose. Although the mere existence of a conflict of interest does not by itself imply any wrongdoing, the failure to recognize and actively address such conflicts does compromise professional integrity and threatens the independence of the profession.

It is impossible to enumerate rules for every conflict. Addressing conflicts of interest should be guided by two principles: the primacy of patient welfare and the independence of the profession. The most common conflict for practicing

clinicians arises from gifts from the pharmaceutical industry.* The guiding principle is that any behavior that puts the clinician's or an industry's interest above that of patients' interests is unethical.

Of particular concern are conflicts faced by psychiatrists who create or disseminate clinical knowledge. They have a special responsibility to maintain their objectivity and independence because their views can broadly shape clinical practice. At minimum, they must not disseminate opinions that are knowingly biased by industry influence. For the vast majority of situations, however, the potential for influence is more subtle. Safeguarding the psychiatrist's role as an independent advocate for science and patient welfare requires adherence to standards that are sensitive to the public's concern and deserving of the public's trust. If at all possible, interactions with the industry that seriously threaten the public's trust in the independence of the psychiatric profession should be eliminated, not merely disclosed. However, because interactions with the pharmaceutical industry can have important benefits for patients, a total elimination of conflicts is not possible. At minimum, disclosure of such conflicts is necessary. Disclosure policies and practices must be designed to serve their intended functions, namely, to allow their recipients to make an informed judgment and to allow a transparent public policy discussion. Therefore, the disclosed information must be publicly available and must detail the nature and extent of the arrangements at issue.

*** The APA endorses the American Medical Association's guidelines (Opinion 8.061) on such matters.**

Topic 3.4.5 Ethical issues in small communities

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

Topic 3.4.6 Professional Use of the Internet

The Internet has created important opportunities for improving delivery and accessibility of health care. The greater reach of communication and access, however, brings greater responsibility for patient safety as well. Because psychiatry depends so heavily on the written and spoken word – perhaps more so than other specialties – it is tempting to use electronic media to facilitate communication. This potential benefit, however, must be sought carefully and guarded from a number of potential pitfalls.

Psychiatrists should keep abreast of evolving practice standards for uses of the Internet in psychiatric or medical practice, as propagated by their state medical

societies or boards or by the APA. Currently, e-mail or interactions through the Internet should be used to supplement and enhance but not replace the person-to-person interaction between a psychiatrist and a patient. As with other clinical practice procedures, such interactions, either diagnostic or therapeutic, may be used only if they meet a sufficient level of scientific evidence showing that benefits clearly outweigh the risks and if they allow the psychiatrist to make decisions based on a thorough clinical evaluation.

One important danger is that online interactions can create a new physician-patient relationship and its attendant obligations that the psychiatrist will not be able to meet. Even with established patients, online communication must be conducted with clear mutual understanding between patients and psychiatrists about transparent policies regarding issues such as privacy, electronic security, proxy access to e-mails, types of information appropriate for online communication, status of archived communications, and ownership of the electronic communications. All online communication from the patient should become part of the medical record, unless the communication falls under the rubric of psychotherapy notes, in which case it should be kept separately from the medical record (and may have special privacy protections, as in the HIPAA Privacy Rule).

Whether on a specific psychiatric practice website or a more general mental health information website, the Internet makes it possible to propagate misinformation rapidly, widely, and irreversibly. Inaccurate information may consequently have broad adverse consequences. Any public representations of psychiatric practice must be based on sound scientific information.

Topic 3.4.7 Public Statements

For some in our profession, psychiatry can extend beyond the physician-patient relationship into the broader domain of public relations: in administration, politics, the courtroom, the media, and the Internet. In this endeavor, psychiatrists are governed with particular force by the ethical principles of scientific rigor, trustworthiness, and professional responsibility. Without this emphasis on the integrity of the professional and the profession, both the professional and the profession are undermined.

Therefore, psychiatrists need to sustain and nurture the ethical integrity of the profession when in the public eye. A psychiatrist may render a professional opinion about an individual after an appropriate clinical examination and accompanying waiver of confidentiality. Psychiatrists should not offer a statement on an individual's diagnosis without having conducted a personal examination and receiving a waiver of confidentiality from the person.. When a personal examination has not been performed and when a psychiatrist is asked for a professional opinion about a person who has received public attention, a general discussion of relevant psychiatric topics – rather than specific diagnoses – is more appropriate. In some circumstances, such as academic scholarship about figures of historical importance, provisional diagnostic evaluations may be made and should be subject to peer review and academic scrutiny based on relevant standards of scholarship. When, without any personal examination, the psychiatrist renders a clinical opinion about persons in the light of public attention, these limitations must be clearly acknowledged. Moreover, labeling public figures cavalierly with psychiatric conditions, based on

limited or indirect clinical knowledge is not consistent with this approach and undermines public trust in the profession of psychiatry.

Topic 3.4.8 Civil disobedience

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

Topic 3.4.9 Execution

Psychiatrists should not participate in a legally authorized execution and may not assume roles that cause them to support, facilitate, enact, or to develop and monitor any techniques that involve such an execution. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. (comment: content does not remark on testimony in Capital cases – whether prosecution or defense – involving guilt / innonence, competence to stand trial, or competence to be executed).

Topic 3.4.10 Torture

Psychiatrists shall not participate in torture. This means that, at a minimum, physicians may not assume roles that cause human torture orto develop and monitor any .

Topic 3.4.11 Psychiatrist participation in interrogations

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. Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating medically 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. Psychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to non-medical authorities (comment: unless authorized by the patient or other authorized person).These guidelines do not 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.

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.

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.

*** This section is taken from APA Policy Statement approved by the Board and the Assembly in May, 2006.**

Section 4. Uses of this document

The overarching aim of the Principles of Ethics and Professionalism in Psychiatry is to serve as an informational document for the field. It has application to the many types of activities that psychiatrists undertake, the diverse populations they serve, and the array of settings in which they work. This document is clinically oriented, but has relevance for other psychiatric endeavors such as research, consultation, leadership, and education. Its primary purpose is to help individual psychiatrists gain a sense of the accepted bounds of professional conduct.

Psychiatrists may find it helpful to read the revised guidelines in entirety, gaining an appreciation for the richness of thought and language that frames ethical dilemmas. This approach can offer a basis for understanding how common ethical principles are applied. Since it is impossible to anticipate every ethical dilemma, this kind of reading can provide the reader with a framework that can be applied to novel situations.

This document is also intended as a reference manual. The index allows the reader to locate specific topics of interest. In addition, the resources section provides assistance in identifying critical documents for further reading and study on particular ethical issues.

This document is written as a resource for psychiatrists who serve in many roles. It may be of particular value to individual psychiatric practitioners in their clinical activities. It may also be helpful to teachers and academic psychiatrists as they convey expectations regarding ethical conduct to the next generation of physicians. In addition, as with previous versions of this document, these guidelines can serve to facilitate fair and systematic peer-review when a concern arises about the conduct of a colleague. The document may also be of assistance to administrators and institutional leaders in establishing expectations for the conduct of psychiatrist employees and faculty members.

This document is not a "rule book". It is a tool, and its value and impact will depend on the ways it is used. It is not intended to cover all ethically important situations and novel ethical questions that psychiatrists may encounter in the course of their careers. Accordingly, it will have limitations. For instance it may not be relevant for the resolution of courtroom disputes which apply legal rather than clinical standards and values, nor is it intended to undermine ethical practitioners serving in communities where scarce mental health resources call for flexibility. Furthermore, it cannot fully capture all of the circumstances that alter the ethical nature of a particular decision or action. The ways in which people understand ethical aspects of their work, and the values influencing the ethical commitments of the profession of medicine naturally evolve, and may require clarifications, reiteration, and re-application of principles.

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

Section 5. Additional Resources: Policy statements, ethics guidelines, and related resource documents of the American Psychiatric Association

American Academy of Psychiatry and the Law, Ethics Guidelines for the Practice of Forensic Psychiatry, 1995, Amer Acad Psychiatry Law, Bloomfield CT

AMA. Opinion of Council on Ethical and Judicial Affairs. E-8.061 Gifts to Physicians From Industry. http://www.ama-assn.org/ama/pub/article/4001-4236.html

AMA CEJA Opinion. E- Addendum II: Council on Ethical and Judicial Affairs Clarification of Gifts to Physicians from Industry
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All trials registered. All results reported.

September 2013

The AllTrials campaign calls for all past and present clinical trials to be registered and their results reported.

Clinical trials are investigations designed to assess the effects – wanted and unwanted - of healthcare interventions in people. The Declaration of Helsinki, which is the World Medical Association's statement of principles for medical research involving people, states that every investigator running a clinical trial should register it and report its results. Millions of volunteers have participated in clinical trials to help find out more about the effects of treatments on disease, yet that important ethical principle about reporting has been widely ignored. Information on what was done and what was found in these trials could be lost forever to doctors and researchers, leading to bad treatment decisions, missed opportunities for good medicine, and trials being repeated. This is what led to the AllTrials campaign in January 2013, a campaign which is now supported by thousands of individual patients, clinicians and researchers across the world, and by hundreds of organisations representing millions of people.

This document sets out more information about achieving a situation globally where all trials are registered and results reported. It is an achievement that will involve regulators and registries, clinical trial funders, universities and institutes, professional and learned societies and medical journals, patients and researchers.

This document is part of a continuing discussion which many different organisations are working on elaborating further over coming weeks and months. Please email views and contributions to: alltrials@senseaboutscience.org

What trial information needs to be registered and reported?

There are four levels of information in clinical trial reporting: (1) knowledge that a trial has been conducted, from a clinical trials register; (2) a brief summary of the trial's results; (3) full details about the trial's methods and results; (4) individual patient data from the trial.

The AllTrials campaign is concerned with the first three. There are now initiatives in many countries to work out how individual patient data can be shared with other researchers.

1. Registration

In brief: Planned clinical trials should be registered, with a summary of the trial protocol, before the first participant is recruited. Past trials that were not registered should now be registered retrospectively. This is essential if the trial was on medicines or interventions that we currently use (this includes some trials conducted before registries were established).

Checks on the registration status of published trials, show that around 40% of clinical trials concerning treatments in current use were not registered[1]. This figure does not include unregistered trials that have never been published.

The situation is improving: increasingly, funders and research organisations are insisting that trials are registered and it is a legal requirement for trials on some medicinal products in the EU, USA and five other countries[2].

The World Health Organization (WHO) has set out a 20 item Trial Registration Data Set[3] of the minimum information that should be included when registering a trial. Registration covers rationale and background to the trial; information on study participants and informed consent; the intervention under investigation, primary and key secondary outcomes; the method of data collection and statistical analysis plans.
For further information see the SPIRIT[4] guidelines published in 2013.

Prospective registration is the gold standard for the reasons set out in the 2005 Ottawa Statement[5]. All trials that were not prospectively registered should still be registered now, i.e. retrospectively. This is particularly important for trials conducted to evaluate the efficacy and safety of a treatment in current use, some of which were done before trial registration was possible. Many registrations are incomplete against the WHO data set and registries should advise on which aspects of these could reasonably be completed.

There is no excuse for not registering planned or completed clinical trials. Clinicaltrials.gov is the world's largest register. It accepts registration from anywhere in the world and allows retrospective registration of trials. There are numerous national and regional registries, and others held by funders, institutions and corporations. About 20 of these are collected in the WHO's Registry Network[6].

[1] Huser 2013, Freshwater 2013, Killeen 2013, van de Wetering 2012, Jones 2012, Scherer 2012, McGee 2011, Mathieu 2009, Rasmussen 2009

[2] http://www.who.int/ictrp/trial_reg/en/index2.html

[3] WHO Trial Registration Data Set http://www.who.int/ictrp/network/trds/en/index.html

[4]SPIRIT 2013 (Standard Protocol Items: Recommendations for Interventional Trials) explanation and elaboration: guidance for protocols of clinical trials http://www.bmj.com/content/346/bmj.e7586

[5] Krleža-Jeric K et al for the Ottawa Group 2005 Principles for international registration of protocol information and results from human trials of health related interventions: Ottawa Statement http://www.bmj.com/content/330/7497/956

[6] The WHO Registry Network http://www.who.int/ictrp/network/en/

The proliferation of registries with different requirements is, though, limiting the usefulness and transparency of reported information. A trial can be registered in multiple registries but the entries are not always connected together. It is not currently possible for researchers or patients to find all trials that have been done on a particular intervention, even if all the trials have been registered somewhere.

The registration system could be streamlined and standardised internationally. There are now discussions about how to achieve this. Drawing down central information to multiple destinations may be more achievable than drawing it in from multiple sources to a central place, which has so far been the model. A small number of global centres would make it possible to standardise the way the data are structured so that entries can be linked and searched. Another option is to ensure that registries require trials to give all other registries' ID numbers for trials that appear on multiple registers. Both strategies would help to ensure that trials can be linked and tracked from registration to publication of results.

Enforcement and Monitoring

It should be impossible to obtain funding for a trial, including funding from Government, or to sell a product, or to obtain permission to do a clinical trial, without proving registration.

Regulatory routes: In some regions the registration requirement has become or will become law for trials related to new marketing authorisation of drugs. The proposed EU Clinical Trials Regulation will require registration as part of approval for any new trial of a medicinal product. The US TEST Act, tabled in 2013, would require trials used to support licensing applications to have been registered before they have started. The FDA Amendments Act 2007 already requires trials with at least one site in the US to be registered within 21 days of the first patient being enrolled. The regulatory and ethical approval processes for clinical trials in every country can be developed to incorporate and monitor compliance with registration.

Funders: Applications for reimbursement and funding could include explicit statements that the trials will be registered and results reported. Some funders have already started to do this. Trial registration IDs should be requested and compliance monitored to the best of an organisation's ability. A declaration that all past trials conducted by the investigator were registered could also be requested.

Journals and professional societies: The International Committee of Medical Journal Editors (ICMJE) committed in 2005 to publish only reports from trials that had been registered at inception. Requesting the trial number will help to monitor compliance with this more effectively. However, in order to overcome the historic gap in trial registration and reporting, journals should look at how they deal with any previously unreported trials that weren't registered or pre-dated the registration requirement. For the future, journals could also ask for disclosure of registration details of all linked trials and commit to making it clear on a trial report if previously undisclosed trials come to light after publication. Professional bodies and learned societies should make it explicit in their codes of conduct that members must register clinical trials, and they can lobby for this to become an international standard.

2. Summary results reporting

In brief: A summary of results should be publicly available where the trial was registered, within one year of completion of the trial. Summary results from all past trials of medicines currently in use should be made publicly available on a register now. Summary results include information on the primary and any secondary outcomes measured and statistical analysis. This is part of the structured information that global registries should support.

An audit published in 2012 found that only a fifth of trials registered on clinicaltrials.gov had reported results within one year of completion[7] and different research found that trials which produced negative results are twice as likely to remain unreported than positive trials[8]. Publication of all results will reduce reporting biases and help researchers and policymakers produce more reliable systematic reviews of the safety and effectiveness of medical interventions.

Millions of patients have volunteered for clinical trials in the expectation that the findings generated by their effort will contribute to the body of knowledge about their conditions and future treatments. Publishing results fulfils clinical trialists' ethical responsibility to patients in clinical trials, as set out in the Helsinki Declaration.

Summary results should be posted publicly within a year of the completion of the trial[9] where the trial was registered. Current discussions about registry development are looking at how to provide a clearer timeline of updates made to each entry and to indicate more clearly where information about the results is missing. As well as helping to improve compliance this will raise awareness among investigators about what is expected.

All past trials which have not reported results for medicines in current use should do this now. Registers should provide space for reporting of requests for results by third parties and include a log of requests for overdue information sent to trial sponsors, as well as responses to such requests.

Reports of clinical trial summary results on a register should at least contain the items on a clinicaltrials.gov results page (which includes summary participant information, protocol and amendments, summary results for pre-specified primary and secondary end points, details of adverse events and statistical analyses)[10]. If they don't, they should be supplemented with extra information added to the register the trial was registered on. Results are produced in a variety of formats - in peer reviewed journal papers, clinical study reports in the case of drugs for which marketing authorisation applications are being

[7] Prayle AP 2012 Compliance with mandatory reporting of clinical trial results on ClinicalTrials.gov: cross sectional study http://www.bmj.com/content/344/bmj.d7373

[8] Song et al 2010 Dissemination and publication of research findings: an updated review of related biases http://www.hta.ac.uk/fullmono/mon1408.pdf

[9] The completion date of a trial is the final date on which data was (or is expected to be) collected.

[10] See Appendix 1 for a suggested list of contents of summary results

made, reports to grant giving bodies, and so on. These may contain all or some of the summary results information required. Links and documents can be uploaded directly onto registers.

Registers currently have different formats for reporting results. Results cannot be uploaded to clinicaltrials.gov as PDFs for example. Ideally every major register could require results to be uploaded in a format that allows the main reported items to be searchable and enables sharing of information between registries. Some registries are curated to ensure there is internal logic in entries. Global registries would certainly have to do this to be useful and manageable.

The ICMJE has stated that prior publication of results on a register is not a barrier to publication in a journal. Journal reports on trials should be linked to the clinical trial unique identifier.

Enforcement and Monitoring

Regulation: The US FDA Amendment Act 2007 requires that results must be posted on clinicaltrials.gov within a year of the completion of the trial for all trials with at least one site in the US. The FDA has the power to fine trial sponsors who do not comply but rarely does this. Whether or not a trial is required to post results – or has been granted an extension - is often the subject of legal discussion, and as a consequence there is no clarity about whether a trial is truly overdue by the terms of the Act. The proposed EU Clinical Trials Regulation will require that summary results for every registered trial must be posted within one year of the completion of the trial, and the European Commission is discussing how to enforce this properly. Trial approval bodies in each country should consider expanding their monitoring of reporting, and ensure there is routine and open public audit of compliance for each individual trial.

Funders: Trials approval, processes such as marketing authorisation and reimbursement for medicinal products, and applications for funding could require an explicit statement that the results of the trial will be made available on a register within a year of trial's end. Some funders have started this, and begun withholding funds until results are shared. A declaration that results from all past trials conducted by the investigator have been reported could also be required.

Journals and professional societies: Journals should state clearly that there are no bars to subsequent publication of a trial report when summary results are posted to a register. A number of journals have supported the Restoring Invisible and Abandoned Trials statement which gives trialists an amnesty of one year to publish results of previously unreported trials[11]. Professional societies should ensure that their professional codes of conduct reflect the requirement to report summary results.

[11] Restoring invisible and abandoned trials: a call for people to publish the findings *BMJ 2013;346:f2865* *http://www.bmj.com/content/346/bmj.f2865*

3. A full report

In brief: Trial sponsors or others who produce a full report for marketing authorisation or any other purpose should make this publicly available. The narrative reports of adverse events and individual patient data in a full report can be redacted and available on request to researchers, in the same way that reports of adverse incidents currently are, with a commitment that no reasonable request will be refused.

Full reports (Clinical Study Reports or their equivalent in non-commercial settings) contain a large amount of detailed information about the methods, analysis, results and conclusions of a clinical trial[12]. This information is needed to make and to scrutinise decisions about medicines and to assess published summary findings. Clinical Study Reports are produced for regulatory and licensing purposes and follow a standard structure set out by ICH GCP guidelines[13]. An equivalent for researchers who do not plan to produce a Clinical Study Report is any document that complies with the 25-item CONSORT statement on trial reporting.[14] Full reports should be made publicly available when they have been created.

Full reports sometimes contain narrative descriptions of adverse events experienced by trial participants. This information is important to understanding the trade off between risks and benefits of a treatment. These paragraphs may contain identifiable patient information which may need to be redacted. These paragraphs should be available on request to researchers who provide a protocol of their study plan, with no reasonable request refused by the academic or company who authored the report. This is similar to the system for releasing the full narrative descriptions in spontaneous reports of possible adverse events to prescribed medications, reported by doctors and patients to regulators through the Yellow Card[15] scheme in the UK.

Clinical Study Reports also contain line by line individual patient data on all participants in one carefully specified section. **We do not call for individual patient data to be made publicly available** though there are extensive discussions at present on how this information could be shared where it is of value to research. The EU Ombudsman has ruled that it is not a significant burden to remove individual patient data from full reports before public sharing. Some organisations (GSK) have committed to making all of their reports publicly available, with this information redacted. Others (Roche) have committed to providing this information on demand.

Enforcement and Monitoring

Regulation: The proposed EU Clinical Trials Regulation will contain guidance that no information in a clinical study report should be considered commercially confidential once a decision about marketing

[12] Doshi & Jefferson, 2012 Clinical study reports of randomised controlled trials: an exploratory review of previously confidential industry reports. *BMJ Open* http://bmjopen.bmj.com/content/3/2/e002496.full

[13] http://www.ich.org/fileadmin/Public_Web_Site/ICH_Products/Guidelines/Efficacy/E3/E3_Guideline.pdf

[14] http://www.consort-statement.org/consort-statement/overview0/

[15] Yellow Card Scheme – MHRA https://yellowcard.mhra.gov.uk

authorisation has been made. The European Medicines Agency's transparency policy is to release any full report it holds on request. Other regions should adopt a similar approach.

4. Individual patient data

The AllTrials campaign is not calling for individual patient data to be made publicly available.

There are currently initiatives in many countries looking at how to improve sharing of this level of information for the benefit of future research. This offers significant opportunities, such as: improving the accuracy of estimates of benefits from a treatment, through individual patient data meta-analyses; and identifying subgroups of patients who respond better, or worse, to a specific treatment. Patient groups, medical research funders and trialists have raised concerns about the inability to reuse past research. They are keen to develop consent protocols that will optimise the ability to reuse findings, and want legislators to look at whether new data protection regulations impose unnecessary burdens and restrictions on reuse of past research.

The AllTrials campaign is an initiative of Bad Science, *BMJ*, Centre for Evidence-based Medicine, Cochrane Collaboration, James Lind Initiative, *PLOS* and Sense About Science and is being led in the US by Dartmouth's Geisel School of Medicine and the Dartmouth Institute for Health Policy & Clinical Practice. It was launched in January 2013 to call for all clinical trials to be registered and results reported.
www.alltrials.net

Appendix 1: Content of the summary of the results of a clinical trial, as set out in Annex IIIa of proposed regulation of the European Parliament and of the Council on clinical trials on medicinal products for human use

1. Trial information:
a) Study identification
b) Identifiers
c) Sponsor details
d) Paediatric regulatory details
e) Result analysis stage
f) General information about the trial including: a structured summary of trial design, methods, results, and conclusions; scientific background and explanation of rationale; specific objectives or hypotheses.
g) Population of trial subjects with actual number of subjects included in the trial

2. Subject disposition:
a) Recruitment
b) Pre-assignment Period
c) Post-assignment Periods

3. Baseline Characteristics:
a) Baseline Characteristics (Required) Age
b) Baseline Characteristics (Required) Gender
c) Baseline Characteristics (Optional) Study Specific Characteristic

4. End Points:
a) Endpoint definitions
b) End Point #1*
Statistical Analyses
c) End Point #2,
Statistical Analyses
*Information shall be provided for as many end points as defined in the protocol.

5. Adverse Events:
a) Adverse events information
b) Adverse event reporting group
c) Serious Adverse Events
d) Non-serious adverse event

6. More Information:
a) Global Substantial Modifications
b) Global Interruptions and re-starts
c) Limitations & Caveats

7. The protocol and its subsequent modifications

Additional Information About AllTrials
(from www.alltrials.net)

What We Would be Signing
http://www.alltrials.net/petition/

It's time all clinical trial results are reported.

Patients, researchers, pharmacists, doctors and regulators everywhere will benefit from publication of clinical trial results. Wherever you are in the world please sign the petition:

Thousands of clinical trials have not reported their results; some have not even been registered.

Information on what was done and what was found in these trials could be lost forever to doctors and researchers, leading to bad treatment decisions, missed opportunities for good medicine, and trials being repeated.

All trials past and present should be registered, and the full methods and the results reported.

We call on governments, regulators and research bodies to implement measures to achieve this.

What We are Obligating Ourselves to Do
http://www.alltrials.net/find-out-more/what-joining-means/

What joining AllTrials means
By signing the AllTrials petition you are signing up to the principle of the AllTrials campaign – that all clinical trials should be registered and results reported.

For organisations this isn't a statement of perfection. As the Medical Research Council told us, "The MRC celebrates its centenary this year and it would be surprising if, in our one hundred year history, there were no unreported or unpublished skeletons in our cupboards" but they, and hundreds of other organisations, made a commitment to do what they can to change the situation.

We want organisations that join to work with us and other groups in their sectors to establish what this means in practice, as the Royal Pharmaceutical Society and British Pharmacological Society have started to do in their joint work on codes of conduct for professional and learned societies.

Companies and trial funders who joined have told us they will put in place measures to grant access to as much clinical trial information as they can. GSK told us for example that it formed as a company in 2000 so it can offer access to information back as far as then.

We expect everyone – individual or organisation – to share the link to the petition far and wide and help spread the word about the campaign by hosting the campaign video on their websites, writing blogs and news pieces, and encouraging friends, family, members, and colleagues to join too.

If you can think of other ways to help or there are other organisations that you believe would support our aims then encourage them to sign up as you have done and get them to contact us.

If your organisation would like to sign the petition, email your logo and a short statement to alltrials@senseaboutscience.org.

Who Else has Signed?
http://www.alltrials.net/supporters/supporters-organisation-list/

AllTrials is an initiative of Bad Science, BMJ, Centre for Evidence-based Medicine, Cochrane Collaboration, James Lind Initiative, PLOS and Sense About Science and is being led in the US by Dartmouth's Geisel School of Medicine and the Dartmouth Institute for Health Policy & Clinical Practice.

The AllTrials petition has been signed by 507 organisations.

AllTrials is an initiative of Bad Science, BMJ, Centre for Evidence-based Medicine, Cochrane Collaboration, James Lind Initiative, PLOS and Sense About Science and is being led in the US by Dartmouth's Geisel School of Medicine and the Dartmouth Institute for Health Policy & Clinical Practice.

The AllTrials petition has been signed by 507 organisations. (For full listing, refer to http://www.alltrials.net/supporters/supporters-organisation-list/)

Myths and Objections
http://www.alltrials.net/find-out-more/faq/

1. The secrecy is all historic – this doesn't happen anymore
It is still happening. The best available review of evidence from 2010 and the most recent studies on publication of clinical trial results show that between 50% and 98% of trials are publishing results. What could possibly make even 1% secrecy forgivable?

The situation is certainly better than it was. Over 500 organisations globally have committed to the aims of AllTrials. Soon there will be laws in Europe to mandate registration and reporting. The future will be different. But the vast majority of medicines we use every day were approved a decade or more ago. Information on what was found in trials on those medicines is missing, and risks being lost forever to the doctors and regulators who make decisions about medicines unless organisations can be persuaded and pressured to report them.

We have to deal with the legacy of secrecy and get past trials published.

2. The estimation that "around half" of clinical trials have not reported results is wrong.
The 50% figure is based on reviews of large numbers of research papers that looked at the situation over a long period of time. In 2010 Song et al produced a very large study of publication bias for the NHS. They looked at hundreds of separate studies of clinical trial publication. Overall, around half of all trials in the studies they examined had never published results, and positive trials were twice as likely to be published as those with negative results[1].

An analysis of trials on the world's largest register clinicaltrials.gov from 2009 found that 46% of all trials the researchers looked at had never published results[2]. More recently, a 2014 study of all the clinical trials investigating treatments for pain on all 15 of the global national registers that are part of the WHO's clinical trial register platform found that half of the trials have not published results[3]. This paper from the Lancet in 2014 summarises the situation. Look at Figure 2 for a breakdown of the publication rates of trials from industry and non-industry, from different countries and by the size of the trial[4].

Some recent individual papers have found a higher rate of publication. These studies have looked at small subsets of all trials, generally the most recent trials, from the past couple of years, on the very newest drugs, over short time periods. With all the campaigning, new regulations and emerging codes of conduct, we would hope and expect some of this improvement to be true (although one industry study on missing data also has several methodological flaws). However, all the evidence needs to be integrated before we can know whether there has been an improvement in transparency overall. Furthermore, the most recent trials represent only a very tiny fraction of the evidence that is needed to guide everyday decisions for patients today. Doctors do not practice medicine using only treatments, or trial results, from the past three years. We need all the results, of all trials from the past three decades, and urgently, because these are the trials that cover the treatments that patients use today. Because around half of all trials were not published over many, many years, we will have to uncover a large number of those older trials, for the percentage of all trials published to change significantly.

1. F Song, S Parekh, L Hooper, YK Loke, J Ryder, AJ Sutton, C Hing, CS Kwok, C Pang, I Harvey. Dissemination and publication of research findings: an updated review of related biases. Health Technology Assessment 2010; Vol. 14: No. 8 http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0005/64751/FullReport-hta14080.pdf

2. Ross JS, Mulvey GK, Hines EM, Nissen SE, Krumholz HM. Trial Publication after Registration in ClinicalTrials.Gov: A Cross-Sectional Analysis. Sim I, editor. PLoS Medicine. 2009 Sep 8;6:e1000144. http://www.plosmedicine.org/article/info:doi%2F10.1371%2Fjournal.pmed.1000144

3. Munch T, Dufka FL, Greene K, Smith SM, Dworkin RH, Rowbotham MC. RReACT goes global: Perils and pitfalls of constructing a global open-access database of registered analgesic clinical trials and trial results. Pain. 2014 Apr 13. pii: S0304-3959(14)00175-4. doi: 10.1016/j.pain.2014.04.007. Online: http://www.ncbi.nlm.nih.gov/pubmed/24726925

4. Chan AW, Song F, Vickers A, Jefferson T, Dickersin K, Gøtzsche PC, Krumholz HM, Ghersi D, van der Worp HB. Increasing value and reducing waste: addressing inaccessible research. The Lancet 18 January 2014 (Volume 383 Issue 9913 Pages 257-266 DOI: 10.1016/S0140-6736(13)62296-5) Online: http://www.anzctr.org.au/docs/An-Wen%20Chan_Lancet%20Series'13_reducing%20waste%20inaccessible%20research_2014.pdf

3. Regulators see everything.
Regulators do not necessarily see everything. In the case of Tamiflu in the UK the manufacturer provided the licensing body MHRA with only 15 out of 74 trials they had conducted. Regulators in many countries do not have legislative power to force trial sponsors to disclose all the information they hold. Furthermore, many trials are conducted on treatments that are already licensed or never put forward to the regulator for licensing.

4. The journals are to blame for refusing to publish negative results.
Lots of journals do, including BMJ Open, Trials and the Journal of Negative Results in Biomedicine.

5. We can't solve this with the current journal publishing system.
Publication in a peer reviewed journal is only one way to get information from clinical trials into the public domain, and may not be the best way. The best format for reporting trials, which we should work towards, is a structured report on a publicly-accessible clinical trial register.

NB: The requirement to report was laid down under the Declaration of Helsinki (the World Medical Association's set of ethical guidelines for medical research using humans) and the 25 items to be reported were set out in the CONSORT (Consolidated Standards of Reporting Trials) checklist. It's not some new requirement introduced by AllTrials! Research funders and organisations should expect to include the 25 items in any style of report, whether a journal article or clinical study report and the report on the register.

6. This is only a problem with industry supported trials.
No. Close to the same percentage of non-industry trials go unreported. Non-industry researchers don't have the same financial incentives to hold back some of their results (eg getting a new drug licensed), so their failure to report affects a more random mix of positive and negative findings (industry's non-reporting is 2:1 negative to positive). While the importance of reporting has been vehemently contested in some industry quarters, it has been neglected much more widely beyond industry.

7. Having all the trials out there will just confuse the picture.
Well-conducted systematic reviews will take account of trial quality. By contrast missing trials can never be adequately replaced and will always lead to bias in the overall picture.

8. Allowing unqualified people access to information from clinical trials risks them doing inappropriate analysis that will undermine researcher's work.
The answer to inadequate analysis is not secrecy! The culture of secrecy that we've had for too long has hardly protected the public from bad science. Moreover, parts of industry have scare-mongered about the risk of unqualified people seeing results. First of all, it's funny that they don't mind these unqualified people hearing about the good ones! And if they want to avoid unfounded public scares about drugs, the best way to achieve this is for independent researchers and commentators to correct misinformation. And the best way to achieve this is for them to have access to all the results!

9. Information from clinical trials contains trade secrets and releasing it risks companies' competitors using it to commercial advantage.

We have challenged people to explain what this is and why it can't be simply redacted and have yet to receive an example. Furthermore, global companies GSK, Boehringer Ingelheim and Johnson & Johnson have all concluded that this is not a problem for them. GSK has said publicly that "the more eyes on our data the better for us." In Europe, the Ombudsman has declared that information in clinical study reports (which are the reports produced for licensing purposes) do not generally contain commercially confidential information. Usually, companies' commercially confidential information is protected in patents. Companies get information about each other's products via patents. Companies are protected from other companies using their data for commercial purposes by something called Regulatory Data Protection for, usually, up to 10 years.

10. All clinical trials should be paid for with public money, private companies should not be allowed to run them.

Clinical trials can include thousands of participants and cost millions of pounds to run. In the UK, the NHS has a budget of £8.8 billion for drugs. This is already overstretched. It could not support running trials. The problem isn't who runs the trials, it's the lack of transparency and reporting – which is also a problem in publicly funded research.

11. Releasing all trials will expose individual patient data.

The AllTrials campaign is not calling for individual patient data to be made publicly available. We expect all clinical trials past and present to be registered and results reported including clinical study reports where these are produced. There are a number of initiatives under way that would allow independent researchers access to anonymised individual patent data from clinical trials without making that data widely publicly available.

12. There are already laws to deal with this.

There is no global law on clinical trial reporting. A small number of countries have laws about registering clinical trials carried out in that country; an even smaller number have laws about reporting results from trials; most do not.

Where laws do exist they are not being enforced. In the US, for example, the FDA Amendment Act 2007 requires that clinical trials carried out in the US on currently licensed drugs after 2009 should be registered on clinicaltrials.gov and report results within a year of their end. The law gives the FDA power to fine researchers who do not comply. An independent audit in 2012 found that only 22% of trials complied with the law [5]. Nevertheless no fine has ever been levied against any company or researcher.

The new clinical trials law recently agreed by the European Parliament will require that trials done in Europe are registered before they begin and results are reported within a year. This law will come into effect in 2016 so will apply to trials conducted after that date and will apply to trials on drugs only.

5. AP Prayle, MN Hurley, AR Smyth, Compliance with mandatory reporting of clinical trial results on ClinicalTrials.gov: cross sectional study. BMJ 2012; 344 doi: http://dx.doi.org/10.1136/bmj.d7373 (Published 3 January 2012)

Joint Reference Committee
October 11, 2014
DRAFT SUMMARY OF ACTIONS
As of October 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: 100% employed at Advocate Health and Hospitals/Advocate Lutheran Hospitals; 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; Hawaii Psychiatric Association; Hawaii Medical Association

Saul Levin, MD, MPA: CEO/Medical Director; receives income from the APA [*via Conference Call*]

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 Committee member; Examiner for ABPN; AACAP Member Benefits Committee

Jeffrey A Lieberman, MD: Excused

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

APA Administration:
Annelle Primm, MD, MPH – Deputy Medical Director
Rodger Currie, Esq. – Chief of Government Affairs
Yoshie Davison, MSW – Chief of Staff
Jon Fanning – Chief RFM and ECP Officer
Kristin Kroeger – Chief, Allied and External Partnerships
Shaun Snyder, Esq. – Chief Operating Officer
Jason Young – Chief of Communications

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
2.A	Review and Approval of the Summary of Actions from the May 2014 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the May 2014 meeting?**	The Joint Reference Committee approved the draft summary of actions from the May 2014 meeting.	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Association Governance
2.B	Approval of the Consent Calendar **Will the Joint Reference Committee approve the Consent Calendar?**	The Joint Reference Committee approved the consent calendar with the following items removed: 8.A.2; 8.E.1; 8.E.3; 8.G.3; 8.I.3; 8.I.4; 8.J.15; 8.L.4	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Association Governance

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3.1	Subspecialty Ex-officio Member of the Councils **Will the Joint Reference Committee recommend that the Board of Trustees approve the creation of an ex-officio, non-voting position on each council for a subspecialty representative on the appropriate related organization [The 5 ABPN defined subspecialties]**? Council on Geriatric Psychiatry (AAGP) Council on Children, Adolescents & Their Families (AACAP) Council on Psychiatry and Law (AAPL) Council on Psychosomatic Medicine (APM) Council on Addiction Psychiatry (AAAP) The JRC recommends that this be done on a pilot basis for the ABPN approved subspecialties with subspecialty organizations that have a medical director or equivalent position. [Some of the subspecialty groups do not have medical directors or equivalent positions and they won't need to participate if not appropriate.] The cost of a representative [travel to the September Components Meetings and conference calls] would be shared between the APA and the subspecialty. The estimated total cost per person per year is $1,043 (2014 dollars) per Council. The APA total = $2,607.50 [5 subspecialty reps/2]	The Joint Reference Committee recommended that the Board of Trustees approve, as a pilot program, that each ABPN subspecialty identify one individual to hold an ex-officio, non-voting position on its corresponding APA council. The cost of this position will be shared between the APA and the subspecialty. The individual chosen must be an APA member. There is no requirement that the council have such a position filled each year. Council on Geriatric Psychiatry (AAGP) Council on Children, Adolescents & Their Families (AACAP) Council on Psychiatry and Law (AAPL) Council on Psychosomatic Medicine (APM) Council on Addiction Psychiatry (AAAP)	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

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3.2	Task Force Report – Ethics Annotations **Will the Joint Reference Committee vote to recommend that the Board of Trustees form a work group to revise and update the 2008 Task Force Report to Update the Ethics Annotations**? The work group will also recommend to the BOT whether the report should replace the current ethics annotations or be published as a separate resource document.	The Joint Reference Committee recommended the Board of Trustees form a work group to review and revise the 2008 Task Force Report to Update the Ethics Annotations. The work group would bring recommendations to the Board of Trustees with regard to whether a revised document might replace the current ethics annotations or be approved as a separate resource document of the APA. The JRC recommended that the work group have representatives from the BOT, Assembly, Ethics Committee, Council on Psychiatry and Law, and also include the APA General Counsel. In addition, the JRC recommended that Drs. Paul Appelbaum and Laura Roberts be appointed as consultants. Names of members recommended by the JRC can be given to Dr. Summergrad who will appoint the workgroup.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman Ethics Committee (for information) Colleen Coyle, JD Jon Fanning Mia Smith	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
4	CEO/Medical Director's Office Report **Updates on Referrals & Other Information**	Dr. Levin updated the JRC on the hiring of a DHHE Director. After interviewing rank order candidates, discussions are underway with a potential new director. It is hoped that the new director will have a December 2014 start date. A second round of interviews will commence for the Director of Education. There have been no final decisions regarding the final candidates. Meetings regarding the use of the DSM copyright occurred between ADMSEP and the APA. ADMSEP had access to the DSM via their library accounts. An agreement has been made with regard to the use of the DSM for ADMSEP's on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5.		

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4.A	Referral Update on the Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Healthcare Reform [JRCMAY148.G.1] The CEO and Medical Director's Office asked staff liaisons, Councils, and the Administration to review the recommendations of the Ad Hoc Work Group on the Role of Psychiatry in Health Reform per the JRC's May request (item 8.G.1). A working document was created in an effort to collect an inventory of the work already underway at the APA.	The Joint Reference Committee thanked the CEO's office for the update and referred this information to the BOT AHWG on Healthcare Reform. It is anticipated that the AHWG will develop recommendations for the Board of Trustees' consideration.	Sam Muszynski, Esq. Becky Yowell	BOT AHWG on Healthcare Reform
4.B	Referral Update: Resident Fellow Position on Council [JRCMAY148.E.1] The JRC was asked to recommend that one member position on a council be designated for a Resident Fellow. The action was referred to the Office of the Chief Executive Officer and Medical Director and a report on the financial implications of this action, were it to be implemented across all the Councils was requested. Please see attachment #4 for financial information related to this request.	The Joint Reference Committee thanked the CEO's office for the detailed information regarding the options for an RFM position on APA Councils. The Joint Reference Committee considered the options and the current assignments of RFM's to the Council's via the fellowship programs. The JRC did not feel that additional RFM positions needed to be created at the present time. Council chairpersons and staff liaisons will be reminded of the existing procedures regarding the participation of RFMs on councils as per the Operations Manual. The Operations Manual state that ***Fellowship Program Participants on Councils:*** *(1) One Fellow assigned to the Council will have voting privileges on the Council for the tenure of his/her assignment as a Fellow to the Council; (2) This individual will be chosen from amongst those fellows assigned to the council, by the fellows themselves.*	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen, MSSW	Council Chairperson and Staff Liaisons Information transmitted not later than 10/31/2014

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5	<u>Issues for Joint Reference Committee Discussion</u> • Mechanisms to Improve Communication between Assembly and Council Chairperson ○ Council chairpersons make themselves available for phone calls from Reference Committee chairpersons during the Assembly meetings ○ Action paper authors confer with APA Staff and Council chairpersons regarding their potential action papers and incorporate their suggestions prior to submitting their action papers. ○ The Joint Reference Committee reviews action papers and sends them to Councils with recommendations for prioritization (i.e. how important is the issue) ○ Council Chairs are responsible for prioritizing action papers based on the work that they are currently doing and the subject matter and APA priorities/strategic goals. They should include these comments with their feedback to the JRC and possibly to the authors of the action papers. • JRC Liaisons (JRC Members) to Councils to Attend September Components Meetings (Budget request)	The JRC discussed methods to improve the efficiency and efficacy of the action paper process, most especially from the component aspect. The sharing of information between the action paper authors and the councils needs to bi-directional. Often action paper authors draft their papers without full knowledge of the ongoing work of the components and where their idea would fit into that work and the priorities for the APA and the component. For November, the Assembly is considering having the Chairpersons from the Council on Healthcare Systems and Financing, Council on Advocacy and Government Relations and Council on Psychiatry and Law available to the Assembly's Reference Committee chairpersons should questions about the action papers arise. Other ideas were suggested such as adjusting the action paper deadline so keyed to the SCM; creating a Super Reference Committee that all action papers go to for review and editing, communication with author and component prior to going to the Assembly; and creating a flowchart or template cover sheet for an action paper to be completed by the action paper author and submitted with the final action paper. **Action Papers** 1) Goes to ASM leadership 2) ASM Leadership has 3 week process a. Refer to staff – Questions to be answered i. Is APA already doing X? ii. Is there a policy? 1. Yes – is the action paper consistent with policy or inconsistent with policy? a. If wanting to change issue/policy need rationale for change 2. No - iii. Discuss with council chairperson 1. Does the Council support? why? 2. Does the Council not support? why? *Cont'd next column*	JRC asks that the AEC to consider a process to ensure that all action papers have information about whether 1) the APA is currently doing what the action paper asks of APA; and 2) confirmation that the issue/idea has been discussed with the relevant council (chairperson/staff liaison) and feedback has been provided. The JRC will work to prioritize the action papers that come from the Assembly within the workload of the Councils and the APA. It was noted that the AEC had begun prioritizing approved action papers after the Assembly meeting, with the understanding that there was no wish to overload either council or administration resources.	

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6	**Assembly Report**	The Assembly continues to improve communication between the action paper authors and the councils. The Assembly will be considering many of the position statements from the JRC on the consent calendar in November and will consider the revised statements in May 2015. At their meeting in November, the Assembly will also consider and work to approve the Practice Guidelines and the Position Statement on Firearms Access.		
7	Awards			
7.A	2015 Jacob Javits Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Jacob Javits Award, Dave Jones (California State Insurance Commissioner)**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Jacob Javits Award (Dave Jones, California State Insurance Commissioner).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.B	2015 Human Rights Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Human Rights Award, Chester Pierce, MD?**	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Human Rights Award (Chester Pierce, MD).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.C	2014 Jack Weinberg Memorial Award in Geriatric Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 nominee for the Jack Weinberg Memorial Award in Geriatric Psychiatry, Robert G. Robinson, MD**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominee for the Jack Weinberg Memorial Award in Geriatric Psychiatry (Robert G. Robinson, MD).	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

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7.D	2014 Member Communications Award **Will the Joint Reference Committee recommend that the Board of Trustees approve bestowing the 2014 Member Communications Award, "Certificate of Continued Excellence in Member Communication," to the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominees for the Member Communications Award, the "Certificate of Continued Excellence in Member Communication" for the following recipients, the Ohio Psychiatric Association, North Carolina Psychiatric Association and Pennsylvania Psychiatric Society.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.E	2015 Adolf Meyer Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award, Dr. Karl Deisseroth**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Adolf Meyer Award recipient, Dr. Karl Deisseroth.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.F	2015 Patient Advocacy Award Lecture **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award, Patrick J. Kennedy**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 nominee for the Patient Advocacy Award recipient, Patrick J. Kennedy.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

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7.G	2014 Psychiatric Services Achievement Awards **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Awards?** **Gold Award for Academically or Institutional Sponsored Programs:** Alliance Health Project Department of Psychiatry, University of California, San Francisco, San Francisco, CA **Gold Award for Community-based Programs:** Bridge for Resilient Youth in Transition Program (BRYT), Brookline Community Mental Health Center, Brookline, MA **Silver:** Children's Community Pediatrics Behavioral Health Services in the Pediatric Medical Home (CCPBHS), Pittsburgh, PA **Bronze:** Shared Psychiatric Services, LifeWorks, Austin, TX **Certificate of Significant Achievement:** • The Mental Health Crisis Alliance, St. Paul MN • GATE-Utah (Giving Access to Everyone) Salt Lake City UT • Behavioral Health Integration Program, University of Washington, Seattle WA	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 nominees for the Psychiatric Services Achievement Award recipients as presented.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
7.H	2015 John Fryer Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2015 John Fryer Award nominee, Laverne Cox**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2015 John Fryer Award recipient, Laverne Cox.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

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7.I	2014 Bruno Lima Award **Will the Joint Reference Committee recommend that the Board of Trustees approve the 2014 Bruno Lima Award nominees, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD**?	The Joint Reference Committee recommended that the Board of Trustees approve the 2014 Bruno Lima Award recipients, Charles P. Ciolino, MD and Jagannathan Srinivasaraghavan, MD.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.A	**Council on Addiction Psychiatry**	The Joint Reference Committee thanked Dr. Levin and the Council for their report and updates.		
8.A.1 CC	Retain Position Statement: Relationship Between Treatment and Self-Help **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Relationship between Treatment and Self Help* and if retained, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Relationship between Treatment and Self Help.* Rationale: The Council on Addiction Psychiatry states that the statement is current, relevant and should be retained.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.A.2	Retain Position Statement: Recognition and Management of Substance Use Disorders Comorbid with HIV **Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Recognition and Management of Substance Use Disorders Comorbid with HIV* and if retained, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee referred the position statement back to the Council on Addiction Psychiatry and the Council on Research to determine which version of the position statement, the 2014 or the 2012, is the most current and should be retained.	Bea Eld William Narrow, MD Emily Kuhl, PhD	Council on Addition Psychiatry (LEAD) Council on Research Report to JRC [JRC Deadline 1/9/2015]
8.A.3 CC	Retire Position Statement: Mental Health & Substance Abuse and Aging: Three Resolutions **Will the Joint Reference Committee recommend that 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**?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Mental Health & Substance Abuse and Aging: Three Resolutions.* 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

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8.A.4	Referral Update: Increasing Buprenorphine Prescribing Limits [ASMMAY1412.G] Representatives of the Council developed a series of recommendations to expand access to buprenorphine treatment, including increases in the patient limits reflected in the Drug Addiction Treatment Act of 2000. The recommendations were endorsed by the American Academy of Addiction Psychiatry and the American Osteopathic Academy of Addiction Medicine (Attachment #1). At the request of government officials, the joint recommendations were forwarded to ONDCP, SAMHSA, and NIDA to inform their current deliberations regarding the issues.	The Joint Reference Committee thanked the Council for the update.		n/a
8.A.5	Substance Abuse in the Elderly	The Joint Reference Committee requested that the Council on Addiction Psychiatry and the Council on Geriatric Psychiatry jointly develop a position statement on Substance Use and Abuse in the Elderly.	Kristin Kroeger Sejal Patel Kristin Kroeger Bea Eld	Council on Geriatric Psychiatry [LEAD] Council on Addiction Psychiatry Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.B	**Council on Advocacy and Government Relations**	The Joint Reference Committee thanked Dr. Bailey and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.1	Referral Update: Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A; JRCMAY146.1] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Multiple Co-payments Charged for Single Prescription." The Council requires more data collection before drafting a comprehensive policy. To date, the Council has shared their recommendations to the Council on Healthcare Systems and Financing (LEAD). DGR staff will work with the Office of Health Care Systems and Financing to compile data to share with the Council.	The Joint Reference Committee thanked the Council for the update on this item. (Please also see 8.G.18)		n/a
8.B.2	Referral Update: Remove Black Box Warning from Antidepressants [ASMMAY1412.K; JRCMAY146.10] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Remove Black Box Warning from Antidepressants." 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 (LEAD) and will await feedback from further investigation by the Council.	The Joint Reference Committee thanked the Council for the update. It was noted that the Council on Research will provide a list of the pros and cons of the black box warnings to CAGR. (Please see also 8.M.4) Please note that the Council on Research is the LEAD component on this item.	William Narrow, MD Kristin Kroeger (for Information)	n/a

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8.B.3	Referral Update: Patient Safety and Veterans Affairs Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP) [[ASMMAY1412.X; JRCMAY146.18] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Patient Safety and Veterans Affair Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP)." The Council 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 Joint Reference Committee thanked the Council for this update.		n/a
8.B.4	Referral Update: Maintaining Community Treatment Standards in Federal Correctional Facilities [ASMMAY1412.C; JRCMAY146.3] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Maintaining Community Treatment Standards in Federal Correctional Facilities." The Council 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 Council members and the author of the action paper.	The Joint Reference Committee thanked the Council for this update and noted that the Task Force Report/Resource Document , "APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition," just approved by the JRC, includes information about Treatment Standards in Federal Correctional Facilities.		n/a

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8.B.5	Referral Update: No Punishment for Choosing Not to Adopt Electronic Medical Records [ASMMAY1412.H; JRCMAY146.8] The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "No Punishment for Choosing Not to Adopt Electronic Medical Records." The Council 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.	The Joint Reference Committee thanked the Council for this update.		
8.C	**Council on Children, Adolescents and Their Families**	The Joint Reference Committee thanked Dr. Kraus and the Council for their report and updates.		
8.C.1	Revision to Position Statement: Child Abuse and Neglect by Adults **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Child Abuse and Neglect by Adults*, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the position statement back to the Council on Children, Adolescents and Their Families requesting that the revision be rewritten. Specifically, the JRC requested the inclusion of more recent data to support the statement, clarity that there are mandatory child abuse reporting laws in all states, and information regarding to whom one should report suspicions. Additionally, the JRC requested that the Council on Psychiatry and Law review the rewritten position statement.	Kristin Kroeger Alison Bondurant Lori Klinedinst Whitaker	Council on Children, Adolescents and Their Families Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.C.2	Revision to Position Statement: College Mental Health **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *College Mental Health*, and if approved, forward it to the Board of Trustees for consideration**?	The Joint Reference Committee referred the position statement back to the Council on Children, Adolescents and Their Families requesting a rewrite of the revision. The statement needs a thorough editing for clarity and tightening of language. The addition of information about FERPA would be helpful. The 3rd bullet needs to be completed. Once the statement has been rewritten, the JRC requested that it be reviewed by the Council on Psychiatry and Law.	Kristin Kroeger Alison Bondurant	Council on Children, Adolescents and Their Families Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.C.3	Funding of the APA Child and Adolescent Psychiatry Fellowship **Will the Joint Reference Committee recommend to the Board of Trustee that APA Fund, on an ongoing basis, the APA Child and Adolescent Psychiatry Fellowship**?	The Joint Reference Committee did not recommend approval of this action item. Prior to making a recommendation, the JRC requested information regarding whether these fellows go into child psychiatry and how many remain APA members. Additionally, the JRC requested data on the number of child psychiatry residency training positions filled and whether they are filled during the match or after the match.	Kristen Kroeger Alison Bondurant	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.D	**Council on Communications**	The Joint Reference Committee thanked Dr. Luo and the Council for their report and updates.		
8.D.1	Revision of Charge to the Council on Communications **Will the Joint Reference Committee recommend that the Board of Trustees approve amending the charge of the Council on Communications to include the entirety of the APA Communications Division (the Office of Corporate Communications & Public Affairs, the Office of Member Communication and the Office of Integrated Marketing), as well as internal and external communications strategies**?	The Joint Reference Committee recommended that the Board of Trustees approve the revised charge to the Council on Communications.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

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8.D.2	APA Branding Initiative **Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the Council on Communications recommendation and support the APA's branding initiative to help brand the APA consistently and demonstrate its value**?	The Joint Reference Committee recommended that the Board of Trustees approve and support branding the APA consistently to demonstrate its value.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.D.3	Referral Update: Council Communications to Members [JRCOCT138.F.1] The council discussed in great detail the JRCOCT 138.F.1 action titled: Council Communications to Members. The action recommends that APA councils provide a brief summary of useful information relevant to members that's published on a timely basis in appropriate venues. Policy positions instituted by councils are easily accessible but there are different ways to cluster council information. The council wanted to know if they're responsible for considering or identifying what activities of a particular council are good ideas. In response to the action the council offered the following suggestions; • Create a one page document to promote council's papers and projects; • Establish a bulletin board on APA's homepage providing access to an executive summary – recent work of each council (member only access); • The COC could offer advice to councils on the most efficient way to promote key issues; • Offer council chairs a venue or place to discuss their issues; and • APA should survey members to find out specifically what they want to know.	The Joint Reference Committee referred this update to the CEO's office and the Division of Communications to develop a list of tools and tips that councils can utilize when communicating both internally and externally. The JRC requested that this information be sent to the Assembly's Work Group on Communications.	Saul Levin, MD, MPA Jason Young Margaret Dewar Allison Moraske	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.E	**Council on Geriatric Psychiatry**	The Joint Reference Committee thanked Dr. Roca and the Council for their report and updates.		

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8.E.1	Retain Position Statement Precepts of Palliative Care ***Will the Joint Reference Committee recommend that the Assembly retain the Position Statement Precepts of Palliative Care and if retained, forward it to the Board of Trustees for consideration****?*	The Joint Reference Committee is considering this action item via email. Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.		
8.E.2 CC	Retain Position Statement Elder Abuse, Neglect and Exploitation Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Elder Abuse, Neglect and Exploitation* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Elder Abuse, Neglect and Exploitation.* Rationale: The Council on Geriatric Psychiatry states that this position statement is still relevant with current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.E.3	Retain Position Statement Ensuring Access to Appropriate Utilization of Psychiatric Service of the Elderly Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Ensuring Access to Appropriate Utilization of Psychiatric Service of the Elderly* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee is considering this action item via email. Rationale: The Council on Geriatric Psychiatry believes that this statement is still relevant with current practice..	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen	
8.E.4	Referral Update: Establishing Guidelines for Interacting with Caregivers [ASMHNOV1312.C; JRCJAN146.1] The Joint Reference Committee referred the action paper *Establishing Guidelines for Interacting with Caregivers* to the Council on Geriatric Psychiatry, Council on Children, Adolescents and Their Families, and the Council on Psychiatry and Law. The Council on Geriatric Psychiatry was designated as the lead Council and has put a workgroup together comprising of members from all three councils. The Workgroup has created a draft document and circulated it to members of the Councils for feedback.	The Joint Reference Committee thanked the Council for the update and requested that the draft document be sent to the action paper author, Dr. Joshua Sonkiss for information.	Sejal Patel	Council on Geriatric Psychiatry

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8.F	**Council on International Psychiatry**	The Joint Reference Committee thanked Dr. Jeste and the Council for their report and updates on progress to date. The JRC looks forward to receiving actionable items from the Council based on all their ideas and recommendations.		
8.G	**Council on Healthcare Systems and Financing**	The Joint Reference Committee thanked Dr. Trivedi and the Council for their report and updates.		
8.G.1	Proposed Joint Position Statement: Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness Will the Joint Reference Committee recommend that the Assembly approve (in an up or down vote) the Joint Position Statement *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness* and if approved, forward it to the Board of Trustees for approval in an up or down vote?	The Joint Reference Committee recommended that that Assembly approve the Joint Position Statement *Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.G.2 CC	Retain Position Statement: Discriminatory Disability Insurance Coverage Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Discriminatory Disability Insurance Coverage* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Discriminatory Disability Insurance Coverage.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.3	Retain Position Statement: Psychiatric Disability Evaluation by Psychiatrists Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Psychiatric Disability Evaluation by Psychiatrists* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the position statement back to the Council on Healthcare Systems and Financing for another review and revision. The JRC questioned whether there was additional information or background that would support retaining the position statement, especially the part about disability evaluations being done "most effectively and efficiently by psychiatric physicians". In the JRC's view, the information regarding reimbursement was the most relevant portion of the statement, but it is unclear whether this continues to be an issue for our field. It was suggested that input be sought from those with expertise in disability evaluation.	Sam Muszynski, Esq. Becky Yowell	Council on Healthcare Systems and Financing Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.4 CC	Retain Position Statement: Psychiatrists Practicing in Managed Care: Rights and Regulations Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Psychiatrists Practicing in Managed Care: Rights and Regulations.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.5 CC	Retain Position Statement: State Mental Health Services Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *State Mental Health Services* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *State Mental Health Services.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.6 CC	Retain Position Statement: Universal Access Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Universal Access* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Universal Access.* [CC] Rationale: The Council on Healthcare Systems and Financing recommend retaining this position statement as it remains relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.7 CC	Retain Position Statement: Federal Exemption from the IMD Exclusion Will the Joint Reference Committee recommend that 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 Joint Reference Committee recommended that the Assembly retain the Position Statement *Federal Exemption from the Institution for Mental Disease (IMD) Exclusion.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.8	Revise Position Statement: Employment Related Psychiatric Examinations Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Employment Related Psychiatric Examinations*, and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the revised Position Statement *Employment Related Psychiatric Examinations* to the Council on Psychiatry and Law and requested their input, feedback and potential revisions for the January JRC meeting, including whether there is a current need for such a position statement **N.B.** If the revised position statement is approved, it will supersede and retire the 2009 version of the position statement.	Lori Klinedinst Whitaker	Council on Psychiatry and Law Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.9	Revise Position Statement: Patient Access to Treatments Prescribed by Their Physicians Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Patient Access to Treatments Prescribed by Their Physicians* and if approved, forward to the Board of Trustees for consideration?	The Joint Reference Committee referred the revised position statement back to the Council on Healthcare Systems and Financing for additional work. It was felt that the title of the position statement should reflect the key message and that the statement itself be succinct and on point.	Sam Muszynski, Esq. Becky Yowell	Council on Healthcare Systems and Financing Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.10	Revise Position Statement: Medical Necessity Definition (Endorsed AMA Policy) Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Medical Necessity Definition (Endorsed AMA Policy)* and if approved, forward it to the Board of Trustees for consideration	The Joint Reference Committee recommended that the Assembly approved the revised Position Statement *Medical Necessity Definition (Endorsed AMA Policy).* **N.B.** If the revised position statement is approved, it will supersede and retire the 2008 version of the position statement. Rationale: The Council on Healthcare Systems and Financing recommends revising this position statement to ensure that it is in line with current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.G.11 CC	Retire Position Statement: 2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retire the 2002 Position Statement *Access to Comprehensive Psychiatric Assessment and Integrated Treatment.* [CC] 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."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.12 CC	Retire Position Statement: Psychotherapy and Managed Care Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Psychotherapy and Managed Care* and if retired, forward to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Psychotherapy and Managed Care.* [CC] 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."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.13 CC	Retire Position Statement: Guidelines for Handling the Transfer of Provider Networks Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Guidelines for Handling the Transfer of Provider Networks.* [CC] 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."	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.14 CC	Retire Position Statement: Active Treatment Will the Joint Reference Committee recommend that the Assembly retire the Position Statement *Active Treatment* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Active Treatment.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.15 CC	Retire Position Statement: Endorsement of Medical Professionalism in the New Millennium: A Physician Charter Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.G.16 CC	Retire Position Statement: Desegregation of Hospitals for the Mentally Ill and Retarded Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *Desegregation of Hospitals for the Mentally Ill and Retarded.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.17	Refer Position Statement: Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services Will the Joint Reference Committee refer the Position Statement *Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services* to the Council on Advocacy and Government Relations for review and to determine if a position on this issue is necessary? If a need to retain the position remains, the CHSF recommends CAGR revise the statement to ensure it is current; otherwise the position should be retired.	The Joint Reference Committee referred the action to the Office of the Chief Executive Officer and the Division of Government Affairs to determine if the APA still needs a position statement on this topic for APA advocacy reasons. If there is not a need, than the JRC would entertain an action to retire the position statement.	Saul Levin, MD, MPA Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.18	Referral Update: Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A; JRCMAY146.1] Action referred to APA's General Counsel to determine legality of the practice. It would be helpful to have specific examples as to where this is happening (geographic location and retail outlet). Need to develop a coherent way of handling the range of issues that relate to prescription copays. A suggestion was made to consider sending a letter to the Attorneys General to cease and desist. The Council on Healthcare Systems and Financing will gather additional details/specific examples while the legal issue is explored.	The Joint Reference Committee thanked the Council for the update. (Please also see item 8.B.1)		n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.19	Referral Update: Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger [ASMMAY1412.F; JRCMAY146.6] 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.	The Joint Reference Committee thanked the Council for the update		n/a
8.G.20	Referral Update: Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project [JRCMAY148.G.3] A small workgroup was convened and developed a written response to concerns about the implementation of the Excellence in Mental Health Act. That group will continue to monitor the situation through the rule writing phase.	The Joint Reference Committee thanked the Council for the update.		n/a
8.G.21	Performance Measures on Integrated Care Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Quality Care to review the performance measures currently in place on integrated care to determine what measures are needed?	The Joint Reference Committee tasked the Council on Quality Care to review performance measures currently in place on integrated care to determine what measures are needed and report that information back to the BOT AHWG on Healthcare Reform	Samantha Shugarman, MS	Council on Quality Care Report to BOT AHWG on Healthcare Reform not later than December 15, 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.22	Current Health Services Literature on Integrated Care Models Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Research to review the current health services literature on integrated care models, including physician-led and non-physician-led models, and summarize and organize this review in such a way that it can be used by APA administrative staff and members for integrated care education and advocacy?	The Joint Reference Committee referred the action to the CEO's Office for referral to the Office of Research for review as requested.	Saul Levin, MD, MPA William Narrow, MD	Office of Research Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.G.23	Identify the Roles and Responsibilities of Psychiatrists Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Council on Psychosomatic Medicine to work together to identify the roles and responsibilities of psychiatrists across the spectrum of models and settings for medical care delivery?	The Joint Reference Committee referred the action to the Council on Psychosomatic Medicine.	William Narrow, MD Diane Pennessi	Council on Psychosomatic Medicine Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
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	Referral Update: Psychiatric Education with Respect to Patients at Risk of Violent Behavior [ASMMAY1412.E] 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).	The Joint Reference Committee thanked the Council for this update and noted that all of this information was a good response to the action paper. The JRC considered this action paper closed.		n/a

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.H.2	Referral Update: Addressing the Shortage of Psychiatrists with Sources of Funding [ASMMAY1412.M] Federally-funded programs already exist that address the AP author's 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 Joint Reference Committee thanked the Council for the update noting that all of this information is available on the APA website. The JRC requested that this information be sent to the Assembly for their knowledge. The JRC considered this action paper closed.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	n/a
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.		
8.I.1 CC	Retain Position Statement: Abortion & Women's Reproductive Health Care Rights Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Abortion & Women's Reproductive Health Care Rights.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.I.2 CC	Retain Position Statement: Xenophobia, Immigration and Mental Health Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Xenophobia, Immigration and Mental Health* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Xenophobia, Immigration and Mental Health.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.I.3	Retain Position Statement: Sexual Harassment Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Sexual Harassment* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred this position statement to the CEO's Office to determine if there is an advocacy/political need to have a position statement on the various types of harassment. The APA opposes all forms of harassment in the workplace. The JRC thought it best to revise the position statement to include all forms of harassment.	CEO and Medical Director Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
8.I.4	Retain Position Statement: Right to Privacy Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Right to Privacy* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the position statement to the CEO's office and the Division of Government Affairs to determine if there is a need for such a position statement. If it is determined that the APA needs a position statement on such an issue, the Joint Reference Committee will assign the task to the appropriate council.	CEO and Medical Director Rodger Currie, Esq.	Report to Joint Reference Committee – January [JRC Deadline 1/9/2015]
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: Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed position statement *Inquiries about Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and Licensing.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.2	Proposed Position Statement: Patient Access to Electronic Mental Health Records Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Patient Access to Electronic Mental Health Records* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Patient Access to Electronic Mental Health Records*.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.J.3	Proposed Position Statement: Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Facilities.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.J.4	APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition Will the Joint Reference Committee approve as a resource document the *APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition*?	The Joint Reference Committee approved the document *APA Guidelines on Psychiatric Services in Correctional Facilities, 3rd Edition* as a resource document of the APA.	Shaun Snyder, Esq. Margaret Dewar Laurie McQueen	
8.J.5 CC	Retire Position Statement: Juvenile Death Sentences Will the Joint Reference Committee recommend that the Assembly retire the Position Statement on *Juvenile Death Sentences* and if retired, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retire the Position Statement *on Juvenile Death Sentences.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

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8.J.6 CC	Retain Position Statement: Peer Review of Expert Testimony Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Peer Review of Expert Testimony* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Peer Review of Expert Testimony.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.7 CC	Retain Position Statement: Joint Resolution Against Torture Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Joint Resolution Against Torture* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Joint Resolution Against Torture.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.8 CC	Retain Position Statement: Moratorium on Capital Punishment in the United States Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Moratorium on Capital Punishment in the United States.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.9 CC	Retain Position Statement: Discrimination Against Persons with Previous Psychiatric Treatment Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Discrimination against Persons with Previous Psychiatry Treatment.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

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8.J.10 CC	Retain Position Statement: Insanity Defense Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Insanity Defense* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Insanity Defense.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.11 CC	Retain Position Statement: Psychiatric Participation in Interrogation of Detainees Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Psychiatric Participation in Interrogation of Detainees* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Psychiatric Participation in Interrogation of Detainees.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.12 CC	Retain Position Statement: Death Sentences for Persons with Dementia or Traumatic Brain Injury Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain the Position Statement *Death Sentences for Persons with Dementia or Traumatic Brain Injury.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.13 CC	Retain Position Statement: Mentally Ill Prisoners and Death Row Will the Joint Reference Committee recommend that 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?	The Joint Reference Committee recommended that the Assembly retain Position Statement *Mentally Ill Prisoners and Death Row.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.14 CC	Retain Position Statement: Diminished Responsibility in Capital Sentencing Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Diminished Responsibility in Capital Sentencing*?	The Joint Reference Committee recommended that the Assembly retain Position Statement *Diminished Responsibility in Capital Sentencing.* [CC] Rationale: The Council on Psychiatry and Law recommends that the position statement be retained as written as it is still relevant for current practice.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.J.15	Retain Position Statement: Ethical Use of Telemedicine Will the Joint Reference Committee recommend that the Assembly retain the Position Statement *Ethical Use of Telemedicine* and if retained, forward it to the Board of Trustees for consideration?	The Joint Reference Committee referred the Position Statement to the Committee on Mental Health Information Technology for their review and feedback and for the Committee to consider development of a resource document. Rationale: The Council on Psychiatry and Law recommends that the position statement be retained. It is suggested that the statement be referred to the appropriate component on technology to consider development of a resource document to accompany it given new technology and use of telemedicine.	William Narrow, MD Lisa Greiner, MSSA	Committee on Mental Health Information Technology Report to Joint Reference Committee – January [JRC Deadline – 1/9/2015]
8.J.16	Human Rights /Isaac Ray Award Committee The Joint Reference Committee discussed separating the Human Rights Award from the Isaac Ray Award Committee. The Council on International Psychiatry is directed to administer the Human Rights Award. If the Board of Trustees approves, the name of the Human Rights/Isaac Ray Award Committee will be revised to the Isaac Ray Award Committee.	The Joint Reference Committee recommended that the Board of Trustees transfer the administration of the Human Rights Award from the Council on Psychiatry and Law to the Council on International Psychiatry. If approved, the name of the Human Rights/Isaac Ray Award Committee will be revised to the Isaac Ray Award Committee.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.K	**Council on Psychosomatic Medicine** (Consultation-Liaison Psychiatry)	The Joint Reference Committee thanked Dr. Gitlin and the Council for their report and updates.		
8.L	**Council on Quality Care**	The Joint Reference Committee thanked Dr. Dalack and the Council for their report and updates.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.1	Proposed Position Statement: Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families* and if approved, forward it to the Board of Trustees for consideration?	The Joint Reference Committee recommended that the Assembly approve the proposed Position Statement *Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families*. The JRC also referred the position statement to the Council on Medical Education and Lifelong Learning for their review and requested their recommendations for any changes be sent to the JRC for their meeting in January.	Kristin Kroeger Nancy Delanoche Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Council on Medical Education and Lifelong Learning Report to Joint Reference Committee – January [Deadline 1/9/2015] Assembly May 2015
8.L.2	Proposed Position Statement on Management of Sensitive Health Information within Health Information Exchanges [ASMNOV1212.B] **Will the Joint Reference Committee recommend that the Assembly approve the proposed Position Statement *Management of Sensitive Health Information within Health Information Exchanges* and if approved, forward to the Board of Trustees for consideration?** Explanation for proposed position statement The Committee on Mental Health Information Technology (CMHIT) developed a Position Statement on the *Management of Sensitive Health Information within Health Information Exchanges*. This area has been evolving quickly over the past 18 months, so the committee 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.	The Joint Reference Committee recommended that the Assembly approved the proposed Position Statement *Management of Sensitive Health Information within Health Information Exchanges.*	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.3	Revised Position Statement: Confidentiality of Electronic Health Information **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement on *Confidentiality of Electronic Health Information* and if approved, forward it to the Board of Trustees for consideration?** **N.B.** If the revised position statement is approved it will supersede and retire the former version of the position statement. **N.B.** This action is a referral update on ASMNOV1312.D Confidentiality of Electronic Health Information What has been done or not done on the referral? • Members of the CMHIT reviewed this statement and suggested minor changes in wording of the position statement would be appropriate in terms of the security of the record. Steve Daviss, M.D. (CMHIT Chair) prepared a revised Position Statement for review and comment by the Committee on Mental Health Information Technology (CMHIT), the Council on Healthcare Systems and Financing and the Council on Psychiatry and Law. The title of the Statement was revised (from *Confidentiality of Computerized Records* to *Confidentiality of Electronic Health Information)* to reflect current terminology. Members of the CMHIT and the two councils reviewed and discussed the revised Position Statement during a joint teleconference on July 22, 2014. The final Position Statement was reviewed and approved by the Committee on Mental Health Information Technology during their September 10, 2014 teleconference. The Council on Healthcare Systems and Financing approved the statement as written on September 17, 2014. • The Council on Psychiatry and Law discussed the proposed position paper and discussed data segmentation allowing a higher degree of protection for sensitive information and the technology surrounding the issue. It was suggested that the APA could have a statement to encourage development of programs and prototypes where this type of segmentation can occur.	The Joint Reference Committee recommended that the Assembly approve the revised Position Statement on *Confidentiality of Electronic Health Information.* **N.B.** If the revised position statement is approved, it will supersede and retire the 2010 version of the position statement.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.4 CC	Referral of Position Statements to the Council on Research **Will the Joint Reference Committee refer the five year review of the following position statements to the Council on Research?** a) 2009 Position Statement on HIV and Adolescents b) 2009 Position Statement on HIV Antibody Testing c) 2009 Position Statement on HIV/AIDS and Confidentiality, Disclosure, and Protection of Others d) 2009 Position Statement on HIV and Inpatient Psychiatric Services e) 2009 Position Statement on HIV and Outpatient Psychiatric Services f) 2012 Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments	The Joint Reference Committee referred the position statements to the Council on Research for evaluation. The JRC encouraged the Council to consolidate the HIV related position statements into a single statement. a) 2009 Position Statement on HIV and Adolescents b) 2009 Position Statement on HIV Antibody Testing d) 2009 Position Statement on HIV and Inpatient Psychiatric Services e) 2009 Position Statement on HIV and Outpatient Psychiatric Services f) 2012 Position Statement on Recognition and Management of HIV-Related Neuropsychiatric Findings and Associated Impairments The JRC referred the following position statement to the Council on Psychiatry and Law for review and update c) 2009 Position Statement on HIV/AIDS and Confidentiality, Disclosure, and Protection of Others	William Narrow, MD Emily Kuhl, PhD	Council on Research Report to Joint Reference Committee – January [Deadline 1/9/2015]
8.L.5 CC	Retain Position Statement: Endorsement of the Patient-Physician Covenant **Will the Joint Reference Committee recommend that 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?**	The Joint Reference Committee recommended that the Assembly retain the 2007 Position Statement *Endorsement of the Patient-Physician Covenant.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.6 CC	Retain Position Statement: Provision of Psychotherapy for Psychiatric Residents **Will the Joint Reference Committee recommend that 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?**	The Joint Reference Committee recommended that the Assembly retain the 2009 Position Statement *Provision of Psychotherapy for Psychiatric Residents.* [CC] 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.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly November 2014
8.M	**Council on Research**	The Joint Reference Committee thanked Dr. Evans and the Council for their report and updates.		
8.M.1	Revision of Charge to Council on Research **Will the Joint Reference Committee recommend that the Board of Trustees approve the revision of the charge to the Council on Research?**	The Joint Reference Committee recommended that the Board of Trustees approved the revision to the charge of the Council on Research.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]
8.M.2	Revised Position Statement: Psychiatric Implications of HIV/HCV Co-Infection **Will the Joint Reference Committee recommend that the Assembly approve the revised Position Statement *Psychiatric Implication of HIV/HCV Co-Infection* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approved the revised Position Statement *Psychiatric Implication of HIV/HCV Co-Infection.* **N.B.** if the revised position statement is approved it will supersede and retire the former version of the position statement.	Shaun Snyder, Esq. Margaret Dewar Allison Moraske	Assembly May 2015
8.M.3	APA Signing onto the AllTrials Registry **Will the Joint Reference Committee recommend that the Board of Trustees approve the APA signing onto the AllTrials registry?**	The Joint Reference Committee recommended that the Board of Trustees sign the APA onto the AllTrials registry.	Shaun Snyder, Esq. Margaret Dewar Ardell Lockerman	Board of Trustees December 2014 [BOT Deadline 11/19/2014]

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.M.4	Referral Update: Remove Black Box Warnings from Antidepressants [ASMMAY1412.K; JRCMAY146.10] The Council was asked by the Joint Reference Committee to provide a list of pros and cons to removing the black box warning from antidepressants. Before providing a formal recommendation to the Joint Reference Committee, the Council wishes to first seek input from Robert Gibbons, Ph.D., University of Chicago, who has studied this issue extensively—particularly data reflecting how the presence of the black box warning has impacted prescribing habits. The Council felt like this could help them provide the Joint Reference Committee a more informed and empirically based response. The next step is for the Council to contact Dr. Gibbons to ascertain his interest and availability in assisting with this matter.	The Joint Reference Committee thanked the Council for the information and looks forward to receiving their recommendations in January.	William Narrow, MD Emily Kuhl, PhD	Council on Research Report to Joint Reference Committee – January [Deadline 1/9/2015]

American Psychiatric Association

Training Psychiatrists for Integrated Behavioral Health Care

A Report by the American Psychiatric Association

Council on Medical Education and Lifelong Learning

2014

Council on Medical Education and Lifelong Learning
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Executive Summary

Integrated behavioral health care has been defined as "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population" (Peek, et al, 2013). Integrated care improves access, outcomes and quality, and represents a decisive new direction for the transformed American health care system with its focus on assessment and treatment of mental illness and enhancement of wellness.

Most medical education regarding mental illness takes place in traditional psychiatric settings, such as hospitals, community mental health centers and clinics, and is based on traditional psychiatrist roles. As the care system shifts from the current norm toward integrated models of care, there is a need across the medical education continuum – undergraduate, graduate and continuing medical education – for programmatic change to teach and lead about integrated care practice.

Integrated care requires new skills and responsibilities for psychiatrists, as well as other health professionals. This report champions education about integrated care and (i) reviews the literature to define these skills and responsibilities, (ii) scans the undergraduate, graduate medical education, and continuing medical education environment to examine the extent and methods used to educate trainees about this model, (iii) discusses challenges and solutions to promoting training in integrated care techniques, and (iv) makes recommendations to educational programs and the American Psychiatric Association (APA). The report represents the work of the Council on Medical Education and Lifelong Learning of the APA, and the individuals with primary responsibility for each section are designated.

Introduction (Art Walaszek, M.D.)

Pursuit of the triple aim of America's health care system – quality, access and cost – challenges our current models of care and points the way toward integrated behavioral care. Although the majority of behavioral health care in the United States takes place in primary care, characterized as the "*de facto* mental health system" (Kessler and Stafford 2008), concerns have been raised about the quality of the care provided (Raney, et al, 2013). For example, the rates of appropriate identification and diagnosis of patients with depression are low; for those patients diagnosed with depression, treatment is often not evidence-based, especially with regard to duration and intensity of treatment.

But, quality is not the only problem. The financial cost of inadequately treated mental illness is staggering and the additional healthcare cost of patients with behavioral co-morbidities in 2012 was estimated at $293 billion (Melek, 2014). Patients with mental illness are overrepresented in populations at risk of hospitalization (Katon and Unutzer, 2013).

Finally, access to mental health services is often poor (Cunningham, 2009), and likely to get worse as many Americans get health insurance through the Affordable Care Act prior to changes in the mental health cares system that could increase access. The total number of psychiatrists is unlikely to increase, at least in the short term, since limited funds are available to create new psychiatry residency training slots. New models that extend psychiatric expertise to larger populations of patients are necessary.

These gaps in the healthcare system lead to new opportunities for psychiatrists to help improve the mental health care of patients in primary care. Indeed, the APA Board of Trustees' Work Group on Health Care Reform has recommended that psychiatrists "must play a major role in formulating integrated care solutions by defining their role and benefit to patients" (APA, 2014a).

The integrated care model

… may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (Peek 2013).

Integrated care comprises a number of different approaches, including co-location, collaborative care, improved primary care for patients with severe mental illness (Raney, et al, 2013), and telepsychiatry. *Co-location* refers to the physical presence of psychiatric treatment in primary care and/or other medical/surgical outpatient settings. The c*ollaborative care model* (CCM) is a population-based approach in which psychiatrists work with primary care providers and behavioral health care managers to manage the behavioral health of a defined population of patients. This includes the use of objective rating scales, regularly scheduled caseload-focused review with the

psychiatrist, adjustment of care based on rating scale results and evidence-based treatment algorithms to reach desired outcomes (treatment to target), and care management, including use of evidence-based brief interventions. *Improved primary care* may involve provision of primary care services in the behavioral health setting (also referred to as *reverse co-location*). Finally, *telemedicine* facilitates psychiatric consultation or collaborative care with medical colleagues in settings with workforce shortages or geographic dispersion.

Of the approaches to integrated care, the strongest database exists for the collaborative care model (CCM), especially for depression. For example, a recent meta-analysis of 57 treatment trials found that CCM consistently improves depression, mental quality of life, physical quality of life, and social role functioning (Woltmann, et al, 2012). A Cochrane review of 79 randomized controlled trials found CCM to be effective in improving depression and anxiety, increasing patient satisfaction, and in providing enduring benefits (Archer, 2012). Most studies of CCM have shown net decreased health care costs (Melek, et al, 2014). Recent clinical trials have found that collaborative care in the setting of multiple medical and psychiatric co-morbidities (e.g., diabetes, heart disease and depression) is effective at improving a wide range of medical outcomes (Katon, et al 2010).

As these new care delivery models emerge, psychiatrists' roles will likely change. They will need to collaborate effectively, communicate with other physicians and health care providers, leverage their knowledge across teams, apply their consultative skills, utilize screening tools, and embrace information technology. The continuum of psychiatry education, including undergraduate and graduate medical education, as well as continuing medical education, must take on the challenge of preparing current and future psychiatrists, and their primary care colleagues, including physician assistants and nurse practitioners, to deliver this sort of patient-centered, team-based, measurement-based and population-oriented care.

A variety of excellent resources are already available to meet this challenge. This report aims to augment these resources by providing an analysis of how the field is responding this need and reflect on the lessons learned so far in order to help psychiatry educational programs further develop their teaching and training.

This report champions education about integrated care and (i) reviews the literature to define these skills and responsibilities, (ii) scans the undergraduate, graduate medical education, and continuing medical education environment to examine the extent and methods used to educate trainees about this model, (iii) discusses challenges and solutions to promoting training in integrated care techniques, and (iv) makes recommendations to educational programs and the American Psychiatric Association (APA). The report represents the work of the Council on Medical Education and Lifelong Learning of the APA, and the individuals with primary responsibility for each section are designated.

Undergraduate Medical Education (Benoit Dubé, M.D.; Marcy Verduin, M.D.)

Crucial issues at the center of discussions about undergraduate medical education include the length of medical school (Emanuel EJ, Fuchs VR, 2012) and the impact of the cost of training and resulting medical student debt on the health care workforce (Greysen SR, 2011, Steinbrook R, 2008). The Affordable Care Act and its mandate for integrated care has added another important and timely issue for educators to consider (Croft B, Parish SL, 2013). Although residency training is more proximate to clinical psychiatry practice, and has been a focus of interest for integrated care experts for some time (Cowley, et al, 2014), clerkship directors and medical school faculty clearly recognize the need to shape student perceptions of the field of psychiatry, expose students to a variety of models of care, and teach future physicians of all specialties to facilitate behavioral health care.

Integrated Care in Undergraduate Medical Education

In August, 2014, all members of the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) were invited to complete a short survey on training and education about integration of physical and behavioral health at their respective institutions (see Dubé B, Verduin M, 2014 for detailed information about the survey). There were several important findings from the survey. First, behavioral health topics are most commonly taught during Introduction to Doctoring, Neurology and Reproduction courses (Figure 1) and they are taught primarily by the psychiatry faculty (Table 1).

Figure 1: Pre-Clinical Course Offering Behavioral Health Content (Excluding the Human Behavior/Psychiatry Pre-clinical Course)

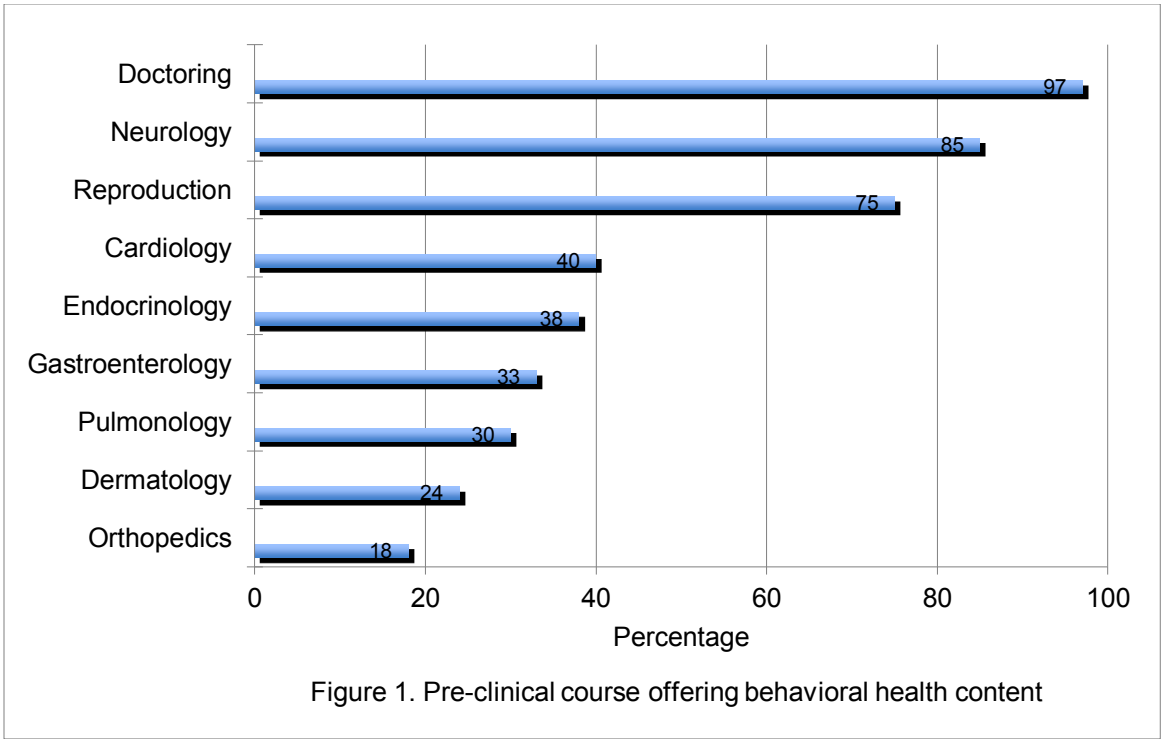

Figure 1. Pre-clinical course offering behavioral health content

Table 1: Specialty of Faculty Teaching About Behavioral Health Topics

Who Teaches Behavioral Health Topics?	Psychiatry Faculty (%)	Non-Psychiatry Faculty (%)
Doctoring	70	30
Neurology	55	45
Reproduction	50	50
Cardiology	10	90
Endocrinology	13	87
Gastroenterology	15	85
Pulmonology	15	85
Dermatology	0	100
Orthopedics	0	100

Second, during non-psychiatry clinical rotations, behavioral health topics are most frequently taught during the Family Medicine clerkship and, conversely, least commonly during the Surgery clerkship (Figure 2). Because these rotations are sponsored by other departments, the teaching faculty are much less likely to be psychiatrists (Table 2).

Figure 2: Clinical Rotation (Excluding Psychiatry) Offering Behavioral Health Content

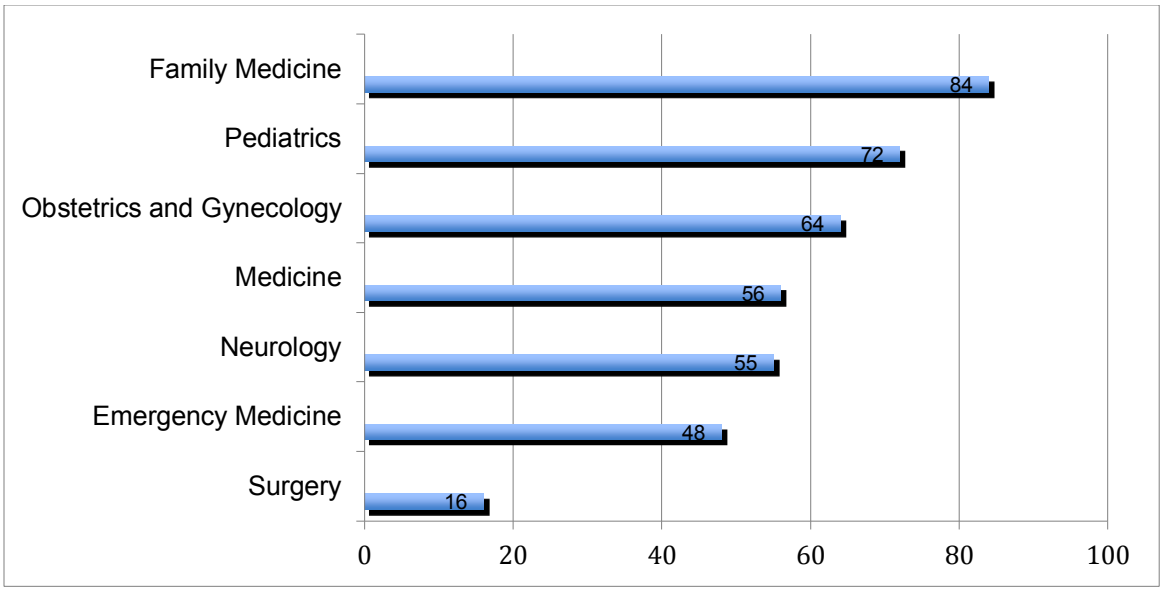

Table 2: Specialty of Faculty Teaching About Behavioral Health Topics on Clinical Rotations

Who Teaches Behavioral Health Topics?	Psychiatry Faculty (%)	Non-Psychiatry Faculty (%)
Family Medicine	33	67
Pediatrics	25	75
Obstetrics and Gynecology	44	56
Medicine	27	73
Neurology	27	73
Emergency Medicine	23	77
Surgery	33	67

Third, integrated care settings are not commonly among the training sites in the Psychiatry clerkship. They are typically optional experiences and usually involve traditional psychiatric consultations in primary care settings. They are also rarely offered as elective rotations (Table 3).

Table 3: Integrated Care Clinical Rotations

Integrated Care Clinical Setting	Psychiatry Clerkship			Psychiatry Elective		
	Yes (mandatory)	Yes (optional)	No	Yes (mandatory)	Yes (optional)	No
Traditional psychiatric consultation in a primary care setting	12%	44%	44%	2%	37%	61%
Traditional psychiatric consultations in a non-primary care medical or surgical outpatient setting	15	35	50	3	28	69
Collaborative care with primary care providers	10	30	60	3	30	67
Collaborative care with other medical colleagues	0	13	87	0	15	85

Finally, there are a wide variety of settings for integrated care rotations (Table 4). The VA System, Federally Qualified Healthcare Centers (FQHCs), and other types of primary clinics were the main venues for these rotations. Telemedicine experiences take place in the VA system and in other unique venues.

Table 4: Integrated Care Rotation Venues

	VA[1]	FQHC[2]	Primary Care Clinic[3]	Medical Surgical Outpatient Clinic[4]	Other[5]
Traditional psychiatric consultation in a primary care setting	26%	30%	35%	4%	5%
Traditional psychiatric consultations in a non-primary care medical or surgical outpatient setting	18	29	0	35	18
Collaborative care with primary care providers	14	29	36	14	7
Telemedicine to provide psychiatric Collaborative Collaborative care with other medical colleagues	20	0	20	0	60

1 Veterans Administration Medical Centers
2 Federally Qualified Health Centers
3 Non-VA, non-Federally Qualified Health Centers
4 Non-VA, non-Federally Qualified Health Centers' medical surgical clinics that are not primary care
5 Includes correctional facilities and juvenile detention centers

These survey data do not allow us to fully appreciate ongoing current efforts. To do so, we would need to query undergraduate curriculum deans. There are some interesting new models of integrated care education for medical students. For example, the University of California at Davis offers a combined medicine/psychiatry elective for their senior students. During a 4-week period, medical students work in a county clinic alongside dual-boarded psychiatry and internal medicine/family medicine faculty to provide medical care for indigent and uninsured patients as well as primary care for

psychiatric patients. While innovative and forward thinking, the paucity of dual-boarded physicians makes this scenario elusive for most medical schools. For most undergraduate educators today, psychiatry is primarily taught in the acute inpatient setting and offers some students the opportunity to join the consultation-liaison team in the hospital.

Some medical school such as Commonwealth University, Dalhousie University in Nova Scotia, Georgia Health Sciences University and University of California at San Francisco offer longitudinal integrated clerkships. These experiences are structured to ensure continuity with the primary preceptor, clinical micro-system, and panel of patients in each clerkship over an extended period of time. They stand in contrast to the traditional block clerkships that occur as one specialty at a time for four to eight weeks and are primarily inpatient-based. Although students rotate through the usual services in this educational model, they follow their patients through the care system and have the opportunity for a bird's-eye view of the degree to which the care is integrated or not. This offers an invaluable learning opportunity in understanding "patient-centered-ness," but does not provide exposure to an effectively functioning integrated care system.

Undergraduate Medical Education Conclusions

Exposure to integrated care for medical students is just the beginning. There are many exciting opportunities for modeling inter-specialty collaboration (discussed more fully in section below), developing team participation skills, and incorporating a population-based framework for understanding illness and care. As the health care system changes to reflect these new values, and clinical services are increasingly organized along these lines, the clinical educational opportunities for medical students will surely improve.

It will be important for undergraduate medical educators to adequately address population-based medicine, behavioral health, and include frequent case material that emphasizes co-morbidity and the opportunities and challenges in collaborating across specialties and professions. Exposure to these new skills for psychiatrists will hopefully respond to medical student concerns about the future of psychiatry and the role of psychiatrists in a transformed health care system and create excitement and recruitment potential. Specific suggestions follow in the Recommendations section below.

Graduate Medical Education (Deborah Cowley, M.D., Claudia Reardon M.D.)

Educational experiences in integrated care for psychiatry residents have been implemented and described in published reports since the 1990s (Kates, 2000; Cowley, et al, 2000; Yudkowsky, 2000; Dobscha and Ganzini, 2001). The number of residency programs offering such experiences has increased in recent years for several reasons.

In this section, we review the results of recent surveys providing information about what residency programs are doing now to teach psychiatry residents about integrated care (Reardon, et al, 2014, 10-12, Burkey, et al, 2014, Annamalai, et al, 2014), types of rotations and didactics offered, clinical settings and supervision, and challenges involved in establishing and maintaining such educational experiences. In addition, we describe best practices and resources that can help in the development of future rotations and didactics, as well as administrative, leadership, and funding issues involved, issues of evaluation, and milestones that can be met through integrated care education.

Core Competencies, Milestones, and Evaluations

There are several skills that psychiatry residents and fellows must learn to work effectively in integrated care settings. These have been articulated in terms of core competencies (Cowley, et al, 2014) and, more recently, Psychiatry Milestones (e.g. Reardon, et al, 2014, AADRPT, 2014, Barkil-Oteo and Huang, 2014). These include providing "curbside" consultation (patients are not evaluated in person or by video), engaging ambivalent patients in mental health treatment and use of brief interventions such as motivational interviewing, problem solving therapy, behavioral activation, and cognitive-behavioral therapy, all of which have proven efficacy in primary care settings (Bell and Zurilla, 2009, Roy-Burne, et al, 2010, Barsky, et al, 2013, Gros and Haren, 2011, Wissow, et al, 2008, Noordman, et al, 2012). In providing primary care to psychiatric patients, lifestyle interventions such as smoking cessation, weight management, and chronic disease management for conditions such as diabetes are important (Annamalai, et al, 2014). Retention of skills in the recognition and treatment of common medical conditions for psychiatrists treating the seriously mentally ill (SMI) population is also an important emerging competency.

Residents must learn to work within the "culture" of primary care. Several authors (Cowley, et al, 2014; Yudkowsky, 2000; Schuyler and Davis, 1999; Brown and Zinberg, 1992) have written about the different "cultures" of psychiatry and primary care. Psychiatric outpatient practice emphasizes regular, scheduled appointments of carefully defined length, clear boundaries, and maintaining the frame of the treatment. Primary care settings are generally more fast-paced, with brief appointments, flexible boundaries, frequent interruptions, and double-booking, adding on, and "squeezing in" additional patient appointments. It is very important for psychiatry residents to learn how to navigate these different "cultures," setting clear expectations for clinic staff and providers while also being responsive. Primary care providers also appreciate prompt, succinct notes and clear recommendations. Residents working in population-based care also need to develop skills in supervising non-psychiatric mental health providers (care managers often trained in social work), assessing their knowledge and skills, and providing guidance and consultation about patients the resident has not personally seen.

It is interesting that the ACGME does not require education of psychiatry residents in preventive and primary medical care beyond the PGY1 year. A recent, small survey suggests that psychiatry residency programs generally do not provide rotations or didactics in this area beyond the PGY1 year, and that residency directors would anticipate resistance from faculty and residents to implementing further training in general medicine (Annamalai, et al, 2014).

Integrated care rotations and curricula provide the opportunity to assess many of the new Psychiatry Milestones. While the milestones most commonly linked with integrated care have been those included in subcompetencies SBP4 (Consultation to non-psychiatric medical providers and non-medical systems) and ICS1 (Relationship development and conflict management with patients, families, colleagues, and members of the health care team), there are several level 3, 4, and 5 milestones across multiple competency domains that are particularly well assessed through these experiences, depending on the type of integrated care rotation (for examples, see Table 5). Although level 1-2 milestones can also be assessed, most integrated care rotations occur later in residency, when the focus is on achieving higher-level milestones.

Table 5: Examples of Advanced Psychiatry Milestones That Can Be Assessed in Integrated Care Rotations

Milestone	Description
PC3/4.1	Devises individualized treatment plan for complex presentations
PC3/4.2	Integrates multiple modalities and providers in comprehensive approach
PC3/5.1	Supervises treatment planning of other learners and multidisciplinary providers
MK2/4.3	Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders
MK2/4.4	Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers
PBLI3/4.1	Gives formal didactic presentation to groups (e.g. grand rounds, case conference, journal club)
SBP4/3.3	Discusses methods for integrating mental health and medical care in treatment planning
SBP4/4.1	Provides integrated care for psychiatric patients through collaboration with other physicians
ICS1/4.1	Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care
ICS1/4.2	Leads a multidisciplinary care team
ICS2/4.1	Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient,

	concise, and pertinent
ICS2/4.2	Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent

Evaluation methods for trainees and faculty are primarily traditional written evaluations, like those used for other residency rotations and didactics. Some of the curricula mentioned above, and some rotations described in the AADPRT compendium, include other evaluation methods such as pre- and post- knowledge tests, self-assessments, 360-degree evaluations by other team members and patients, observed interviews by attendings, patient outcomes, or video simulations to test competencies in telemental health and interventions such as motivational interviewing.

Few studies have evaluated longer-term outcomes of integrated care experiences for psychiatry residents or fellows, such as effects on their career choices and future clinical practice, patient care and outcomes, or attitudes toward psychiatry and patients with mental health problems among primary care providers and staff. Patients at the Portland VA who received both primary medical and psychiatric care from a single Oregon Health Sciences University psychiatry resident reported a high level of satisfaction with their care and showed no differences from matched controls on psychiatric symptom burden, active medical problems, or preventive health screenings over the course of a year (Snyder, et al, 2008). Psychiatry residents completing this elective rotation endorsed greater preparation to address their patients' medical problems and comfort in making medical referrals, but no greater likelihood of performing medical evaluations or providing medical care after graduation (Dobscha, et al, 2005). Residents working in the Yale Psychiatry Primary Care program were more aware of medical comorbidities of their patients and the importance of collaboration with primary care providers, but were no more likely than their peers to choose to provide medical care for their psychiatric patients or to incorporate primary care practices into patient care (Rohrbaugh, et al, 2009).

Surveys Regarding Current Graduate Medical Education in Integrated Care

In May and June, 2014, the American Association of Directors of Psychiatric Residency Training (AADPRT) Integrated Care Task Force conducted a survey on integrated care education (described in detail in Reardon, et al, 2014). Of respondents, 78% of general psychiatry and 72% of Child and Adolescent Psychiatry (CAP) program directors stated that they offered one or more integrated care rotations. Of these, 65% of general psychiatry rotations and 40% of CAP rotations were elective. Most were offered in the senior years of training.

The most common type of integrated care rotation was psychiatric consultation within a primary care clinic, while the least common was provision of both primary care and psychiatric care by psychiatry residents. Ninety-five percent of program directors

reported supervisors for at least some of their rotations were psychiatrists, with 18% having some rotations supervised by dually-trained physicians, 18% by psychologists or social workers, and 16% by primary care physicians. Most supervisors were on site at the same time as the resident. In general psychiatry residency programs, rotations were most commonly offered in VA settings, followed by other primary care clinics, while the most common sites for CAP rotations were Federally Qualified Health Centers. Forty-three percent of programs also offered didactics about integrated care.

Using the most conservative estimate, and assuming that none of the non-respondents offer integrated care experiences, these results indicate that at least 20% of general psychiatry and 23% of CAP programs nationally are offering at least one integrated care rotation.

A separate survey by the American Academy of Child and Adolescent Psychiatry (AACAP), was sent to CAP program directors in June 2013. Forty-three percent of eligible participants responded and 98% of these had an affiliated pediatrics residency program in their institution (Burkey, et al, 2014). Eighty-eight percent of respondents reported that their fellows regularly participated in teaching, clinical care, and/or consultation in a primary care pediatric setting. Forty-four percent reported that fellows performed indirect consultation (i.e. without seeing the patient), 31% reported direct consultation by fellows, and 13% indicated that fellows regularly provided ongoing psychiatric care in a primary care setting. Thirty-seven percent of programs required at least one integrated care rotation. In 63% of programs, fellows taught pediatric residents and 77% provided didactics about integrated care for CAP fellows. Seventy-seven percent disagreed or strongly disagreed that CAP programs are already preparing fellows for changes in health care delivery and 62% reported plans to increase fellows' exposure to integrated care within the next three years. Major barriers were competing clinical demands for fellows and lack of sustainable funding for fellows and faculty to provide indirect consultation to primary care providers.

These results confirm a pattern of increasing interest in, recognition of the importance of, and provision of educational experiences in integrated care for psychiatry trainees, as well as reiterating common concerns about financial sustainability of these health care delivery and educational models.

Integrated Care Education Best Practices

The AADPRT website (www.aadprt.org) Virtual Training Office (accessible to AADPRT members) provides several general collections of best practices and examples related to integrated care education (AADPRT, 2014). These include a list of general and child and adolescent psychiatry residency programs that offer integrated care rotations and curricula, together with information about rotation structure, supervision, challenges, and evaluation; Frequently Asked Questions (FAQs); and a collection of detailed curriculum materials from several residency programs, including rotation and

curriculum goals and objectives, rotation descriptions, slide sets, bibliographies, training manuals, and evaluation forms. These materials are intended to help program directors wishing to implement integrated care rotations and/or curricula. Access to these materials requires an AADPRT login and password.

Below, we discuss some best practices in integrated care education for psychiatry residents and fellows, derived from these AADPRT resources, other online resources, and the published literature.

Rotations and Clinical Experiences

The AADPRT compendium of integrated care experiences includes 33 separate clinical experiences submitted by 25 different programs. Consistent with the AADPRT survey results described above, rotations are primarily co-located psychiatric consultation within primary care settings for senior psychiatry residents. Three are specifically designed for child and adolescent psychiatry fellows and four mention inclusion of psychosomatic medicine fellows in addition to general psychiatry residents. A minority of these programs report offering rotations providing co-located psychiatric consultation in other medical/surgical settings (e.g. oncology, neurology, pain, infectious disease, HIV, cardiology, high-risk obstetrics clinics), population-based collaborative care, telepsychiatry consultation, or primary care medicine delivery by psychiatry residents. Most rotations are half a day to one day per week for one to twelve months.

Several of these rotations feature noteworthy best practices. For example, the University of Washington's Idaho Advanced Clinician Track focuses on working closely with family medicine residents and requires that PGY3 and PGY4 psychiatry residents rotate in the Family Medicine Residency of Idaho Clinic for at least one day per week for two years. This experience includes supervision in health psychology and lifestyle interventions such as smoking cessation and weight loss, as well as a very well-received "PGY4 attending room consultation" component, in which PGY4s are available in the clinic's provider room for curbside consultation and to see patients jointly with family medicine residents. The University of California San Diego (UCSD), Oregon Health and Sciences University (OHSU), and Emory programs offer rotations in which psychiatry residents provide both psychiatric and primary medical care for patients. At Emory, this experience is based in a community psychiatry rotation, emphasizes medical care of seriously and chronically mentally ill individuals, and may involve doing a project (e.g. leading a smoking cessation group, developing lectures or curricula about diagnosis and/or treatment of common medical conditions).

In general, this compendium provides a wide variety of examples of rotations of varying type and duration. For a summary of possible integrated care rotations at different PG years of a general psychiatry residency program, please see Table 6. Of note, optimal timing during residency may vary, depending on the order of rotations and clinical experiences within a particular residency program. However, upper-level residents, or

those with experience in outpatient and consultation-liaison psychiatry, are generally better prepared for integrated care rotations.

Table 6: Potential Integrated Care Experiences and Timing During Psychiatry Training

Integrated Care Experience	**Timing During Residency**
Outpatient primary care, or other primary care rotation focusing on medical problems commonly seen in psychiatric patients	PGY1 (part of four-month primary care requirement) PGY3/PGY4 (preventive and/or primary medical care of psychiatric outpatients, or part of community psychiatry rotation)
Co-located psychiatric consultation	PGY3/PGY4 (prior experience in outpatient and consultation-liaison psychiatry ideal)
Collaborative Care/Population-Based Care	PGY4 (prior experience in co-located care ideal)
Telemental Health	PGY3/PGY4
Integrated Care Didactics	PGY2/PGY3/PGY4

Didactics, Supervision, and Mentoring

The AADPRT resources include a number of approaches to integrated care didactics, including detailed curricula from several residency programs. A basic curriculum regarding collaborative care, consisting of two 60-minute sessions, has been developed at Yale (Barkil-Oteo and Huang, 2014) and is particularly useful for programs unable to provide clinical experiences in this area. The curriculum includes goals and objectives, milestones assessed, a detailed faculty guide and slides for each session, pre- and post-tests, case examples, and references.

Included among the AADPRT resources are training manuals and curricula from Boston University and Loyola University that describe their clinical rotations, with Boston University materials including milestones-based objectives. The Yale Telemental Health training materials describe the telemental health rotation and competencies, and include evaluation forms and references.

An AADPRT Model Curriculum focusing on collaborative care is also publicly available on the website for the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) website (Ratzliff and Basinski, 2014). This curriculum is used as part of

a PGY4 elective collaborative care rotation and provides background readings, didactic sessions with slides, faculty guides, and discussion points. Elements of this curriculum can be used for didactic sessions in programs without integrated care clinical experiences or with clinical rotations that do not include a population-based care component, to teach basic knowledge and skills in collaborative care.

Other approaches to didactic teaching already in place in programs with integrated care rotations include lunchtime, pre-clinic, or post-clinic teaching sessions, case conferences, and/or journal clubs focusing on topics in mental health and primary care medicine. These teaching sessions frequently involve trainees from different disciplines (e.g. psychiatry residents and fellows, residents from primary care or other specialties, trainees from other mental health fields). Some programs have psychiatry and primary care residents teach each other. Other teaching methods include sessions about integrated care within core residency didactics, online modules, and the Loyola University Integrated Care Grand Rounds.

Most supervision in integrated care rotations is provided by psychiatry faculty members, most of whom are physically present in the clinic with the resident. An early study of co-located rotations showed that resident satisfaction was greater when there was a faculty psychiatrist supervisor who had already been working within the clinic as a consultant, and who could provide not only clinical case supervision, but also guidance regarding the administrative, practice style, and interpersonal challenges involved in working as a psychiatrist in primary care settings (Cowley, et al, 2000). Residents providing primary medical care, telemental health services, and population-based collaborative care require a high level of supervision by faculty members with expertise in these areas.

Administration, Funding, and Leadership

In the AADPRT survey (Reardon, et al, 2014), respondents were queried about funding for faculty supervision time, with multiple responses regarding funding sources allowed. Fifty-two percent reported funding by psychiatry departments, 43% by billing revenues generated in the integrated care clinic, 22% by the primary care or other department, and 17% by grants. Several programs included in the AADPRT compendium of example programs and rotations reported a transition of funding from initial grants to intermediate sources of funding through their own or other departments, with an ultimate goal of sustainability through clinical or other billing. Common sources of funding for rotations were the VA and FQHCs. One population-based collaborative care service and rotation was funded by a state contract.

Administration and leadership of integrated care rotations for residents most commonly lies with the residency program director and faculty members supervising the rotation. However, multiple programs commented on the importance of enthusiasm at the level of the other department, leaders and staff of the particular clinic, psychiatry

department leadership, the institution, and the Graduate Medical Education (GME) Office, both for integrated clinical services in general and for including psychiatry trainees.

Challenges

Multiple challenges to the success of integrated care education have been mentioned in the literature and in the surveys described above (Kates, 2000; Cowley, et al, 2014; Yudkowsky, 2000; Dobscha and Ganzini, 2001; Cowley, et al, 2014, Reardon, et al, 2014; Burkey, et al, 2014; Annamalai , et al, 2014). Chief among these have been sustainable financial support, especially for indirect consultation not involving direct face-to-face patient interactions; finding time in the psychiatry residency curriculum; acceptance of this care model by primary care providers, staff, and psychiatry faculty and trainees; availability of qualified psychiatry faculty supervisors; and finding office space within busy primary care settings.

Funding for faculty supervision time has been a major issue, given the patient case mix, no show rate, and poor reimbursement for mental health services in many of these settings. With parity of mental health care reimbursement and the requirements for mental health services within patient-centered medical homes and ACOs, reimbursement for faculty time through billings or by the institution may improve. It is particularly important that psychiatrists working in integrated care be reimbursed for the indirect consultation involved in collaborative care and for telemental health services. The demonstrated cost-effectiveness of collaborative care (Katon and Unutzer, 2011; Katon, et al, 2005) will help to argue for such support at a health system level.

Currently, the ACGME does not require experience in integrated care for psychiatry residents or fellows. It may be difficult to incorporate a new rotation into the residency or fellowship curriculum without such a requirement, given competing demands for trainee time and clinical experiences. Interestingly, the Canadian Psychiatric Association and the College of Family Physicians of Canada have a longstanding partnership in support of collaborative mental health care (Kates, et al, 2011). The Royal College of Physicians and Surgeons of Canada now requires that psychiatry residents spend a minimum of eight weeks in collaborative projects, ideally in primary care.

Many AADPRT members who reported implementing integrated care rotations discussed barriers related to acceptance of integrated mental health care by providers and staff. These included initial lack of enthusiasm for having psychiatrists and/or psychiatry residents in their clinic, a wish to just refer patients to psychiatry and have the psychiatrist assume care of the patient rather than managing mental health problems collaboratively, and issues of lack of office space and differences in scheduling. Some programs reported resistance from psychiatry residents, who preferred ongoing treatment of patients in their outpatient clinic practice to a

consultative model. It may be difficult to find qualified and interested psychiatry faculty members to supervise rotations.

Rotations teaching residents to provide preventive and primary care to psychiatric patients are even more difficult to implement, given the need for both psychiatry and primary care faculty supervisors or dually-trained faculty and the fact that most psychiatrists, including faculty attendings, do not view medical care of their patients as part of their practice. Although it appears clear that psychiatry residents should be educated to ensure adequate medical screening and care of their patients, it is far from clear how such education should be delivered and what the expectations of psychiatrists should be. One study showed enhanced medical care and outcomes of chronically mentally ill patients with the incorporation of nurse care managers to facilitate referrals to primary care, provide health education, and coach patients in communication with primary care providers (Druss, et al, 2010). In models like this, psychiatrists would not need to deliver primary medical care, but would still need to recognize and screen for medical conditions requiring referral.

Graduate Medical Education Conclusions

Significant numbers of general psychiatry and child and adolescent psychiatry residency programs are now offering rotations and/or didactics in integrated care. Rotations primarily involve co-located psychiatric consultation in primary care clinics, but in some cases include consultation in other medical/surgical clinics, population-based collaborative care, telemental health consultation, or delivering primary medical care for psychiatric patients. The VA and Federally Qualified Health Centers often have integrated mental health services amenable to psychiatry residency training. Most rotations are for senior residents or fellows who already have familiarity with and skills in both outpatient and consultation-liaison psychiatry. Multidisciplinary didactics, case conferences, and journal clubs can provide teaching about and modeling of a collaborative, integrated approach and give residents opportunities to teach trainees in other fields. There are also curricula about integrated care that can be used by programs unable to offer integrated care rotations. Integrated care didactics and clinical experiences can be used to assess and meet multiple Psychiatry milestones.

Challenges to integrated care education include finding sustainable funding for faculty supervision time, competing demands for resident time since integrated care education is not required by the ACGME, the need for acceptance of novel care delivery models by faculty and trainees in both psychiatry and primary care, finding qualified psychiatry faculty supervisors, and logistical issues such as office space.

Continuing Medical Education (Kristin Moeller, Mark Rapaport, M.D., Melinda Young, M.D.)

There is a continuing medical education learning gap for psychiatrists, and physicians in general, about collaborative practice, consultation/integrated models of care, and types of team-based care. Up until very recently, solo practice was the primary practice model emphasized in many residency training programs. Thus, neither experienced practitioners nor newly trained psychiatrists are familiar with the new models for health care delivery and/or reimbursement. The learning gap includes both an understanding of the evolving models of care and the skills and tools necessary to be successful in the new clinical settings associated with collaborative practice.

Current State of CME on Integrated Care

There have been a number of important recent developments that have moved the current state of CME forward. The SAMHSA-HRSA Center for Integrated Health Solutions contracted for a set of integrated care and workforce core competencies that would reinforce or enhance the basic competencies of each discipline. The Core Competencies for Integrated Behavioral Health and Primary Care (http://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf) is a useful launching point for determining what psychiatrists need to know now and will need to know in the future when integrated care systems become more established. The recommended competencies include: interpersonal communication, collaboration, and teamwork, screening and assessment, care planning, and care coordination, intervention, cultural competence and adaption, systems-oriented practice, practice-based learning and quality improvement and informatics.

The APA has taken a lead in developing CME on Integrated Care. A recent issue of *FOCUS: Journal of Lifelong Learning in Psychiatry* was on Psychosomatic Medicine and Integrated Care in Fall, 2013, with Deane L. Wolcott, M.D. as the Guest Editor. The APA Department of Healthcare Financing developed the Healthcare Financing Seminar on Healthcare Reform and Integrated Care in Fall, 2013. This training program brought representatives of District Branches up-to-date on this topic with the goal of stimulating District Branches to present the seminar curriculum to their members at local meetings. Primary Care Updates for Psychiatrists, a course chaired by Lori Raney, M.D., with presentations by dual-boarded med-psych physicians was presented at APA meetings and then produced as an Online Course in November 2013. The topics included: Basic Preventive Medicine; Diabetes; High Blood Pressure; Dyslipidemias; Smoking Cessation.

The APA presidents and the Scientific Program Committees of APA meetings have made integrated care a focus. The integrated care tracks at recent Annual Meetings and Institute on Psychiatric Services meetings have included sessions on clinical information, as well as information about collaboration models, systems, and patient risk.

The APA has studied other continuing medical education providers and has determined that CME providers with a large multispecialty audience such as Medscape are in a strong position to offer multidisciplinary and multispecialty continuing education since

their learner group is not specific to a specialty. For example, the *Journal of Clinical Psychiatry* publishes a *Primary Care Companion for CNS Disorders,* a web-based, peer-reviewed, abstracted publication for primary care physicians and other health care professionals.

Although the audience for most continuing medical education programs of American Psychiatric Association is primarily psychiatrists, the Division of Education has begun to make a concerted effort to disseminate its educational products to other fields in order to further the integration of psychiatric knowledge into other specialties. One innovation is that the DSM-5 online course provides credit to most mental health disciplines. Earlier this year, APA worked with the American Association of Physician Assistants (AAPA) to add AAPA credit to physician assistants for APA's Maintenance of Certification (MOC) programs, FOCUS, and APA Performance in Practice Modules.

Challenges

There are some significant challenges in developing CME materials on integrated care. First, there are regional differences in the rate that integrated care models are being introduced. Because the penetration of these care models is limited at present, and focused in a few regions and settings, there is limited motivation and interest among practicing psychiatrists. Second, since integrated care is relatively new, many different models of integrated care are being promulgated. There is substantial convergence in the work of the leaders of the field, but the terminology, best practices and evidence are still emerging.

Third, there is a lack of alignment between MOC requirements, Joint Commission requirements, and what psychiatrists actually need to learn and incorporate into their practices to prepare for the transitions in healthcare. Both the ABPN, through measures of Performance in Practice, and The Joint Commission, through Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), require the assessment and documentation of psychiatrists practice, but at this time the two processes are not synchronized. Thus, the clinician must engage in two separate practice reviews in order to fulfill these related but not identical requirements. Unfortunately, neither of these processes is currently designed to help psychiatrists assess the skills they need to develop to be successful leaders in integrated medicine. There is an opportunity to create a better coordination between Performance in Practice assessments, OPPE and FPPE in order to better meet the need of busy clinicians.

Finally, the electronic medical record may represent an obstacle to the development of integrated care because many psychiatrists still employ paper charts, and many electronic medical record systems either do not contain a module for psychiatry or have a poorly developed one.

Recommended Content of CME Programs on Integrated Care

Raney L, et al (2013) recommended the following essential components for CME Programs on integrated care:

- Understanding of new models of care and encouragement for additional training.
- Updating the knowledge base and skill set in the treatment of common medical conditions to enhance work in collaborative settings.
- Learning how to use rating scales to track progress and adjust treatment when goals are not being met.
- Focus on leadership skills and team building to prepare for new psychiatric roles.

Conclusions:

Psychiatrists recognize the need to learn about integrated care and want the field to develop "user friendly" MOC and Lifelong Learning products to educate them about this new area. APA has taken the lead in this area and developed many valuable programs. There are a number of barriers to the creation and implementation of these products aside from the usual challenges faced by the busy practitioner of time and cost. These include the rapid evolution of the field, the lack of alignment among the various accrediting agencies to which practitioners are subject, and the inadequate integration of psychiatric modules into electronic medical record systems.

Inter-Specialty and Inter-Professional Education and Training (Justin Kuttner M.D., Kristin Kroeger)

Educational Collaboration with Other Specialties

Primary care doctors have risen to the challenge of treating behavioral health problems and this trend has accelerated because more Americans are seeking care following the passage of the ACA and there is a marked shortage of psychiatrists. But, few feel they have adequate clinical training or knowledge about mental health care, including an understanding of the system of care. Collaborative practice models have arisen to meet these needs, but education of psychiatrists about collaborative practice is done almost entirely by psychiatrists and there has been little involvement of primary care physicians, or their organizations, in the process.

These realities presented a clear opportunity for APA to be a leader in establishing cross-educational opportunities for psychiatrists and primary care physicians during residency and throughout their careers. In June 2014, APA convened a meeting with the American Academy of Family Practice (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Academy of Obstetrics and Gynecology (ACOG) to begin discussions about what these organizations are doing to

educate their members about mental health treatment and integrated care models, and consider how APA and these organizations can collaborate on joint education activities.

It became clear at the meeting that all of the national organizations recognized the importance of residency education about mental health care. But, it was also clear that there was little collaboration across organizations in developing educational interventions. They affirmed the need for clinical rotations for their residents in both inpatient and outpatient psychiatric centers and continued exposure to psychiatric diagnosis and management through resident continuity clinics. Some are providing CME activities. AAFP offers a course on behavioral interventions for office-based care along with other educational modules on mental health issues in primary care and family practice. AAP created curricula on behavioral health for training directors and has worked with the American Academy of Child and Adolescent Psychiatry (AACAP) on a number of advocacy initiatives; this has led to the development of a course on psychopharmacology for primary care doctors that is presented at both at AACAP and AAP annual meetings.

The American Academy of Pediatrics has a toolkit for pediatricians on mental health problems along with other materials. The American College of Obstetricians and Gynecologists (ACOG) has materials on 180 topics in mental healthcare for their physicians. Some specialties have developed integrated care programs for specific disorders, such as COPD, or depression and diabetes.

APA's education products in this area include packaging online programs for primary care physicians from presentations at the Institute on Psychiatric Services and planning a pre-annual meeting event for primary care physicians. Neither of these activities has been substantially successful in reaching the appropriate audience. However, the Performance in Practice tools on substance use disorder, depression, and suicide and an eFOCUS program on *Understanding the Evidence: Off Label Use of Atypical Antipsychotics* are APA products that would be useful for primary care physicians, but these are not currently marketed to them.

The major lesson learned from the meeting of primary care specialty organizations was the importance of working hand-in-hand with other organizations to develop educational content. Materials that are authored in collaboration with primary care physicians, rather than repackaged and marketed to them, may be more effective. APA may have an important coordinating role in developing these educational initiatives. Presentations at each other's annual meetings, focusing on multiple areas such as psychopharmacology, diagnosis of specific disorders, management of mental health issues within a practice and when to refer, and service delivery and collaborative care models, would be a good start. For training directors, joint presentations at each other's training directors meetings, and shared and co-authored curricula would be desirable. Although there is an uneasiness and sometimes confusion among each organization's members about recertification demands, there might also be an

opportunity for coordination between specialty boards for approved maintenance of certification products to ensure this is a part of primary care physicians' life-long learning.

Inter-Professional Education

Government, accrediting organizations, and health care delivery systems have placed increasing emphasis on developing curricula to change the way health professionals are educated and trained. Nurses, physicians, psychologists, social workers, other behavioral health clinicians, physical therapists, and speech therapists must learn together if they are to understand each other and work together in a meaningful way. As our health system transitions from a subdivided, fee-for-service system arranged around medical specialties to a more integrated, value-based, and patient-centered system oriented around a patient's specific disease process, increased coordination of care and inter-professional collaboration will be critical to both improving the quality of care and decreasing the cost of managing a population of patients.

To meet this need for coordination and collaboration within our health care system, inter-professional education is seen as one of the critical workforce solutions. If these future health care professionals do not learn together, how will they be able to work together? According to the World Health Organization (WHO, 1988), inter-professional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Inter-professional education is a necessary step in preparing a "collaborative practice-ready" health workforce that is better prepared to respond to local health needs. The Institute of Medicine (IOM, 2003) declared that "health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team." The IOM, as well as many other organizations, have stated that patients receive safer and higher quality care when health care professionals work effectively in a team, communicate productively, and understand each other's roles. While an abundance of evidence exists supporting the need for inter-professional education in health professions schools, it is unfortunately not the norm in most health profession educational programs.

The Liaison Committee on Medical Education (LCME) has finalized standard ED-19-A which states that "The core curriculum of a medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions" (LCME, 2014). It is not enough to think about collaboration and integration within the "house of medicine," but medical students must also be exposed to the other traditionally silo-ed professions such as nursing, respiratory therapy, and occupational therapy amongst many others. The LCME's primary rationale, like that of the WHO and IOM, is ensuring improved patient outcomes, enhanced safety and quality of care.

Psychiatry may be in a natural position to become a leader in inter-professional education within medical schools. Students rotating on an inpatient unit or in an intensive, wrap-around outpatient program are directly exposed to the range of mental health professionals required for the optimal care of a sick individual. For example, case managers are uniquely positioned to teach medical students about the important social determinants of mental health and they can offer insights on how psychosocial interventions can help address these key factors.

Conclusions

Inter-specialty and Inter-professional collaboration will need to be a priority across the continuum of medical education. The integrated care model rests on collaboration among healthcare professionals, cross-fertilization of medical knowledge across specialties, shared technology platforms and new approaches to collecting empirical data. Education about collaboration and collaboration in education will surely improve these essential components of care and specific recommendations about this are found below.

Conclusions and Recommendations (Richard F. Summers, M.D., John Q. Young, M.D., Sandra Sexson, M.D.)

We strongly recommend educating psychiatrists about integrated behavioral health care and responding to the need to train a generation of physicians who can take on clinical and advocacy roles in integrated care. Further, we conclude that all components of the psychiatric education continuum will need to examine their current practices and consider how to incorporate integrated care models and techniques into didactic and clinical training in order to meet this need. We anticipate building excitement and enthusiasm around these new models and developing psychiatrists who are both competent and confident in the provision of these new models of care. We recognize that our conclusions and specific recommendations reflect the view from 2014, and know that we will learn much from greater experience with integrated care models and educating students and practitioners for these roles. These recommendations will surely need to be updated with that additional experience.

The impetus for system change provided by the Affordable Care Act and the impressive data supporting the improvement in cost effectiveness, quality of care and the increased access provided by integrated behavioral health care (especially the collaborative practice model) make this a propitious time for psychiatry to assert its importance in the health care system. To do so, we will need well-trained psychiatrists who are conversant in working in integrated care settings to advocate for well-designed care systems and then staff them when they are created. In most healthcare systems, we are struggling with the “chicken and egg” problem of waiting for reimbursement

reform while wishing to create integrated care systems to address current needs and be ready to take advantage of changes in financing when they do take place.

Before discussing specific recommendations for UME, GME, and CME programs, we will first describe four tensions that must be addressed by educational programs: psychiatric basics versus the new model, culture versus techniques, early versus late, and didactics versus experiential. Each educational program and each institution will surely find their own local responses and solutions to these tensions.

First, there is a tension between the "nuts and bolts" psychiatric skills involved in all direct patient care, including rapport-building, diagnostic interviewing, treatment planning and implementation of biopsychosocial treatments, and the population-based care skills of screening, health maintenance, interdisciplinary collaboration with each clinician providing care "at the top of his/her license," and consultation with and without direct patient contact. No matter how pervasive the development of collaborative practice models, psychiatrists will need substantial experience in direct patient care with longitudinal follow-up, using a wide variety of treatment modalities, including general psychosocial management, psychopharmacology, and psychotherapy.

Medical students will need to learn the fundamental skills of psychiatric care along with their application in integrated care systems. Residents must hone their ability to provide the nuanced diagnostic assessment and multi-modality treatment that some complex patients require. Continuing medical education will be required to help practitioners learn new knowledge about illnesses and their treatment, and refresh their basic medical skills. We expect that integrated care practice will grow substantially, but there will likely continue to be specialty psychiatric clinics, single modality care settings, and private practice care. We must make sure that psychiatrists learn the essential knowledge and skills of our specialty, both broadly and deeply, at the same time that they learn how to deploy those skills in evolving new care settings.

Second, integrated care is both a care model and a set of specific techniques. The attitudes and culture of integrated care involve collaboration, shared responsibility, and more flexible roles for psychiatrists. Education about integrated care must reflect this. Immersion in settings with clinicians who live and breathe these values and have this vision of healthcare is essential. At the same time, the specific techniques of integrated care, including screening tools, decision support software, registries, and educational interventions for patients and other clinicians, are required to make this model work. On each level of the educational continuum, attention will be required to both the model and the tools.

Third, there is a tension between early and late educational attention to integrated care. Medical education is necessarily developmental, and early introduction to ideas leads to increased interest and salience, but simpler ideas and skills are the building blocks for more complex ones. While early introduction to integrated models for medical students

will bring early attention to the importance of collaboration, interdisciplinary communication, population-based thinking, and new important roles for psychiatrists, students must understand psychiatric illness and treatment in order to appreciate the problems the system is designed to treat. Residents will be more respected, and will function with greater confidence in collaborative and interdisciplinary roles when they have the knowledge and confidence about psychiatry to bring to their work. If exposure to integrated care is too late, the "cake is already baked" and trainees are less open, but if it is too early there may be a loss of attention to direct care skills.

Finally, learning about integrated care requires both didactic attention and clinical experience. It is important to understand the evidence supporting the approach, the rationale for the model, and learn about the essential techniques. Of course, actual clinical experience is critical to learning about how integrated actually works. Because it is efficient and fast-paced, the opportunities for real time teaching will have to be planned for and protected. Trainees will need exposure to the ideas and immersion in the integrated care system to fully develop their skills.

Recommendations

We recommend the following steps, taking into account the four tensions we have just described, for educational programs and for the American Psychiatric Association.

Undergraduate, Graduate and Continuing Medical Education programs should:

1. Develop new learning experiences across the medical education continuum that promote the development of knowledge, skills and attitudes necessary to advocate for and provide integrated behavioral healthcare.
2. Make use of the existing resources in this area (referenced throughout this document) to develop new curricula and rotations organized around the specific care settings available, and study the effectiveness of these educational interventions with the goal of improving pedagogy about integrated care.
3. Emphasize inter-specialty and inter-professional education to help trainees and practitioners develop the attitudes and skills necessary for collaborative practice.

Undergraduate Medical Education programs should:

1. Promote a view of medical care, including integrated behavioral health care, as a collaborative, inter-specialty and inter-disciplinary enterprise through the creation of didactic content and early pre-clinical exposure to role models and care systems.
2. Develop early clinical exposure to primary care settings with effective integrated behavioral health to the extent it exists in the available clinical learning settings.
3. Develop clinical case material and simulation experiences that emphasize medical-psychiatric co-morbidity.

4. Engage medical students in a range of activities designed to improve inter-professional and inter-disciplinary communication, beginning in the pre-clinical years, to promote the development of interpersonal and teamwork skills. This should include didactics that emphasize cross-system understanding of pathology, interdisciplinary collaboration and collaborative service delivery.
5. Develop integrated care clinical experiences as part of the Psychiatry Clerkship, when possible, utilizing effective teaching sites where residents, fellows, and attending psychiatrists experienced in integrated care are working.
6. Share experiences about the use of already developed educational resources to promote best use of existing materials, and develop new educational materials for medical students about integrated behavioral health care.
7. Support innovation in rotation design, especially in settings offering integrated behavioral health, and study the educational outcomes of these experiences. Programs should consider the potential for longitudinal educational experiences, which by their nature involve inter-disciplinary and inter-specialty collaborative experiences.
8. Include the psychiatrist's role in integrated behavioral health care in discussions about physician career choice in recruitment activities.

Graduate Medical Education programs should:

1. Develop a comprehensive four-year developmental sequence of educational experiences to prepare residents to provide psychiatric care in integrated settings.
2. Create a didactic experience in integrated care, probably in PGY3 or PGY4 year of residency. A minimal educational experience for a residency would probably be a didactic experience in the later years of the residency.
3. Engage residents in a range of activities designed to improve inter-professional and inter-disciplinary communication, including didactics that emphasize cross-system understanding of pathology, shared clinical case conferences and Grand Rounds, and collaborative service delivery.
4. Provide clinical experience in recognition of and management of common medical conditions, metabolic side effects of psychopharmacologic treatments, causes of early mortality in patients with psychiatric illness, motivational interviewing, and lifestyle interventions such as smoking cessation, and techniques for psychiatrists to ensure adequate primary medical care for their patients.
5. Identify and develop faculty members with interest and experience in integrated behavioral health care to teach didactics, supervise residents, and advocate for collaborative practice in the institution.
6. Focus the majority of clinical experiences regarding integrated care later in the residency when trainees have developed core psychiatric skills.
7. Plan clinical experiences for residents and fellows that arise organically out of existing integrated care settings, rather than attempting to graft rotations for trainees onto clinical services that are functioning without behavioral health input. Co-location, improved primary care and telemedicine settings may be more

available in some institutions currently, while collaborative practice models are less prevalent but expanding. Programs should look to the VA Health Care System, Federally Qualified Healthcare Centers and primary care settings for current clinical learning opportunities and anticipate that more rotation sites will likely develop with further health care system change.
8. Use existing online AADPRT resources on integrated to develop curricula and clinical experiences.

Continuing Medical Education programs should (specific recommendations for the APA regarding CME are in the next section):

1. Develop tools that help practitioners assess whether they have the knowledge to be successful in the new health care environment.
2. Focus on the components of integrated care that are knowledge and skills-based, such as supporting evidence base, screening tools, and registry technology.
3. Develop materials across the range of integrated behavioral healthcare including providing consultation in the primary care setting and addressing the health status of the SMI population.

The American Psychiatric Association should:

1. Continue to champion the integrated care model through advocacy for reimbursement reform to facilitate population-based care, educational outreach efforts, and development of systematic outcome data collection.
2. Pursue partnerships with other specialty professional associations, including the American Psychological Association, to advocate for reimbursement reform to support integrated care.
3. Serve a catalyzing role in promoting communication and collaboration among primary care specialty organizations and continue to promote inter-specialty educational planning meetings. This includes supporting cross-presentation at national meetings and training director collaborations across specialties.
4. Serve a catalyzing role in promoting communication and collaboration among mental health professional organizations to promote inter-professional education.
5. Continue collaboration among Councils working to promote integrated behavioral health care, including the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing.
6. Develop and publicize new CME materials about integrated care on an ongoing basis, and:
    a. Include materials about caring for the health status of the SMI population.
    b. Focus on the components of integrated care that are knowledge and skills-based, such as the supporting evidence base, screening tools, and registry technology.
    c. Include an advocacy focus to support practitioners working in systems that may be considering evolution of service delivery toward this model.

    d. Create tools that can help practitioners assess whether they have the knowledge to be successful in the new health care environment.
7. Update the APA website and provide ample resource materials regarding integrated care, including educational resources and career planning information.
8. Encourage American Psychiatric Publishing to continue to find authors and develop publications on the topic of integrated care.
9. Continue and expand the Integrated and Collaborative Care Track at all APA meetings and insure that a range of topics are covered to provide regular presentations on new research in integrated care.
10. Provide training about integrated care to members through the District Branches.
11. Support flexibility in timing of the four-month primary care requirement in residency to allow for rotations past PGY1 year to count toward the requirement.
12. Advocate for increased inclusion of integrated care skills in the Psychiatry Milestones at the next opportunity for revision.
13. Consider the feasibility of collaborating with representatives from the ABPN and The Joint Commission to determine the potential for reconciliation of expectations about the monitoring of psychiatric practice when psychiatrists are part of integrated care systems.

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Scientific Program Committee of the Institute on Psychiatric Services (SPC-IPS)

Rationale for Change

The rationale for the change in the SPC-IPS Committee structure is to invigorate the committee by involving members from different practice settings and encouraging members from different practice settings and our allied clinicians to come to the IPS meeting. We want to maintain all the positive aspects and bring fresh new ideas to the meeting. The increase in size represents an acknowledgement of the importance of the IPS meeting. The current IPS committee has 6 members. Most councils have 12 members. By comparison, the Annual Meeting SPC currently has 18 members and 7 consultants. The IPS committee is the only committee that has had the unique structure of the "ladder", whereby members move up each year until they become chair in the sixth year. A longstanding concern has been that this rigid structure doesn't allow the APA to react in a timely manner to incorporate new members, which often stimulate fresh ideas. In addition, the President-elect does not have the discretion to make appointments which will impact the meeting held during their tenure as APA leaders. This component should not continue to deviate from the appointment process common to all other components.

Budgetary Impact

The potential budget impact would include funding for additional travel and meeting expenses for the new planning meeting members; the possible loss of registration fees due to the new IPS members receiving complimentary registration; and additional food costs at the IPS committee meetings during the meeting. The current budget for the IPS committee is $12K, taking the above mentioned into consideration, the budgetary impact would be an increase to $27k ($15k more).

Implementation of Proposed SPC-IPS Structure:

Given that planning for the SPC IPS is already underway, it is imperative to move forward as soon as possible after Board approval, to allow the expanded group time to coalesce and work effectively together. Tenure and terms:

Proposed SPC-IPS Revisions and the Effect on Tenures

It should be noted that current members of the committee will retain their appointments. New appointees will have staggered terms of 1, 2, or 3 years

The appointments to the Scientific Program Committee of the Institute on Psychiatric Services (SPC-IPS) will be staggered such that each President-elect will have the same number of appointments each year. The proposal calls for six new members to the Committee and to maintain staggered tenures, two members each must receive a one-year tenure; a two-year tenure and a three-year tenure.

2015-2016 [two members]
2015-2017 [two members]

2015-2018 [two members]

The current 6 members of the Committee currently have staggered tenures as follows:

2009-2015 – Member
2013-2016 – Member
2011-2017 – Member
2012-2018 – Member
2013-2019 – Member
2014-2020 – Member

With the proposed restructure of the IPS SPC, the stagger of the existing 6 positions would be maintained as those currently in the positions rotate off the Committee, as follows:

	New Tenure	Next Term/Reappointment
2009-2015 – Member	2015-2018	2018-2021
2013-2016 – Member	2016-2019	2019-2022
2011-2017 – Member	2017-2020	2020-2023
2012-2018 – Member	2018-2021	
2013-2019 – Member	2019-2022	
2014-2020 – Member	2020-2023	

As detailed above, by 2020 each President-elect will have 4 member appointments to make to the proposed twelve member Committee.

Proposed Revision to SPC-IPS Charge

Scientific Program Committee of the Institute on Psychiatric Services: The Committee meets in-person three times during the year to select the program for the meeting, which is held each fall. The first meeting is held at the time of the prior year's meeting, where the incoming chair and members of the Committee, who were appointed or reappointed on September 1, begin planning the next meeting. Also during the meeting, the Committee for the current meeting meets daily to review any programmatic issues, assist in monitoring sessions, and fill any vacant roles of introducing speakers. The second in-person meeting is usually held in late January to select the scientific program. The Committee also meets for a third time during the APA Annual Meeting to finalize arrangements, speakers, and programmatic issues. The APA CEO and Medical Director assigns a staff member to serve as the APA Administration Liaison to the Scientific Program Committee. He/she has responsibility for coordinating Program Committee plans and providing staff support necessary to carry them out. His/her office serves as a communications center of the operation. He/she is assisted by other APA Administration, including the CME Conference Manager. The Director of the Meetings and Conventions Department oversees the staff support for logistics, registration, and exhibits, which includes a Senior Meeting Planner, Associate Director for Registration, the Associate Director for Exhibits, and the Meetings Assistant.

Composition: Twelve members and 2 consultants (including advocacy representative and a local member), three liaisons (APA Fellow, a representative from *Psychiatric Services* Journal, and the chair or a member of the Annual Meeting Scientific Program Committee.) Each member serves three years and may be reappointed for an additional three year term, not to exceed a total of six years. Each consultant and liaison serve one-year terms and are appointed annually. The composition of the Committee should include diverse members who work in various practice settings, including, but not limited to, community-based, collaborative/integrated care practices, administration, and/or public funded systems and centers. New members are appointed no later than September 1 of each year, by the President-Elect (who will be

President at the time of the Meeting for which those appointments will serve), beginning his/her term in the October of the President-Elect's year and serving a three-year term. The chair of the Committee will be appointed or reappointed annually by the President-Elect.

History: Established 1949; name changed 1994 and 1999; restructured May 2002; composition revised December 2004.

ACTION: Will the Board of Trustees vote to approve the revised composition and charge to the Scientific Program Committee of the Institute of Psychiatric Services?

APA OPERATIONS MANUAL- Current and Red-lined versions of SPC-IPS charge

Scientific Program Committee of the Institute of Psychiatric Services: The committee meets two times during the year to select the program for the institutes, which are held each fall. The first meeting is usually held in January to select the Scientific Program. The second meeting is held at the time of the Institute when members assist in monitoring sessions, introducing speakers, and filling faculty roles. The committee meets informally during the Annual Meeting. The Medical Director has designated the Director of the Division of Education and Career Development to serve as Executive Secretary of the Institute. He/she has responsibility for coordinating Program Committee plans and staff support necessary to carry them out. His/her office serves as a communications center of the operation. He/she is assisted by APA staff, which includes the Director of the Annual Meetings Department, the Associate Director of the Institute, the CME Course Coordinator, the Administrator for Commercially-Supported Activities, the CME Program Administrator, the Registrar, and the Exhibits Manager. The expenses of the Program Committee (including attendance at the Institute) are included in the budget for the Institute, which is self-supporting through fees for registration, CME courses, industry-supported symposia, and exhibits. The committee counts as two committees for budget purposes.

Composition: Six members, with one six-year tenured member appointment made annually, two consultants (Advocacy representative and Local Arrangements), and three liaisons (APA/BMS Fellow and representative from *Psychiatric Services* Journal). Each member serves six years, the last of which is as chairperson of the committee. The new member is appointed in the summer by the President-Elect (who will be President at the time of the Institute for which those appointments will serve), beginning his/her term in the October of the President-Elect's year and serving a six-year term. (This tenure structure will take effect with the 2005 Presidential appointment cycle and the IPS SPC appointments that will be made in July 2004.)

History: Established 1949; name changed 1994 and 1999; restructured May 2002; composition revised December 2004.

Redline Version

Scientific Program Committee of the Institute of Psychiatric Services: The committee meets in-person ~~two~~ three times during the year to select the program for the meeting ~~Institute~~, which ~~are~~ is held each fall. The first meeting is ~~usually held in January to select the Scientific Program. The second meeting is~~ held at the time of the prior year's meeting, ~~Institute when~~ where the incoming chair and members of the Committee, who were appointed or reappointed on September 1, begin planning the next meeting. Also during the meeting, the Committee for the current meeting meets daily to review any programmatic issues, assist in monitoring sessions, and fill any vacant roles of introducing speakers. The second in-person meeting is usually held in late January to select the scientific program. The Committee

also meets for a third time during the APA Annual Meeting to finalize arrangements, speakers and programmatic issues. ~~members assist in monitoring sessions, introducing speakers, and filling faculty roles. The committee meets informally during the Annual Meeting.~~ The APA CEO and Medical Director assigns a staff member to serve as the APA Administration Liaison to the Scientific Program Committee. ~~has designated the Director of the Division of Education and Career Development to serve as Executive Secretary of the Institute.~~ He/she has responsibility for coordinating Program Committee plans and staff support necessary to carry them out. His/her office serves as a communications center of the operation. He/she is assisted by other APA ~~staff~~ Administration, ~~which~~ includinges the CME Conference Manager. ~~the Director of the Annual Meetings Department, the Associate Director of the Institute, the CME Course Coordinator, the Administrator for Commercially-Supported Activities, the CME Program Administrator, the Registrar, and the Exhibits Manager. The expenses of the Program Committee (including attendance at the Institute) are included in the budget for the Institute, which is self-supporting through fees for registration, CME courses, industry-supported symposia, and exhibits. The committee counts as two committees for budget purposes.~~ The Director of the Meetings and Conventions Department oversees the staff support for logistics, registration, and exhibits, which includes a Senior Meeting Planner, Associate Director for Registration, Associate Director for Exhibits and the Meetings Assistant.

Composition: Twelve ~~Six~~ members and ~~with one six-year tenured member appointment made annually,~~ two consultants (including advocacy representative and local member ~~arrangements~~), ~~and~~ three liaisons (APA~~/BMS~~ Fellow, ~~and~~ representative from *Psychiatric Services* Journal, and the chair or a member of the Annual Meeting Scientific Program Committee). Each member serves three years ~~six years~~ and may be reappointed for an additional three-year term, not to exceed a total of six years. Each consultant and liaison serve one-year terms and are appointed annually. The composition of the Committee should include diverse members who work in various practice settings, including, but not limited to, community-based, collaborative/integrated care practices, administration, and/or public funded systems and centers. New members are appointed no later than September 1 of each year by the President-elect ~~the last of which is as chairperson of the committee. The new member is appointed in the summer by the President-Elect~~ (who will be President at the time of the ~~Institute~~ Meeting for which those appointments will serve), beginning his/her term in the October of the President-elect's year and serving a ~~six-year~~ three-year term. ~~(This tenure structure will take effect with the 2005 Presidential appointment cycle and the IPS-SPC appointments that will be made in July 2004.)~~ The chairperson of the Committee will be appointed or reappointed annually by the President-elect.

History: Established 1949; name changed 1994 and 1999; restructured May 2002; composition revised December 2004.

Report of the Membership Committee
Executive Summary

1. DB/SAs Competitive Grants Overview

   Will the Board of Trustees approve the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report?

2. International Resident-Fellow Members

   Will the Board of Trustees approve the recommendation of the Membership Committee to establish a new category of International Resident-Fellow Members for applicants who meet the following criteria?
   - Physicians enrolled in an accredited residency training program in psychiatry or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, which is verified by the training program director. International Resident-Fellow Member status shall not exceed ten years, and upon completion of approved residency training, members shall be advanced to International Membership.

3. Lump Sum Dues Option for Internationals

   Will the Board of Trustees approve the recommendation of the Membership Committee to approve the concept of offering lump sum dues rates to International Members (Fellows and Distinguished Fellows) and request that the Finance & Budget Committee propose specific amounts to the BOT for approval?

4. Dues Payment Policies

   Will the Board of Trustees approve the following recommendations of the Membership Committee to change the dues policies as outlined below, effective with the 2016 dues year (recommend approving all items below as a package since each idea is inter-reliant on all the other ideas together):

   4.1. Change the payment deadline to March 31;
   a. reaffirm that the current administrative reinstatement period of six months be continued (full year of dues must be paid to be administratively reinstated retroactive to March 31);
   b. declare the first quarter of the year as a grace period; dropped members will not have any dues obligation in the first quarter in order to reinstate, unless they do so during the administrative reinstatement period; *after* the administrative reinstatement period, payment of future dues (only) will be required.

   4.2. Require new and reinstating members to pay dues in advance, prior to enrollment (new members) or reinstatement (former members);

4.3. Offer final Dues Amnesty Program:
a) extend to the approximate 750 psychiatrists who have received it in the past;
b) extend to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty, and
c) allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in a new DB jurisdiction), even if dues are owed to the former DB (i.e., because it doesn't offer amnesty).

5. Fellowship Applications

Will the Board of Trustees vote that the Members listed in Attachment F be approved for Fellowship and Life Fellowship?

6. International Fellowship Applications

Will the Board of Trustees vote that the Members listed in Attachment G be approved for International Fellowship?

7. Distinguished Fellowship Nominations

Will the Board of Trustees vote that the Members listed in Attachment H be advanced to Distinguished Fellow or Distinguished Life Fellow?

8. International Distinguished Fellowship Nomination

Will the Board of Trustees vote to approve the nomination listed in Attachment J for International Distinguished Fellow of the APA?

9. Dropping of Members – Membership Terminated by APA (off cycle)

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment M for failure to meet the requirements of membership?

10. Dropping of Members – Membership Terminated by District Branches

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment N, who have been dropped by their district branches?

11. International Membership

Will the Board of Trustees vote to approve the applicants listed in Attachment O for International Membership?

12. Dues Relief Requests

Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment P?

**Report of the Membership Committee
to the APA Board of Trustees**

Rahn K. Bailey, M.D., D.F.A.P.A., Chairperson

The Membership Committee met October 17-19, 2014 to discuss a variety of membership issues, which are highlighted in this report.

PRESENT: *Members:* Rahn K. Bailey, MD, DFAPA (Chairperson), William Arroyo, MD (Vice Chairperson), Jonathan M. Amiel, MD, Karon Dawkins, Elizabeth A. Morrison, MD, Joseph E.V. Rubin, MD, Emily S. Stein, MD, Megan E. Testa, MD; *Consultants:* Teri Harnisch, Robin Huffman, David Safani, MD, MBA; *Corresponding Members:* Kenneth G. Busch, MD; *Staff:* Susan Kuper, Louise Martin, Yolanda Brunson, Jon Fanning, Ricardo Juarez, Mia Smith

UNABLE TO ATTEND: *Members:* Carol A. Bernstein, MD, Nioaka N. Campbell, MD, Ana E. Campo, *Corresponding Member:* Vihang N. Vahia, MD

Membership Transaction Activity in 2014

- New Medical Student Members total 1,230 through October 2014, as compared to 871 through October 2013.
- New and reinstating Resident-Fellows Members total 1,413 through October 2014, as compared to 1,564 through October 2013.
- New and reinstating General Members total 1,411 through October 2014, as compared to 1,378 through October 2013.
- New and reinstating International Members total 644 through October 2014, as compared to 335 through October 2013.
- Resident-Fellow Members advancing to General Member status total 907 through October 2014, as compared to 942 through October 2013.
- Medical Students advancing to Resident-Fellow Member status total 219 through October 2014, as compared to 173 through October 2013.
- District Branch transfers total 717 through October 2014, as compared to 722 through October 2013.

Attachment A shows an annual comparison of dues-paying and dues-exempt membership categories from January 2004 through January 2014, as well as monthly comparisons in 2014 through October. Attachment B shows gains and losses by membership class for all membership transactions in the month of October 2014, as well as year-to-date totals. This includes new members, reinstatements, drops, resignations, deceased members, as well as changes from one membership category to another (i.e., Resident-Fellow Member to General Member advancements or Life Member to Inactive Member status). Attachment C shows an annual comparison of membership totals by Area and District Branch from January 2011 through January 2014 and October 2014. During the period between 2011 and 2014, APA had an overall 1.9% increase in membership; three Areas also had an increase (4, 5 and 7). Since the start of 2014, APA has had an overall increase of 3.7% and all but two Areas (3, 5) have also had an increase.

DB/SAs Competitive Grants Overview
The APA Board of Trustees (BOT) voted to allocate $180,000 in the 2014 fiscal year in Competitive grant awards to District Branches and State Associations (DB/SAs). The grant funding is divided into two categories specifically, Expedited and Innovative funds. The APA Membership Committee is tasked with the responsibility to review submissions for grant funding and make recommendations to the BOT. Of the monies allocated, $150,000 is ear marked for the Expedited grants and the remaining funding of $30,000 for the Innovative grant.

The Membership Committee is charged with administering the process, reviewing submissions and making recommendations to the Board of Trustees. The first grant category, *Expedited* grants is a total grant amount of $150,000. This year, we had a total of 55 grantees with awards totaling $149,985. To date, 49 grants totaling $133,623.00 have been dispersed, three states repealed their award, and three distributions are pending receipt of the grant agreement as determined by the grantor and grantee. Therefore, the remaining disbursement amount is approximately $8,316.

The second category*, Innovative* grants had an original total of seven submissions. Of the seven submissions, six applicants are being recommended by the Membership Committee to receive grants totaling $30,000. The following is a summary of the Innovative grant submissions. There were four applicants seeking $5K, two applicants seeking $10K, and one applicant seeking $15K. Due to the timing of an appointment to a leadership position on the Membership Committee, the DB/SA grant submission for $15K was retracted from consideration by the applicant. Yet, the grant request is reflected in this report as a point of information. However, the total number of grant submissions to be considered is six. A summary of the grant submissions, as well as the review and scoring process, is provided in Attachment D.

As previously mentioned, the available funding for the 2014 Innovative grant is $30,000. Grant submission requests totaled $40,000. Upon completion of scoring, and deliberation among the Committee members, the Committee recommends the following DB/SAs receive Innovative grant awards as follows:

1. New York County Psychiatric Society $ 5,000
2. Society of Uniformed Services Psychiatrists $ 5,000
3. Psychiatric Society of Virginia $ 5,000
4. Minnesota Psychiatric Society $ 5,000
5. North Carolina and Florida Psychiatric Associations $10,000

Will the Board of Trustees approve the recommendation of the Membership Committee that the $30,000 for the DB/SA Competitive Grant funds be awarded as listed on page 4 of the committee's report?

International Dues-Related Issues
Elizabeth Morrison, MD, Chair of the International Dues-Related Workgroup, reported to the committee on the workgroup's summer meeting, where they discussed a variety of issues including new membership categories for international medical students and residents, lump sum dues options for internationals, industry sponsorship for internationals, increasing membership, and a few other items.

International Resident-Fellow Members
The idea to establish a category of membership for international residents was introduced a few years ago by a member of the Board of Trustees. At the time, the committee discussed concerns that some countries do not have an accrediting organization similar to the ACGME and therefore the quality of training throughout the world varies and is not fully understood. The workgroup and committee noted that applicants for International Membership are required to provide information about psychiatry residency training, but the information is not vetted (documentation of the applicant's medical license must be provided). Several medical specialty societies offer membership for international residents, including the American College of Physicians, American Academy of Ophthalmology, American Urological Association and the American Academy of Family Physicians. The length of time required to train varies and at least two organizations allow international residents to continue in the category for up to 10 years. Most also require the residency program director to verify that the resident is in good standing. Membership dues for U.S. and Canadian residents are 18% of the full member rate. It is recommended that the same formula be used for international residents, if the category is approved. The Membership Committee unanimously approved the recommendation of the workgroup to establish a new membership category for international residents and fellows.

Will the Board of Trustees approve the recommendation of the Membership Committee to establish a new category of International Resident-Fellow Members for applicants who meet the following criteria?

- **Physicians enrolled in an accredited residency training program in psychiatry or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, which is verified by the training program director. International Resident-Fellow Member status shall not exceed ten years, and upon completion of approved residency training, members shall be advanced to International Membership.**

If approved, the category description must be added to the Bylaws by the Bylaws Committee, with changes to the Bylaws approved by the Board of Trustees and ratified by the Assembly. The Finance and Budget Committee should recommend dues rates to the Board of Trustees for approval.

Lump Sum Dues
The idea of allowing international members to pay one fee to cover their lifetime of membership was introduced a few years ago for the Membership Committee to explore. The Lump Sum dues rates for U.S. and Canadian members are determined by a complex set of factors using actuarial and other data that varies from one country to another. The Membership Committee agreed to move forward with a recommendation to the Board of Trustees that a Lump Sum Dues option be offered to international members and suggested that the Finance & Budget Committee recommend proposed amounts for approval.

Will the Board of Trustees approve the recommendation of the Membership Committee to approve the concept of offering lump sum dues rates to International Members (Fellows and Distinguished Fellows) and request that the Finance & Budget Committee propose specific amounts to the BOT for approval?

The APA received an inquiry from a pharmaceutical company that was potentially interested in sponsoring memberships of psychiatrists who live outside the U.S. and Canada. Although there was ultimately no follow through with the inquiry, the general idea was discussed by the committee. There was no support for having industry sponsored memberships in the APA. The Council on International Psychiatry also did not support this idea.

Dues Payment Policies
William Arroyo, MD, Chair of the Dues Payment Policies Workgroup, reported to the committee on the workgroup's summer meeting. The workgroup was tasked with reviewing policies regarding dues payments for current members, dues obligations for lapsed members who want to reinstate, and dues amnesty and making recommendations for improvement. The workgroup met during the summer and developed a series of recommendations that, if approved as a package, would decrease the length of time members are carried on the rolls without paying dues and would allow for a smoother transition to rejoin the association at a later date. The workgroup's ideas were sent to the District Branch/State Association (DB/SA) Presidents and Membership Committee Chairs by Drs. Bailey and Arroyo to solicit their feedback. The workgroup's ideas were also sent to the DB/SA Executives by Ms. Harnisch and Ms. Huffman, DB/SA Executives who are Consultants to the Membership Committee and who were also members of the workgroup. The Membership Committee considered a series of ideas that, if implemented, would improve membership processing, create more clarity for members and remove barriers for those who want to reinstate. Overall, the Committee anticipates that with the establishment of a reasonable final dues payment deadline and a process that no longer requires the management of dues amnesty, there will be improvements in member retention.

1. ***Dues Payment Deadline: Change from June 30 to March 31:*** The Membership Committee recommends that members must either pay dues in full or enroll in the Scheduled Payment Plan by March 31 to avoid being dropped. Continued exceptions will be made for members paying with employer funds that are not available until after March 31.

   Note: the membership renewal cycle begins in October, before the first of the year, so members would have a full six months to receive dues notices and email reminders before the deadline. To accommodate this change, APA would also start retention efforts, including the national calling program with the outside vendor, much earlier in the year.

   a. Rejoining During the Administrative Reinstatement Period: Continue with current policy.
   The Administrative Reinstatement period is the time immediately following the drop action, during which dropped members who pay the full yearly dues are automatically added back to the membership rolls with continuous membership (e.g., membership ends March 31, membership re-starts April 1). *The Membership Committee reaffirmed that the current administrative reinstatement period of six months should be continued.*

   b. Rejoining <u>After</u> Administrative Reinstatement Period: Pay Only Future Dues to Reinstate (no requirement to pay dues for the first quarter)
   Beginning October 1, lapsed members can re-join again at any time, by paying in advance a quarterly pro-rated dues amount for the remainder of the year (reinstatements

in the last quarter are required to also pay the following year in advance). Under the proposed policy, *the Membership Committee recommends that the first quarter of the year would be treated as a grace period and the member would only be required to pay the current year's dues in advance in order to reinstate after the Administrative Reinstatement period.*

Changing the dues payment deadline, offering a true grace period, and revising amnesty guidelines (as proposed below) will eliminate the need to have to re-visit amnesty in the future because it won't be needed (assuming the recommendation below is approved).

2. New and Reinstating Members: Collect Dues in Advance Prior to Enrollment or Reinstatement instead of billing them later.

Dues are currently not collected from membership applicants in advance. New members are added to the membership rolls and then sent a dues invoice at a later date. If new members don't pay, they become part of the dues drop cycle. Requiring payment of dues in advance will avoid the need to drop new members for non-payment later in the year.

Note: Most new members are Resident-Fellow Members and APA dues are waived for the year (and all but six DB/SAs waive RFM dues). Reinstating members must pay back dues to reinstate, but future dues are not collected in advance, unless members are reinstating through dues amnesty (more information about amnesty is provided below). *The Membership Committee recommends that new and reinstating members be required to pay dues in advance, prior to enrollment (new members) or reinstatement (former members).*

3. Dues Amnesty: Continue Program with Changes

Background: Over ten years ago, the Board of Trustees approved a recommendation from the Membership Committee to offer dues amnesty of APA dues to former members if they met the following criteria: the district branch offers amnesty, the former member had been lapsed from membership for more than a year, dues are paid in advance for the current year prior to reinstatement, and dues amnesty has never been granted in the past. Approximately 3,000 lapsed members have reinstated in the past 10+ years with the one-time dues amnesty offer; approximately 75% are still active members. About 750 are no longer members and most likely owe back dues. Almost all of the district branches offer dues amnesty and of the six that do not, they generally review requests to waive back dues on a case by case basis.

In order to remove any financial barriers to former members wanting to reinstate, the *Membership Committee recommends that dues amnesty guidelines be revised one final time with the following changes to the current policy:*

a. *extend to the 750 (approximately) psychiatrists who have been granted amnesty, but were later dropped for non-payment, with the understanding that reinstating members will never need amnesty again because if dues are not paid by March 31, they will be dropped without a dues obligation to reinstate in the future;*

b. *extend dues amnesty to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty;*
c. *allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in a new DB jurisdiction), even if dues are owed to the former DB because it does not offer amnesty.*

Note: The Committee acknowledges that the six District Branches not offering dues amnesty are essentially following APA policy that was put in place many years ago that states former members who apply for reinstatement are responsible for all past District Branch dues. However, after realizing the positive impact the Dues Amnesty program has had over the past ten years for the overall membership, the Committee wants to extend amnesty to former members in the six District Branches that have not yet been given the opportunity to re-join with a clean slate. APA has been very successful recruiting former members who appreciate the ease of re-joining without the burden of back dues. The Committee wants to welcome this group of former members back into the organization. Not being able to do so results in long-term lost revenue and, in some cases, is a source of animosity.

If the above noted recommendations are implemented, members who do not pay dues by March 31 or enroll in the Scheduled Payment Plan will be dropped from the membership rolls and will not owe dues in the future if they want to re-join the association (unless it's immediately following the drop action during the administrative reinstatement period). If dues amnesty is extended to those who have received it in the past, it would be for the final time because members dropped in the future would not have a dues obligation to pay in order to reinstate.

It should also be noted that while there was general support for many of the ideas, several district branches expressed concern about the potential loss, although likely temporary, of members with the earlier payment deadline. Although a temporary loss of members will likely occur in the first two years until members get used to the change, we will likely be able to gain back most of them based on past experience with the drop date and reinstatement period. Questions were asked about what additional steps will be taken to retain members within the shorter timeframe in which to pay dues. The APA is planning to roll out member value that is intended to more easily demonstrate the value of membership. Several of the district branches that do not offer dues amnesty expressed concern about extending dues amnesty to those who have received it in the past or permitting former members to reinstate into a new district branch if outstanding dues to the former branch have not been paid However, the Membership Committee voted to move forward with the recommendations outlined below to go into effect with the 2016 dues year. They determined that, in the long run, these recommendations would simplify the process for our members and have a positive impact on membership.

Will the Board of Trustees approve the following recommendations of the Membership Committee to change the dues policies as outlined below, effective with the 2016 dues year (recommend approving all items below as a package since each idea is inter-reliant on all the other ideas together):

1. **Change the payment deadline to March 31;**
   a. reaffirm that the current administrative reinstatement period of six months be continued (full year of dues must be paid to be administratively reinstated retroactive to March 31);
   b. declare the first quarter of the year as a grace period; dropped members will not have any dues obligation in the first quarter in order to reinstate, unless they do so during the administrative reinstatement period; *after* the administrative reinstatement period, payment of future dues (only) will be required.

2. **Require new and reinstating members to pay dues in advance, prior to enrollment (new members) or reinstatement (former members);**

3. **Offer final Dues Amnesty Program:**
   a) extend to the approximate 750 psychiatrists who have received it in the past;
   b) extend to former members who belonged to one of the six district branches that do not offer amnesty and therefore had not been eligible for APA dues amnesty, and
   c) allow former members from the six district branches that do not offer amnesty to reinstate into a different district branch (if they live or work in a new DB jurisdiction), even if dues are owed to the former DB (i.e., because it doesn't offer amnesty).

Other Dues Related Items

Lump Sum Dues Options – U.S. and Canada

The Membership Committee reviewed the new calculations for the current U.S. rates for the lump sum dues program and suggested that the Finance & Budget Committee weigh in on the proposed changes. The Committee also reviewed the proposal to offer the program to Canadian members, but did not take action other than to suggest that the Finance & Budget Committee weigh in on the proposed amounts.

Dues Increases for Future Years

Following up discussion at the May meeting, the Committee discussed whether there should be a recommendation to automatically increase dues on an annual basis based on the rate of inflation. Most committee members did not support having an automatic increase. They would prefer that the Board of Trustees have a discussion each year about whether dues should be increased.

Membership Recruitment and Retention Activities

Louise Martin, Associate Director of Membership Development, reported on the various recruitment and retention activities implemented by the APA Membership Department since the last committee meeting. General promotions included the Annual Meeting rebate program, Fellowship and International Fellowship, Inalink Calling Program to members at risk, "Know the Facts About APA Membership" campaign, and the DB/SA Resource support program. She also highlighted efforts to recruit Resident-Fellow Members through the 100% Club, efforts to retain Early Career Psychiatrists through the Members-in-Transit calling program, and efforts to recruit

International Members through the International Membership Ambassador Program. Information about the above mentioned items and other projects are detailed in Attachment E.

Fellowship Applications
There were 1,057 applications for Fellowship this year representing applicants from 70 District Branch/State Associations (DB/SAs).The names of all Fellowship applicants were provided to the DB/SAs in September for the 30-day comment period. Only a few responded with comments, but those that did had positive, supportive comments about the applicants. The Membership Committee discussed whether an application from a Resident-Fellow Member should be approved and agreed that since the 5-year General Member requirement was removed by the BOT a few years ago, the only requirement is that the applicant be board certified. Therefore, the committee agreed that the RFM is eligible for Fellowship, as are two General Members who will be entering subspecialty fellowship training in 2015. The Membership Committee voted that all 1,057 applications for Fellowship be approved (from 973 General Members, 82 Life Members, 1 Resident-Fellow Member, and 1 Inactive Member).

> **Will the Board of Trustees vote that the Members listed in Attachment F be approved for Fellowship and Life Fellowship?**

International Fellowship Applications
This is the second year of eligibility for the new membership category of International Fellowship. There were 282 applications submitted from members and applicants from 58 countries.

> **Will the Board of Trustees vote that the Members listed in Attachment G be approved for International Fellowship?**

Distinguished Fellowship Nominations
This year the Committee received 129 nominations for Distinguished Fellowship from 43 District Branch/State Associations. Each nomination was assigned a preliminary, secondary, and tertiary reviewer who received the nominations in August to score in advance of the Committee's meeting. The reviewers submitted their scores which were then compiled by staff to determine which nominations would be reviewed at the meeting. Nominations that scored below the threshold of 25 points and 5 categories were reviewed and discussed by the Committee. Of the 129 nominations, 128 were approved (from 37 General Members, 77 Fellows, 3 Life Members, and 11 Life Fellows listed in Attachment H) and 1 was deferred (Attachment I).

> **Will the Board of Trustees vote that the Members listed in Attachment H be advanced to Distinguished Fellow or Distinguished Life Fellow?**

The committee also agreed to re-visit the Guidelines for Distinguish Fellowship and the scoring criteria for clarity. A small work group was formed with Drs. Busch, Rubin, Safani and Stein and Dr. Safani serving as the chairperson.

International Distinguished Fellowship Nomination
The Committee reviewed and approved 1 nomination for International Distinguished Fellowship listed in Attachment J.

Will the Board of Trustees vote to approve the nomination listed in Attachment J for International Distinguished Fellow of the APA?

Resignations
With the authorization of the Board of Trustees, the Medical Director has regretfully accepted the resignations of 22 members listed in Attachment K (August 1 – October 31, 2014).

Medical Student Members Whose Memberships Have Expired
Medical Student Members who have graduated in 2014 are listed in Attachment L (n=591) and will have their memberships expire on December 31, 2014, since they are no longer eligible for medical student membership.

Membership Processing Action Items
Dropping of Members – Membership Terminated by APA (off cycle)

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment M for failure to meet the requirements of membership?

Dropping of Members – Membership Terminated by District Branches
It is a requirement that a member must belong to both the APA and his/her local district branch. The Membership Department has been notified that the members listed in Attachment N have been dropped by their district branches. These members are no longer eligible for membership in the APA and must be dropped.

Will the Board of Trustees authorize dropping from APA membership the Members listed in Attachment N, who have been dropped by their district branches?

International Membership
From August through October, 39 applications for International Membership were reviewed and approved by Membership staff. The applicant names are provided in Attachment O for the Board's approval.

Will the Board of Trustees vote to approve the applicants listed in Attachment O for International Membership?

Dues Relief Requests
The Membership Committee reviewed 16 requests for dues relief (see Attachment P) and recommends that:

9 dues waivers be approved
13 dues reductions be approved
9 transfers to Permanent Inactive Member/Fellow status be approved

Will the Board of Trustees vote to approve the Membership Committee's recommendations on the due relief requests as listed in Attachment P?

Respectfully submitted,

Rahn K. Bailey, M.D., D.F.A.P.A.
Chairperson, APA Membership Committee

Comparison of Membership Totals 2004 - Present
Dues-Paying and Dues-Exempt Membership Categories

Number of Members in Dues-Paying Member Categories

Mbr Class	Jan-04	Jan-05	Jan-06	Jan-07	Jan-08	Jan-09	Jan-10	Jan-11	Jan-12	Jan-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
RFM	4,559	4,129	4,370	4,339	4,357	4,432	4,249	4,187	3,725	3,939	4,396	4,541	4,663	4,792	4,830	4,708	3,561	3,827	4,047	4,233
GM	16,069	15,545	15,486	15,433	15,552	15,335	14,947	14,136	13,366	13,116	12,666	12,777	12,938	13,154	13,227	13,510	13,013	13,135	13,207	13,314
DF	2,481	2,257	2,072	2,032	1,996	1,910	1,777	1,642	1,552	1,482	1,425	1,426	1,423	1,424	1,424	1,424	1,400	1,402	1,405	1,405
FE	779	886	934	1,045	1,039	1,210	1,406	1,587	2,010	2,177	2,620	2,624	2,628	2,636	2,640	2,641	2,570	2,576	2,579	2,583
AM	13	13	11	9	6	6	4	3	3	3	1	1	1	1	1	1	1	1	1	1
LM	1,790	1,819	1,874	1,908	2,023	2,060	2,133	2,185	2,135	2,167	2,125	2,124	2,117	2,115	2,115	2,115	2,021	2,026	2,027	2,028
DLF	1,491	1,591	1,636	1,657	1,651	1,656	1,625	1,656	1,638	1,640	1,597	1,595	1,591	1,592	1,592	1,591	1,572	1,571	1,569	1,568
LF	43	78	101	155	198	286	355	406	550	609	668	668	668	668	667	667	652	652	653	653
LA	30	24	21	16	17	12	6	6	5	4	4	4	4	4	4	4	3	3	3	3
IMBR	1,100	1,251	1,213	1,363	1,531	1,582	1,693	1,515	1,388	1,424	1,525	1,613	1,729	1,842	1,935	1,941	1,752	1,760	1,772	1,798
IFE	62	62	62	63	62	59	53	46			147	147	147	148	148	148	145	145	145	145
IDF									49	64	68	68	68	68	67	67	63	63	64	64
Sub total	28,417	27,655	27,780	28,020	28,432	28,548	28,248	27,369	26,421	26,625	27,242	27,588	27,977	28,444	28,650	28,817	26,753	27,161	27,472	27,795

Number of Members in Dues Exempt Member Categories

MS[3]	989	1,344	1,980	2,256	1,910	1,217	1,152	1,017	981	1,111	1,456	1,621	1,776	1,959	2,026	2,064	2,090	2,160	2,268	2,345
LM	1,624	1,658	1,664	1,673	1,693	1,715	1,594	1,651	1,675	1,719	1,801	1,793	1,787	1,784	1,780	1,773	1,764	1,759	1,753	1,749
DLF	2,266	2,297	2,267	2,280	2,230	2,227	2,113	2,165	2,186	2,245	2,322	2,293	2,285	2,278	2,270	2,263	2,256	2,253	2,247	2,239
LF	2	4	2	4	20	29	39	56	87	132	170	169	169	168	168	168	168	168	168	168
LA	52	55	55	55	51	54	53	51	49	48	44	44	44	44	43	43	43	42	42	42
IM/IF	1,951	2,014	2,010	2,096	2,078	2,057	1,986	1,978	1,942	1,937	1,924	1,920	1,935	1,933	1,922	1,920	1,925	1,926	1,926	1,926
HF	58	59	58	54	53	52	52	51	46	45	44	43	43	43	43	43	43	43	42	42
Sub total	6,942	7,431	8,036	8,418	8,035	7,351	6,989	6,969	6,966	7,237	7,761	7,883	8,039	8,209	8,252	8,274	8,289	8,351	8,446	8,511
TOTAL	**35,359**	**35,086**	**35,816**	**36,438**	**36,467**	**35,899**	**35,237**	**34,338**	**33,387**	**33,862**	**35,003**	**35,471**	**36,016**	**36,653**	**36,902**	**37,091**	**35,042**	**35,512**	**35,918**	**36,306**

RFM Resident-Fellow Memb
GM General Member
DF Distinguished Fellow
FE Fellow
AM Associate Member
LM Life Member
DLF Distinguished Life Fello

LF	Life Fellow
LA	Life Associate
IMBR	International Member
IFE	International Fellow (re-named IDF and new criteria established for IFE 2013)
IDF	Intl Distinguished Fellow (*IFE category name changed to IDF Jan 2012)
MS	Medical Student
IM/IF	Inactive Member/Inactive Fellow
HF	Honorary Fellow

I:\Membership Statistics\duespay nonduespay comparison 2004-present

Item 8.A
Board of Trustees
December 13-14, 2014
Attachment A

Membership Transactions -- Gains and Losses
October 2014

DUES-PAYING MEMBER CATEGORIES																							
		GAINS								LOSSES													
Member Class	Mbr Counts 9/30/14	New		Reinstate		Class Changes In		Subtotal Gains		Drop		Resign		Deceased		Class Changes Out		Subtotal Loss		Net Gain/Loss		Member Counts End of Month
		Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	Mo	YTD	
RFM	4,047	141	1,109	27	304	52	292	220	1,705		801		6	1	2	33	907	34	1,716	186	-11	4,233
GM	13,207	11	163	94	1,248	34	918	139	2,329	6	1,444	4	59	3	7	19	995	32	2,505	107	-176	13,314
DF	1,405		0	1	25		86	1	111		33		2	1	2		144	1	181	0	-70	1,405
FE	2,579		0	6	63		620	6	683		90	1	1		4	1	150	2	245	4	438	2,583
AM	1		0		0		0	0	0		0		0		0		1	0	1	0	-1	1
LM	2,027		0	4	34		272	4	306		98	1	11	2	11		205	3	325	1	-19	2,028
DLF	1,569		0	1	7		156	1	163		18	1	4	1	6		149	2	177	-1	-14	1,568
LF	653		0		5		114	0	119		15		0		2		41	0	58	0	61	653
LA	3		0		1		1	0	2		2		0		0		0	0	2	0	0	3
Intl Mbr	1,772	27	533	2	111		8	29	652		218	2	12		0	1	159	3	389	26	263	1,798
Intl FE	145		0		0		148	0	148		3		0		0		0	0	3	0	145	145
Intl DF	64		0		0		8	0	8		4		0		1		1	0	6	0	2	64
Subtotal	**27,472**	**179**	**1,805**	**135**	**1,798**	**86**	**2,623**	**400**	**6,226**	**6**	**2,726**	**9**	**95**	**8**	**35**	**54**	**2,752**	**77**	**5,608**	**323**	**618**	**27,795**
NON DUES-PAYING CATEGORIES																						
MS	2,268	110	1,230		0		0	110	1,230		33		0		0	33	219	33	252	77	978	2,345
LM	1,753		0		1		148	0	149		1		1	4	55		7	4	64	-4	85	1,749
DLF	2,247		0		0		144	0	144		0		3	8	84		7	8	94	-8	50	2,239
LF	168		0		0		37	0	37		0		0		2		1	0	3	0	34	168
LA	42		0		0		0	0	0		0		0		2		0	0	2	0	-2	42
Inact	1,926		0		2	1	53	1	55		0		0	1	39		18	1	57	0	-2	1,926
HF	42		0		0		0	0	0		0		0		2		0	0	2	0	-2	42
Subtotal	**8,446**	**110**	**1,230**	**0**	**3**	**1**	**382**	**111**	**1,615**	**0**	**34**	**0**	**4**	**13**	**184**	**33**	**252**	**46**	**474**	**65**	**1,141**	**8,511**
TOTAL	**35,918**	**289**	**3,035**	**135**	**1,801**	**87**	**3,005**	**511**	**7,841**	**6**	**2,760**	**9**	**99**	**21**	**219**	**87**	**3,004**	**123**	**6,082**	**388**	**1,759**	**36,306**

Item 8.A
Board of Trustees
December 13-14, 2014
Attachment B

Comparison of Area and District Branch Membership -- 1/1/2011 - 1/1/2014 (updated thru 10/1/2014)

Area	DB#	DB NAME	Total Mbr Count 01/11	Total Mbr Count 01/12	Total Mbr Count 1/13	Total Mbr Count 1/14	Total Mbr Count 10/14	3 YR % Change 01/11 - 01/14	1 YR % Change 01/13 - 01/14	10 Month % Change 01/14 - 10/14
1	7	Connecticut Psychiatric Society	737	712	744	704	724	-4.5%	-5.4%	2.8%
1	62	Maine Psychiatric Association	175	176	181	182	184	4.0%	0.6%	1.1%
1	32	Massachusetts Psychiatric Society	1,581	1,548	1,556	1,610	1,612	1.8%	3.5%	0.1%
1	68	New Hampshire Psychiatric Society	160	141	142	136	141	-15.0%	-4.2%	3.7%
1	37	Ontario District Branch	737	722	721	751	766	1.9%	4.2%	2.0%
1	39	Quebec & Eastern Canada District Branch	425	399	378	387	417	-8.9%	2.4%	7.8%
1	41	Rhode Island Psychiatric Society	235	229	243	244	243	3.8%	0.4%	-0.4%
1	66	Vermont Psychiatric Association	133	130	133	133	127	0.0%	0.0%	-4.5%
		Total Area 1	4,183	4,057	4,098	4,147	4,214	-0.9%	1.2%	1.6%
2	2	Bronx District Branch	156	137	147	162	160	3.8%	10.2%	-1.2%
2	3	Brooklyn Psychiatric Society, Inc	277	261	313	293	312	5.8%	-6.4%	6.5%
2	56	Central New York District Branch	146	142	133	140	140	-4.1%	5.3%	0.0%
2	5	Genesee Valley Psychiatric Association	168	165	156	157	156	-6.5%	0.6%	-0.6%
2	25	Greater Long Island Psychiatric Society	597	577	571	583	571	-2.3%	2.1%	-2.1%
2	24	Mid-Hudson Psychiatric Society	81	78	78	73	71	-9.9%	-6.4%	-2.7%
2	27	New York County District Branch	1,877	1,761	1,763	1,827	1,903	-2.7%	3.6%	4.2%
2	28	New York State Capital District Branch	169	160	150	161	166	-4.7%	7.3%	3.1%
2	59	Northern New York District Branch	42	43	40	38	38	-9.5%	-5.0%	0.0%
2	40	Queens County District Branch	236	224	236	227	249	-3.8%	-3.8%	9.7%
2	49	Psychiatric Society of Westchester County, Inc	486	447	445	447	441	-8.0%	0.4%	-1.3%
2	51	Western New York Psychiatric Society	141	149	150	152	152	7.8%	1.3%	0.0%
2	55	West Hudson Psychiatric Society	125	110	109	104	110	-16.8%	-4.6%	5.8%
		Total Area 2	4,501	4,254	4,291	4,364	4,469	-3.0%	1.7%	2.4%
3	8	Psychiatric Society of Delaware	107	107	106	105	100	-1.9%	-0.9%	-4.8%
3	20	Maryland Psychiatric Society, Inc	717	688	700	705	720	-1.7%	0.7%	2.1%
3	26	New Jersey Psychiatric Association	906	862	859	849	873	-6.3%	-1.2%	2.8%
3	38	Pennsylvania Psychiatric Society	1,596	1,569	1,614	1,593	1,576	-0.2%	-1.3%	-1.1%
3	48	Washington Psychiatric Society	910	911	913	901	899	-1.0%	-1.3%	-0.2%
		Total Area 3	4,236	4,137	4,192	4,153	4,168	-2.0%	-0.9%	0.4%
4	13	Illinois Psychiatric Society	1,053	1,034	1,063	1,047	1,043	-0.6%	-1.5%	-0.4%
4	14	Indiana Psychiatric Society	338	343	337	342	333	1.2%	1.5%	-2.6%
4	16	Iowa Psychiatric Society	210	211	216	207	199	-1.4%	-4.2%	-3.9%
4	17	Kansas Psychiatric Society	215	217	220	210	213	-2.3%	-4.5%	1.4%
4	21	Michigan Psychiatric Society	731	717	743	761	767	4.1%	2.4%	0.8%
4	22	Minnesota Psychiatric Society	412	423	420	441	442	7.0%	5.0%	0.2%
4	9	Missouri Psychiatric Association*	479	459	422	453	438	-5.4%	7.3%	-3.3%
4	34	Nebraska Psychiatric Society	152	150	155	151	157	-0.7%	-2.6%	4.0%
4	63	North Dakota Psychiatric Society	56	54	54	55	52	-1.8%	1.9%	-5.5%
4	35	Ohio Psychiatric Physicians Association	975	950	989	1,004	972	3.0%	1.5%	-3.2%
4	72	South Dakota Psychiatric Association	53	63	69	76	72	43.4%	10.1%	-5.3%
4	52	Wisconsin Psychiatric Association	404	393	397	391	393	-3.2%	-1.5%	0.5%
		Total Area 4	5,078	5,014	5,085	5,138	5,081	1.2%	1.0%	-1.1%
*3 Missouri district branches merged into MPA in 2012										

Comparison of Area and District Branch Membership -- 1/1/2011 - 1/1/2014 (updated thru 10/1/2014)

Area	DB#	DB NAME	Total Mbr Count 01/11	Total Mbr Count 01/12	Total Mbr Count 1/13	Total Mbr Count 1/14	Total Mbr Count 10/14	3 YR % Change 01/11 - 01/14	1 YR % Change 01/13 - 01/14	10 Month% Change 01/14 - 10/14
5	60	Alabama Psychiatric Physicians Association	256	256	269	263	262	2.7%	-2.2%	-0.4%
5	1	Arkansas Psychiatric Society	132	139	130	144	140	9.1%	10.8%	-2.8%
5	10	Florida Psychiatric Society	1,049	1,040	1,055	1,122	1,163	7.0%	6.4%	3.7%
5	11	Georgia Psychiatric Physicians Association, Inc	631	638	658	658	640	4.3%	0.0%	-2.7%
5	18	Kentucky Psychiatric Association	332	315	315	302	300	-9.0%	-4.1%	-0.7%
5	19	Louisiana Psychiatric Medical Association	362	327	321	332	322	-8.3%	3.4%	-3.0%
5	23	Mississippi Psychiatric Association, Inc	185	176	163	162	159	-12.4%	-0.6%	-1.9%
5	29	North Carolina Psychiatric Association	890	858	861	890	907	0.0%	3.4%	1.9%
5	36	Oklahoma Psychiatric Association	253	219	217	221	222	-12.6%	1.8%	0.5%
5	70	Puerto Rico Psychiatric Society	123	115	108	132	148	7.3%	22.2%	12.1%
5	42	South Carolina Psychiatric Association	362	351	352	370	369	2.2%	5.1%	-0.3%
5	45	Tennessee Psychiatric Association	336	327	330	339	321	0.9%	2.7%	-5.3%
5	46	Texas Society of Psychiatric Physicians	1,167	1,161	1,189	1,215	1,201	4.1%	2.2%	-1.2%
5	77	Society of Uniformed Services Psychiatrists	264	271	276	325	342	23.1%	17.8%	5.2%
5	47	Psychiatric Society of Virginia, Inc	589	596	640	652	617	10.7%	1.9%	-5.4%
5	54	West Virginia Psychiatric Association	175	163	167	173	174	-1.1%	3.6%	0.6%
		Total Area 5	7,106	6,952	7,051	7,300	7,287	2.7%	3.5%	-0.2%
6	4	Central California Psychiatric Society	373	359	350	379	382	1.6%	8.3%	0.8%
6	30	Northern California Psychiatric Society	1,084	1,063	1,070	1,086	1,081	0.2%	1.5%	-0.5%
6	76	Orange County Psychiatric Society	257	257	258	257	267	0.0%	-0.4%	3.9%
6	64	San Diego Psychiatric Society	356	345	337	358	353	0.6%	6.2%	-1.4%
6	43	Southern California Psychiatric Society	1,096	1,041	1,032	1,072	1,073	-2.2%	3.9%	0.1%
		Total Area 6	3,166	3,065	3,047	3,152	3,156	-0.4%	3.4%	0.1%
7	71	Alaska District Branch	58	65	67	67	65	15.5%	0.0%	-3.0%
7	57	Arizona Psychiatric Society	377	369	374	398	419	5.6%	6.4%	5.3%
7	6	Colorado Psychiatric Society	479	471	475	472	456	-1.5%	-0.6%	-3.4%
7	12	Hawaii Psychiatric Medical Association	179	188	173	181	182	1.1%	4.6%	0.6%
7	15	Idaho Psychiatric Association	57	54	51	52	60	-8.8%	2.0%	15.4%
7	73	Montana Psychiatric Association	58	58	58	56	56	-3.4%	-3.4%	0.0%
7	74	Nevada Psychiatric Association	124	120	126	137	154	10.5%	8.7%	12.4%
7	67	Psychiatric Medical Association of New Mexico	168	155	158	156	158	-7.1%	-1.3%	1.3%
7	58	Oregon Psychiatric Association	400	416	418	411	412	2.8%	-1.7%	0.2%
7	61	Utah Psychiatric Association	159	158	160	170	170	6.9%	6.3%	0.0%
7	33	Washington State Psychiatric Association	531	532	542	541	537	1.9%	-0.2%	-0.7%
7	53	Western Canada District Branch	435	462	467	496	513	14.0%	6.2%	3.4%
7	75	Wyoming Psychiatric Society	29	25	24	25	24	-13.8%	4.2%	-4.0%
		Total Area 7	3,054	3,073	3,093	3,162	3,206	3.5%	2.2%	1.4%
		Total District Branch Membership (Areas 1-7)	31,324	30,552	30,857	31,416	31,581	0.3%	1.8%	0.5%
		Honorary Fellows	51	46	45	44	42	-13.7%	-2.2%	-4.5%
		Medical Student Members	1,017	981	1,111	1,456	2,345	43.2%	31.1%	61.1%
		International Members/Fellows	1,561	1,437	1,488	1,740	2,007	11.5%	16.9%	15.3%
		General Members-at-Large (DF, Lifes, etc)	385	371	361	347	331	-9.9%	-3.9%	-4.6%
		Total At-Large Membership	3,014	2,835	3,005	3,587	4,725	19.0%	19.4%	31.7%
		Total APA Membership (DB & At-Large Mbrs)	34,338	33,387	33,862	35,003	36,306	1.9%	3.4%	3.7%

2014 DB/SA Grant Allocation Report

DB/SAs Competitive Grants Overview

The APA Board of Trustees (BOT) voted to allocate $180,000 in the 2014 fiscal year in Competitive grant awards to District Branches and State Associations (DB/SAs). The grant funding is divided into two categories specifically, Expedited and Innovative funds. The APA Membership Committee is tasked with the responsibility to review submissions for grant funding and make recommendations to the BOT. Of the monies allocated, $150,000 is ear marked for the Expedited grants and the remaining funding of $30,000 for the Innovative grant.

The Membership Committee is charged with administering the process, reviewing submissions and making recommendations to the Board of Trustees. The first grant category, *Expedited* grants is a total grant amount of $150,000. This year, we had a total of 55 grantees with awards totaling $149,985. To date, 49 grants totaling $133,623.00 have been dispersed, three states repealed their award, and three distributions are pending receipt of the grant agreement as determined by the grantor and grantee. Therefore, the remaining disbursement amount is approximately $8, 316.

The second category*, Innovative* grants had an original total of seven submissions. Of the seven submissions, six applicants are being recommended by the Membership Committee to receive grants totaling $30,000. The following is a summary of the Innovative grant submissions. There were four applicants seeking $5K, two applicants seeking $10K, and one applicant seeking $15K. Due to the timing of an appointment to a leadership position on the Membership Committee, the DB/SA grant submission for $15K was retracted from consideration by the applicant. Yet, the grant request is reflected in this report as a point of information. However, the total number of grant submissions to be considered is six.

Summary of the seven DB/SA 2014 Innovative Grant Submissions:

Grant applicants seeking $5,000:

I. Michigan Psychiatric Society

A one-night “speed-dating” event targeted at medical students and residents offering a unique venue for them to meet the various residency and fellowship directors in one location, helping them determine their career path. Michigan has 9 psychiatric residencies and many more fellowships spread across the state. It provides an opportunity for medical students and residents to meet these programs all in one, centralized location. The residency and fellowship directors will also have a separate meeting at the event with the MPS president to engage them in membership recruitment and retention efforts, while also promoting their participation in the organization.

II. New York County Psychiatric Society

Approximately two-thirds of practicing psychiatrists will suffer the loss of a patient to suicide. Reactions to patient suicide are characterized by anger and guilt. Distress is greater amongst psychiatrists in training or early in their career. Several studies report that discussion of the case with colleagues reduces the psychiatrist’s distress. In contrast, institutional reviews are less helpful. This grant seeks funding to train several members

2014 DB/SA Grant Allocation Report

of the district branch to provide education and support to psychiatrists and psychiatric training programs about psychiatrist's reactions to patient suicide.

III. Society of Uniformed Services Psychiatrists

The Society of Uniformed Services Psychiatrists (SUSP) is distinct among APA branches in that its members are dispersed across the world. Yet, as with all APA members, Maintenance of Board Certification (MOC) through the American Board of Psychiatry and Neurology (ABPN) is essential to practicing psychiatry today. To meet the needs of our world-wide membership, SUSP is proposing development of and deployment of a combination webinar\on line meeting that members could access on the internet. The webinar would provide information on the certification, on MOC and on resources. Online meetings, conducted live using current technology, would be led by one or more SUSP members and include experts as applicable. SUSP envisions in person meetings with access to the meetings via web access technology.

IV. Psychiatric Society of Virginia

PSV proposes creating a mobile app to communicate with the Virginia society members and non-member psychiatrists on relevant membership and governmental affairs information. This would create a mobile responsive way of pushing information out to the membership; in addition to posting information on the PSV website, in the PSV newsletter, and mailing it out to members. Most importantly, the app will be the prime communication vehicle on legislative issues and updates.

Grant applicants seeking $10,000:

V. Minnesota Psychiatric Society

Organized Medicine Elective – MPS will partner with the University of Minnesota on a new elective for PGY3 residents offering structure and opportunity to explore and build connections for lifelong engagement with organized medicine, advocacy groups, government, etc. The elective conceptualized by Matt Kruse, MD offers residents an access point within their training programs to gain leadership experience, enhance professional development and identity, and strengthen community engagement, both individually and among the profession at large. The partners will team to support its adoption in all Minnesota training programs, and conceivably nationwide.

VI. North Carolina Psychiatric Association and Florida Psychiatric Society

To develop a polished curriculum and coordinating resources to offer practice management training for psychiatrists. Funding will be used to hire marketing/physician practice consultants to synthesize existing APA and national resources and develop a series of coordinated modules/presentations for use individually or collectively in various settings from a dinner meeting to a full-day conference. Florida and NC will collaborate with the consultants to develop the product and pilot it in those states. The goal is to have a turnkey product that any DB can use to provide CME training for members (as a benefit) or non-members (as a recruitment tool.)

2014 DB/SA Grant Allocation Report

Grant applicant(s) seeking $15,000:

VII. Tennessee Psychiatric Association

Major Depressive Disorder (MDD) is the world's 4th leading cause of disability and non-fatal disease burden for almost 12% of total years lived with disability. In next 20 years, depression is leading cause of disability worldwide and in USA. In the U.S, the lifetime prevalence of MDD ranges from 14 to 17%. Major depression is a common, disabling condition seen frequently in primary care practices. Non-psychiatrist ambulatory providers are increasingly responsible for diagnosing, and primarily managing patients suffering from major depressive disorder (MDD). The goal of this proposed project is to help primary care providers to understand the natural history of MDD, identify practical tools for screening, and a thoughtful approach to management.

Prior to the Membership meeting in October, each Committee member received a "Reviewer" packet that included copies of each grant submission and a review sheet by which to score each submission. In October, the Membership Committee met as a body and tallied their overall scores for grant submissions and made assessments about the grant submissions based on the predetermined criteria. The following reflects the assessment outcomes:

DB	Ave	Rank	SD	Request	Fund?	How much?
Michigan	**22.7**	**6**	3.4	5,000	N	-
NY	**24.2**	**1**	3.9	5,000	Y	5,000
SUSP	**22.8**	**4**	3.9	5,000	Y	5,000
Virginia	**22.9**	**3**	3.8	5,000	Y	5,000
Minnesota	**22.8**	**4**	3.3	10,000	Partial	5,000
NC	**23.9**	**2**	4.9	10,000	Y	10,000
				40,000		30,000

As previously mentioned, the available funding for the 2014 Innovative grant is $30,000. Grant submission requests totaled $40,000. Upon completion of scoring, and deliberation among the Committee members, the Committee recommends the following DB/SAs receive Innovative grant awards as follows:

1. New York County Psychiatric Society, $5,000;
2. Society of Uniformed Services Psychiatrists, $5,000;
3. Psychiatric Society of Virginia, $5,000;
4. Minnesota Psychiatric Society, $ 5,000; and
5. North Carolina and Florida Psychiatric Associations $10,000.

2014 DB/SA Grant Allocation Report

Moreover, upon the Membership Committee reaching a funding consensus on the grant submissions, the Director of DB/SA Relations scheduled a follow-up conference call with the Minnesota Psychiatric Society and the Membership Committee Chair to discuss the committee's proposed funding adjustment. The Minnesota Psychiatric Society graciously accepted the committee's proposed funding amount.

It is the Committee's hope that the Board of Trustees will concur with its recommendation to fund the aforementioned Grant submissions in the amounts defined for a total of $30,000 in awards for the 2014 fiscal year.

Membership Recruitment and Retention Activities

Report Submitted by Louise Martin, Associate Director, Membership Development

GENERAL PROMOTIONS

APA Annual Meeting Rebate Program

Seventy (70) General Member membership applications were submitted onsite at the APA Annual Meeting in New York City in May in response to the Annual Meeting Rebate program. A postcard promoting the Rebate Program was mailed in April to 370 nonmember psychiatrists who had pre-registered to attend the Annual Meeting in NYC at the nonmember full program rate. The attendees were eligible to receive a rebate equal to the difference of the nonmember vs. member registration fee on their APA/DB membership dues if they submitted a General Membership application onsite in NYC. Of the 70 applications received, 58 new members were eligible to receive the rebate.

The Annual Meeting Rebate Program has continued to see success since its incorporation. Featured below are some Annual Rebate statistics from previous Annual Meetings:

Location	Year	Eligible Applicants	Still Active Members	% Active	Deceased	Dropped	Resigned
Atlanta	2005	22	13	59%		6	3
Toronto	2006	15	7	47%		7	1
San Diego	2007	91	41	45%	1	46	3
Washington DC	2008	42	16	38%	2	22	2
San Francisco	2009	52	24	46%	1	25	2
New Orleans	2010	49	25	51%		24	
Hawaii	2011	31	20	65%		11	
Philadelphia	2012	49	28	57%		20	1
San Francisco	2013	86	66	77%		19	1
New York City	2014	58	58	TBD			
TOTAL		495	298	60%	4	180	13

Fellowship/International Fellowship

Email blasts to eligible APA members promoting Fellow and International Fellow membership were sent in May, June and July from the APA Membership Committee Chair inviting members to apply (n= INTLS: 1,830; US/CAN: 11,200). The Fellowship programs and deadlines were also promoted in *APA Headlines* and *Psychiatric News Update*. Due to the increased promotional efforts, there was a significant increase in Fellow applications submitted this year compared to years past, with 1,000+ applications received from members in the US & Canada and 300+ from International Members.

Membership Recruitment and Retention Activities

Inalink Calling Program to Members at Risk

In May, Inalink, the outside vendor that APA Membership has used for the past three years to call members who are in danger of dropping for non-payment of dues on June 30th, began calls to members who had not yet paid 2014 membership dues. A second round of calls immediately followed in July to contact those who had been dropped on June 30th for nonpayment of dues. More information about the calling program results is provided in the Dues Drop Summary information.

"Know the Facts About APA Membership" Campaign

The series of house ads that were developed by the APA Membership Department earlier this year continue to run on a space available basis in *Psychiatric News* and as rotating banner ads on the APA website to educate members and nonmembers alike to the benefits of membership. The ads focus on specific APA resources such as member registration discounts to scientific meetings, research, practice management, educational and CME opportunities, advocacy, and the availability of the APA Scheduled Payment Plan for members who want to sign up to pay their membership dues in installments. The ads were also turned into a series of postcards which are currently being mailed monthly to new members as part of Membership's "new member contact program" and are also distributed at events that Membership staff attends. The Scheduled Payment Plan postcard was mailed in April to Resident-Fellow Members who had not yet paid 2014 membership dues. Membership will continue to use the postcards in other promotional mailings throughout the year.

District Branch and State Association Resource Support Program

Nancy Archey in the APA Membership Department has contacted all District Branch/State Association Executives since January to obtain their annual meeting dates and to provide them with a variety of resources from the APA to have on hand at their meetings. To date, Nancy has provided more than 35 branches with APA print and digital resources on topics including membership and member benefits, education, advocacy, publications, and the APA Foundation. Recently, materials were shipped to 9 branches that were having Fall meetings (AZ, FL, GLIPS, MD, MO, NC, Sacramento, San Diego, and VA). Membership staff continues to post membership promotional materials and membership forms to the APA website in a special area created specifically for District Branches on the Membership page. Membership also continues to work with and encourage any branch that is interested in partnering with us on a joint membership campaign in their state to contact us.

RESIDENT-FELLOW MEMBER PROMOTIONS

100% Club

In mid-June, Membership conducted its annual direct mailing to the 200+ general psychiatry residency training programs in the United States and Canada to promote the APA 100% Club. The APA 100% Club is a program that recognizes training programs that enroll all or the majority of its residents in APA membership.

Beginning with the 2013-2014 training year, the 100% Club program was expanded to include more programs by recognizing those that enroll the majority of their residents into membership.

Membership Recruitment and Retention Activities

Since then, the program has seen significant growth. *For the 2013-2014 training year, 68 training programs achieved 100% Club status,* compared to 45 in 2012-2013; 31 in 2011-2012; 15 in 2010-2011; 25 in 2009-2010; and 17 in 2008-2009.

Recruitment efforts for the 2014-2015 training year, which began July 1, started in mid-May when Neila Ariasaif in the APA Membership Department emailed the residency training coordinators at current 100% Club training programs to request the names of incoming and outgoing residents so that Membership could begin enrolling new residents and advancing outgoing residents to General Member status. From June through October, Neila has continued to work with training programs to obtain resident rosters, facilitate enrollments, and to conduct direct recruitment mailings to non-member residents. Targeted recruitment letters specific to the resident's training year were mailed to non-members under the signature of the APA Membership Committee Chair. New this year and at the request of the District Branches, Membership began sharing incoming resident rosters with District Branches/State Associations on a monthly basis so they could track programs in their states and contact programs on their own.

There are 71 training programs confirmed for 100% Club status for 2014-2015. **The deadline for enrolling residents into membership to qualify for the current training year was October 31.**

100% Club List of Residency Programs for 2014-2015

Platinum Level (Gold Level 5 Consecutive Years): 6
Gold Level (100%): 45
Silver Level (90-99%): 8
Bronze Level (80-89%): 12
Total Programs in all: 71

Platinum Level

Jamaica Hospital Medical Center
Nassau University Medical Center
San Mateo County Mental Health Services
Wake Forest University School of Medicine
West Virginia University/Charleston Area Medical Center
University of South Alabama

Gold Level

Albany Medical College
Allegheny General Hospital
Butler Hospital (Brown University)
Carilion Clinic/Virginia Tech Carilion School of Medicine Program
Cooper University Hospital
Delaware Psychiatric Center

Membership Recruitment and Retention Activities

Einstein Medical Center
Harvard University-Longwood
Hennepin County Medical Center/Regions Hospital Program, MN
Henry Ford Hospital-Wayne State University
Indiana University
John A Burns-University of Hawaii
Kaweah Delta Health Care District
Largo Medical Center
Larkin Community Hospital
Louisiana State University
Maimonides Medical Center
Medical College of Wisconsin
Michigan State University
Morehouse School of Medicine
National Capital Consortium at Walter Reed
New Jersey Medical School
OUCOM/Grandview Hospital
Palm Beach Consortium Columbia University
Pine Rest Psychiatry Residency
Samaritan Mental Health
Southern Illinois University
St Louis University School of Medicine Program
St. John's Episcopal Hospital
St. Mary Mercy Hospital
Stony Brook University
Thomas Jefferson University School of Medicine
University of Alabama
University of California-Irvine
University of California-Riverside County
University of Cincinnati
University of Florida College of Medicine
University of Kansas-Wichita
University of Louisville
University of Massachusetts
University of Mississippi
University of South Carolina-Greenville
University of South Dakota School of Medicine
University of Toledo
Veteran's Administration-Ponce School of Medicine

Silver Level

Boston University
Columbia University
Creedmoor Psychiatric Center
Creighton-Nebraska Residency Training Program

Membership Recruitment and Retention Activities

Maricopa Medical Center
Palmetto Health
Penn State-Hershey
University of Cincinnati Family Med Psychiatry

Bronze Level

Bergen Regional Medical Center Program
Brookdale University Hospital Medical Center Program
Detroit Medical Center-Wayne State University
Kaiser Permanente-Fontana
Lincoln Hospital
Loyola University Medical Center
Medical College of Georgia
NSLIJHS-Hofstra North Shore-LIJ School of Medicine at The Zucker Hillside Hospital
Ohio State University
SUNY Downstate
University of Buffalo
University of Minnesota

Post-Annual Meeting Recruitment
An email was sent in August from APA Member Services to Qty. 132 non-member residents in the US who attended the 2014 Annual Meeting in New York City inviting them to join. Due to new email marketing restrictions in Canada, the email excluded residents from Canada (n=58). However, we anticipate that these potential members were reached as part of our efforts in following up with training programs and residents in Canada for the 100% Club.

EARLY CAREER PSYCHIATRIST (ECP) PROMOTIONS

Members-in-Transit Calling Program for New ECPs
In mid-July, the APA Membership Department implemented a new telemarketing campaign to 875 graduating residents who were scheduled to automatically advance to General Member status and had not contacted the APA regarding their plans. The purpose of this program was to contact resident members by phone to: 1) thank them for their participation/membership; 2) find out if they were planning to move into practice or deciding to continue with fellowship training; 3) depending on whether they moved into practice or decided to continue with fellowship training, review their respective “new” benefits, and how APA membership will help them, while providing them with what communications they can expect to receive from APA, and 4) update their contact information so APA can stay in touch. This new campaign was conducted by Inalink, the same outside firm that calls members-at-risk to encourage them to renew. For those graduating residents who had been dropped from APA membership on June 30 for non-payment of dues (n=226), Inalink also asked for credit card renewal/membership by phone or by invoice and tried to find out why these individuals had decided not to renew.

Membership Recruitment and Retention Activities

Out of the 875 residents on the initial list, 830 of the records were called. Inalink had actual conversations with 242 and left messages for the remainder, some of whom called Inalink back to either renew their membership or to provide new contact information. 300 of the records contained bad phone information. Inalink did a limited number of searching for correct phone information when they encountered a wrong number.

A brief summary of the Members-in-Transit program results is shown below:

Call Attempt Result	Count	$ Amount
Renewed via credit card – moving to practice	10	1,860
Renewed via credit card – staying in training	3	502
Renewing online	5	407
Payment will be sent – no invoice required	14	1,957
Completed welcome call – updated contact info	174	
Completed welcome call – partial update / contact information not available yet	8	
Declined to participate in call (paid members only)	3	
No longer participating in psychiatry / leaving medicine	2	
Has no intention of continuing with APA after graduation	2	
APA not primary association	2	
No longer with company and could not be contacted at home	4	
Other	2	
Member unsure what his/her direction will be after graduation	6	
Special case (out of country, language barrier, deceased)	5	
Only joins for Annual Meeting	1	
Waiting until 2015 to renew	1	
Total	242	$4,726

RFM-GM Advancements

The effort to advance Resident-Fellow Members (RFMs) to General Member (GM) status starts several months before RFMs complete training. A congratulatory email is sent from the Membership Committee Chairperson with information about the benefits of membership as an Early Career Psychiatrist and also an explanation of the requirements for GM status. RFMs are

Membership Recruitment and Retention Activities

asked to provide verification of their credentials and to provide additional information if continuing in fellowship training. All RFMs who do not inform APA that they are continuing training are automatically advanced to General Membership. Membership staff is proactive in their attempts to verify each member's credentials by checking licensing website and contacting the training programs to confirm training completion. These efforts continue for up to a year with periodic email and written reminders requesting the necessary information. Approximately 1,100 RFMs are contacted at the start of the advancement process and the number decreases through the year as credentials are verified or additional training is reported. Approximately 20% of the RFMs that complete training are dropped in June for non-payment of dues. After a year, the remaining RFMs who have not responded to inquiries and for whom staff is not able to verify credentials, are dropped from membership (approximately 25 members).

New ECP Contact Program – To Be Developed for 2015
Based on feedback from the RFM-ECP Transition Work Group during its conference call earlier this year, Membership staff will be working on developing a new ECP contact and/or member recognition program for 2015 to contact members in this group. Staff has also been in contact with Inalink, who administered the new APA Members-in-Transit campaign this year and who we also use to call APA at- risk members, to discuss the possibility of developing a new telemarketing campaign for ECP members.

INTERNATIONAL MEMBER PROMOTIONS

International Membership Ambassador Program
The International Membership Ambassador Program (IMAP) has gotten off to a slow start. The results thus far show that IMAP has produced only a handful of new international members in the past 12 months. In spite of reaching out in 2013 to 40 members from five countries who agreed to be ambassadors, only several participated after the initial communication, and the result was one new member in 2013.

Below is a comparison of 2013 over 2014:

2013 *(Program Launch - June 2013)*

- 38 ambassadors from 5 countries (Australia, Brazil, India, Japan, Netherlands)
- 38 prospect leads came from 4 ambassadors
- One prospect became a member in 2013

2014 *(Results through Qtr. 3 2014)*

- 8 prospects from 2013 joined in 2014
  - 22% conversion rate from 2013 (8 of 38)
- 19 ambassadors from 8 countries (80 members were invited)
  - Added Argentina, Spain, and UK to 2013 countries
  - 9 ambassadors are returnees from 2013 (2 from Japan, 7 from India)
- To date, there have been 5 prospect leads from 1 ambassador, with zero conversions

Membership Recruitment and Retention Activities

For 2014, we made the following program adjustments in an effort to improve results:

- Focused on fewer, seemingly more engaged participants, starting with 19 ambassadors from 8 countries;
- Simplified the program requirements in order for ambassadors to receive an incentive for fewer member conversions;
- Sent a hard-copy mailing of ambassador resources in addition to the email attachment;
- Provided additional resources for ambassadors to use in engaging their nonmember colleagues in person;
- Communicated to ambassadors once per quarter, more often than last year, to keep in touch and top of mind.

Our expectations from this program were that each year prospects would be identified and would join within months. Perhaps we need to look at our efforts as planting the seeds that will bear fruit over time, as demonstrated by our 2013 efforts bearing fruit in 2014. Membership can look into other ways to supplement what we are doing to improve results and realize a return on investment.

International Exhibits
APA Membership staff exhibited at the World Psychiatric Association's (WPA) World Congress of Psychiatry in Madrid, Spain on September 15-18, 2014. WPA's World Congress is held every three years, the last time being in 2011 in Buenos Aires, Argentina. There were an estimated 7,000 attendees in Madrid, down dramatically from the 15,000 who attended Buenos Aires in 2011. In a new joint venture, the APA exhibit space in Madrid was shared by APA Membership, American Psychiatric Publishing (APP), and Panamericana, APP's publishing partner for the Spanish language edition of DSM-5, which was launched during the meeting.

As a special incentive for joining at the meeting, APP had approved offering new International Members a free 6-month subscription to Psychiatryonline.org if they joined in Madrid during the meeting. A paid banner ad regarding the promotion was emailed to WPA attendees and potential registrants in August prior to the meeting in one of WPA's communications, and APA Member Services sent an email to International non-members who attended the 2014 APA Annual Meeting (n=864) promoting International Membership in general and the special incentive if they were attending WPA in Madrid.

18 International Membership applications were received onsite in Madrid, about the same amount of applications received in Buenos Aires in 2011. The new members who joined in Madrid were from Australia – 2; China – 1; India – 2; Iran – 2; Netherlands – 1; Nigeria – 6; South Africa – 3; Spain – 1.

Membership staff also exhibited at the Royal College of Psychiatrists' (RCP) annual International Congress in London on June 24 – 27, 2014.

Membership Recruitment and Retention Activities

OTHER MEMBERSHIP PROMOTIONS

- October – “We want you back” recruitment mailing from the Membership Committee Chair to former members who were dropped in 2012 and 2013 (n=1,404). Mailing was limited in size to use up remaining 2014 General Member brochures.

- September/October – The first email blast and print mailing of the 2015 APA membership dues invoices were sent. As in years past, District Branches/State Associations were invited to submit a cover letter or promotional flyer for inclusion in the print mailing to members in their states outlining DB/SA resources. This year, 26 DBs/SAs participated, compared to 39 that participated in 2013 and 45 that participated in 2014.

- September/October – APA membership staff exhibited at the Canadian Psychiatric Association’s annual meeting in Toronto on September 11-13, 2014. Estimated attendance was approximately 1,200. APA Membership staff also exhibited at AACAP on October 22-24 in San Diego (estimated attendance 4,000) and the APA Institute of Psychiatric Services meeting in San Francisco on October 30-November 1 (estimated attendance 2,000).

- August/September – Email blasts from Member Services to non-member prospects from the 2014 APA Annual Meeting in NYC inviting them to join (n= 440 General Members; 864 Internationals; 132 Resident-Fellows). Emails and direct mail efforts to these prospects will be ongoing.

2014 Fellowship Applications-Approved
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APA_ID	LAST_NAME	FIRST_NAME	DB#	DB_NAME	MBR_CLASS
89480	Jabi	Rawah		APA	GM
78857	Bauknight-Boles	Nichole	1	Arkansas Psychiatric Society	GM
1008375	Goodson	Bradley	1	Arkansas Psychiatric Society	GM
74102	Gramling VanScoy	Sara	1	Arkansas Psychiatric Society	GM
67088	Neal	Linda	1	Arkansas Psychiatric Society	GM
30470	Snyder	Norman	1	Arkansas Psychiatric Society	LM
88332	Wong	Kathleen	1	Arkansas Psychiatric Society	GM
87005	Adames-Jennings	Marilena	2	Bronx District Branch	GM
76028	Colon	Lillian	2	Bronx District Branch	GM
89663	Gonzalez	Ruben	2	Bronx District Branch	GM
303919	Gonzalez	Luisa	2	Bronx District Branch	GM
70559	Schneider	Matthew	2	Bronx District Branch	GM
1010135	Bobb	Vanessa	3	Brooklyn Psychiatric Society, Inc	GM
1037315	Bodic	Maria	3	Brooklyn Psychiatric Society, Inc	GM
1021893	Chawla	Jatinder	3	Brooklyn Psychiatric Society, Inc	GM
1004048	Herbert	Farah	3	Brooklyn Psychiatric Society, Inc	GM
310168	Konrad	Steven	3	Brooklyn Psychiatric Society, Inc	GM
1000611	Krishnappa	Ritesha	3	Brooklyn Psychiatric Society, Inc	GM
68762	Owens	Mark	3	Brooklyn Psychiatric Society, Inc	GM
40052	Tropnas	Jean	3	Brooklyn Psychiatric Society, Inc	LM
70724	Carter	Cameron	4	Central California Psychiatric Society	GM
1000435	Munir	Syeda	4	Central California Psychiatric Society	GM
80704	Murugesan	Selvi	4	Central California Psychiatric Society	GM
91336	Singletary	DeJuan	4	Central California Psychiatric Society	GM
74349	Weinstein	David	4	Central California Psychiatric Society	GM
79716	Wiebe	Jacqueline	4	Central California Psychiatric Society	GM
1000748	Zafar	Masood	4	Central California Psychiatric Society	GM
86268	Rehmani	Shahida	5	Genesee Valley Psychiatric Association	GM
76149	Rosica	Lisa	5	Genesee Valley Psychiatric Association	GM
1062005	Chisty	Khaja	6	Colorado Psychiatric Society	GM
1001432	Davis	Rachel	6	Colorado Psychiatric Society	GM
38113	Evans	Leon	6	Colorado Psychiatric Society	IM
59791	Fukutaki	Karen	6	Colorado Psychiatric Society	GM
1001767	Higgins	Aileen	6	Colorado Psychiatric Society	GM
1001471	Lippolis	L. Charolette	6	Colorado Psychiatric Society	GM
1009465	Lowdermilk	Elizabeth	6	Colorado Psychiatric Society	GM
312338	McKay	Scot	6	Colorado Psychiatric Society	GM
310688	Rice	Karen	6	Colorado Psychiatric Society	GM
41042	Schieve	Catherine	6	Colorado Psychiatric Society	LM
75531	Weiss	David	6	Colorado Psychiatric Society	GM
1006775	Wheeler	Ashley	6	Colorado Psychiatric Society	GM
306130	Winner	Joel	6	Colorado Psychiatric Society	GM
1008716	Wongngamnit	Narin	6	Colorado Psychiatric Society	GM
91406	Wortzel	Hal	6	Colorado Psychiatric Society	GM
1014003	Yancey	Genevieve	6	Colorado Psychiatric Society	GM
30481	Zeller	Clifford	6	Colorado Psychiatric Society	LM
308482	Binder	Anna	7	Connecticut Psychiatric Society	GM
1017497	Burgos-Chapman	Isis	7	Connecticut Psychiatric Society	GM
1002285	Chaudhary	Jessica	7	Connecticut Psychiatric Society	GM
70451	Downes	M	7	Connecticut Psychiatric Society	GM
301309	Friedlander	Miriam	7	Connecticut Psychiatric Society	GM
1002414	Geigle	Eric	7	Connecticut Psychiatric Society	GM
33986	Greenberg	Jonathan	7	Connecticut Psychiatric Society	LM
59408	Herrick	Charles	7	Connecticut Psychiatric Society	GM
310091	Imam	Azhar	7	Connecticut Psychiatric Society	GM
1005079	Jain	Neha	7	Connecticut Psychiatric Society	GM

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1013910	Joksovic	Pavle	7	Connecticut Psychiatric Society	GM
308448	Lee	Jennifer	7	Connecticut Psychiatric Society	GM
86183	Lopez	David	7	Connecticut Psychiatric Society	GM
307496	Malik	Salma	7	Connecticut Psychiatric Society	GM
59131	Mohrer	Peter	7	Connecticut Psychiatric Society	GM
1004976	Pittenger	Christopher	7	Connecticut Psychiatric Society	GM
58632	Plotke	Gary	7	Connecticut Psychiatric Society	GM
41030	Ramji	Alnoor	7	Connecticut Psychiatric Society	GM
30211	Rousell	Charles	7	Connecticut Psychiatric Society	LM
312470	Sharp	Sherrie	7	Connecticut Psychiatric Society	GM
65225	Starr	Carol	7	Connecticut Psychiatric Society	GM
87233	Brown	Rachel	9	Missouri Psychiatric Association	GM
305929	Derlukiewicz	Katarzyna	9	Missouri Psychiatric Association	GM
82332	Gundersen	Karl	9	Missouri Psychiatric Association	GM
1002761	Khan	Mehnaz	9	Missouri Psychiatric Association	GM
59342	Parks	Joseph	9	Missouri Psychiatric Association	GM
102171	Sabapathypillai	Mercy	9	Missouri Psychiatric Association	GM
1005093	Saleem	Shazia	9	Missouri Psychiatric Association	GM
301005	Sarma	Subbu	9	Missouri Psychiatric Association	GM
311407	Shoyinka	Sosunmolu	9	Missouri Psychiatric Association	GM
71277	Syed	Ahsan	9	Missouri Psychiatric Association	GM
1004570	Terry	David	9	Missouri Psychiatric Association	GM
36165	Barton	Charles	10	Florida Psychiatric Society	LM
306094	Baxley	Micah	10	Florida Psychiatric Society	GM
79631	Boutrouille	Jacqueline	10	Florida Psychiatric Society	GM
29349	Brenner	Sayers	10	Florida Psychiatric Society	LM
59621	Campo	Anthony	10	Florida Psychiatric Society	GM
308586	Cooke	Brian	10	Florida Psychiatric Society	GM
42344	Cuervo	Mario	10	Florida Psychiatric Society	GM
305016	Dhungana	Pritha	10	Florida Psychiatric Society	GM
69551	Dunn	Kelly	10	Florida Psychiatric Society	GM
1013905	Fayad	Sarah	10	Florida Psychiatric Society	GM
44955	Feinstein	Harris	10	Florida Psychiatric Society	GM
1088535	Fernandez	Jamie	10	Florida Psychiatric Society	GM
1013639	Hagstrom	Alan	10	Florida Psychiatric Society	GM
1011969	Hervey	William	10	Florida Psychiatric Society	GM
310197	Hidalgo	Rosario	10	Florida Psychiatric Society	GM
59907	Hutcheson	Mary	10	Florida Psychiatric Society	GM
1040733	Iqbal	Nayyer	10	Florida Psychiatric Society	GM
310436	Jacob	Thomas	10	Florida Psychiatric Society	GM
1094681	Kenneth	Arline	10	Florida Psychiatric Society	GM
67345	Kirsch	Debra	10	Florida Psychiatric Society	GM
62321	Krotenberg	Jeffrey	10	Florida Psychiatric Society	GM
83152	Lossada	Mery	10	Florida Psychiatric Society	GM
1010666	Luca	Catrina	10	Florida Psychiatric Society	GM
62371	Mangrola	Raju	10	Florida Psychiatric Society	GM
1008954	Mayol-Sabatier	Laura	10	Florida Psychiatric Society	GM
78897	Newport	D	10	Florida Psychiatric Society	GM
306714	Ning	Autumn	10	Florida Psychiatric Society	GM
311451	Perez	Alexander	10	Florida Psychiatric Society	GM
304069	Potluri	Ajith	10	Florida Psychiatric Society	GM
73983	Rahman	Riaz	10	Florida Psychiatric Society	GM
1021346	Rahmani	Mariam	10	Florida Psychiatric Society	GM
1005668	Ramirez-Cook	Onelia	10	Florida Psychiatric Society	GM
1008787	Reyes	Lina	10	Florida Psychiatric Society	GM
1004812	Sadek	Reham	10	Florida Psychiatric Society	GM
56180	Saveanu	Teri	10	Florida Psychiatric Society	GM

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307466	Seibell	Phillip	10	Florida Psychiatric Society	GM
1006714	Shapiro	Michael	10	Florida Psychiatric Society	GM
41052	Speiser	Steven	10	Florida Psychiatric Society	LM
60154	Stevens	Michael	10	Florida Psychiatric Society	GM
307600	Strozeski	Janet	10	Florida Psychiatric Society	GM
92509	Taylor	Phyliss	10	Florida Psychiatric Society	GM
26606	Trovato	Frank	10	Florida Psychiatric Society	LM
91993	Vanterpool	Joycelyn	10	Florida Psychiatric Society	GM
307472	Vidal	Elizabeth	10	Florida Psychiatric Society	GM
311068	Yokum	Kelley	10	Florida Psychiatric Society	GM
70040	Zaglul	Jose	10	Florida Psychiatric Society	GM
70382	Ahluwalia	Gurpreet	11	Georgia Psychiatric Physicians Association, Inc	GM
92002	Ahmed	Muhammad	11	Georgia Psychiatric Physicians Association, Inc	GM
1008546	Albright	Mitzi	11	Georgia Psychiatric Physicians Association, Inc	GM
1007258	Avasthi	RK	11	Georgia Psychiatric Physicians Association, Inc	GM
301880	Babatope	Olasimbo	11	Georgia Psychiatric Physicians Association, Inc	GM
71120	Banov	Michael	11	Georgia Psychiatric Physicians Association, Inc	GM
311651	Beck	Corey	11	Georgia Psychiatric Physicians Association, Inc	GM
1010940	Bhat	Ishrat	11	Georgia Psychiatric Physicians Association, Inc	GM
78219	Carter	Walker	11	Georgia Psychiatric Physicians Association, Inc	GM
32832	Casals	Michelle	11	Georgia Psychiatric Physicians Association, Inc	LM
53838	Corsale	Mark	11	Georgia Psychiatric Physicians Association, Inc	GM
310952	Dev	Parul	11	Georgia Psychiatric Physicians Association, Inc	GM
77659	Diehl	Sandra	11	Georgia Psychiatric Physicians Association, Inc	GM
63053	Dirksen	John	11	Georgia Psychiatric Physicians Association, Inc	GM
61477	Drexler	Karen	11	Georgia Psychiatric Physicians Association, Inc	GM
65677	Fell	Donna	11	Georgia Psychiatric Physicians Association, Inc	GM
1007580	Fortuchang	Shaw	11	Georgia Psychiatric Physicians Association, Inc	GM
82001	Furbish	Elizabeth	11	Georgia Psychiatric Physicians Association, Inc	GM
1016820	Gaffney	Ebony	11	Georgia Psychiatric Physicians Association, Inc	GM
79365	Gbadebo	Olufowobi	11	Georgia Psychiatric Physicians Association, Inc	GM
1013557	Graham	Krystle	11	Georgia Psychiatric Physicians Association, Inc	GM
305063	Griffin	Dauda	11	Georgia Psychiatric Physicians Association, Inc	GM
57521	Herbert	Sarah	11	Georgia Psychiatric Physicians Association, Inc	LM
67216	Hindash	Osama	11	Georgia Psychiatric Physicians Association, Inc	GM
28108	Howard	James	11	Georgia Psychiatric Physicians Association, Inc	LM
69158	Johnson	Robin	11	Georgia Psychiatric Physicians Association, Inc	GM
58606	Kahn	Neil	11	Georgia Psychiatric Physicians Association, Inc	GM
77249	Kanawati	Yassar	11	Georgia Psychiatric Physicians Association, Inc	GM
1001531	Karim	Sanjana	11	Georgia Psychiatric Physicians Association, Inc	GM
305375	Katragadda	Suneel	11	Georgia Psychiatric Physicians Association, Inc	GM
312312	Khan	Rizwan	11	Georgia Psychiatric Physicians Association, Inc	GM
40514	Lee	Steven	11	Georgia Psychiatric Physicians Association, Inc	GM
1001256	McCormick	Charles	11	Georgia Psychiatric Physicians Association, Inc	GM
1005358	Millan Sanchez	Martha	11	Georgia Psychiatric Physicians Association, Inc	GM
311031	Miller	Brian	11	Georgia Psychiatric Physicians Association, Inc	GM
85525	Minor	Edward	11	Georgia Psychiatric Physicians Association, Inc	GM
44687	Morgan	Gwen	11	Georgia Psychiatric Physicians Association, Inc	GM
1008012	Natarajan	Nirupama	11	Georgia Psychiatric Physicians Association, Inc	GM
32707	O'Griofa	Fionan	11	Georgia Psychiatric Physicians Association, Inc	LM
68363	Panarites	Helen	11	Georgia Psychiatric Physicians Association, Inc	GM
35084	Parekh	Kashmira	11	Georgia Psychiatric Physicians Association, Inc	LM
61862	Pathiraja	Ananda	11	Georgia Psychiatric Physicians Association, Inc	GM
104104	Peeples	Dale	11	Georgia Psychiatric Physicians Association, Inc	GM
83068	Radulovacki	Branko	11	Georgia Psychiatric Physicians Association, Inc	GM
306693	Rakofsky	Jeffrey	11	Georgia Psychiatric Physicians Association, Inc	GM
33149	Riddell	Chris	11	Georgia Psychiatric Physicians Association, Inc	LM

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1011898	Sawicki	Alexandra	11	Georgia Psychiatric Physicians Association, Inc	GM
32563	Sebastian	C	11	Georgia Psychiatric Physicians Association, Inc	GM
33604	Snyder	Scott	11	Georgia Psychiatric Physicians Association, Inc	LM
30747	Song	Young	11	Georgia Psychiatric Physicians Association, Inc	LM
72189	Stoute	Beverly	11	Georgia Psychiatric Physicians Association, Inc	GM
77441	Strauch	Nancy	11	Georgia Psychiatric Physicians Association, Inc	GM
102784	Syed	Abdul	11	Georgia Psychiatric Physicians Association, Inc	GM
310256	Thompson	Joseph	11	Georgia Psychiatric Physicians Association, Inc	GM
66409	Tyson	Mary	11	Georgia Psychiatric Physicians Association, Inc	GM
77694	Van Sant	Scott	11	Georgia Psychiatric Physicians Association, Inc	GM
300683	Vayalapalli	Sreedevi	11	Georgia Psychiatric Physicians Association, Inc	GM
312700	Vinson	Sarah	11	Georgia Psychiatric Physicians Association, Inc	GM
35196	Wanzo	Cassandra	11	Georgia Psychiatric Physicians Association, Inc	GM
1049928	Ghiasuddin	Asad	12	Hawaii Psychiatric Medical Association	GM
1002502	Agarwal	Gaurava	13	Illinois Psychiatric Society	GM
309973	Alluri	Vinod	13	Illinois Psychiatric Society	GM
43431	Aronson	Sari	13	Illinois Psychiatric Society	GM
312226	Ballard	Rachel	13	Illinois Psychiatric Society	GM
53365	Beck	John	13	Illinois Psychiatric Society	GM
8449	Berkwits	Gloria	13	Illinois Psychiatric Society	LM
58742	Broquet	Karen	13	Illinois Psychiatric Society	GM
1016451	Chang	Jason	13	Illinois Psychiatric Society	GM
303678	Dini	Kourosh	13	Illinois Psychiatric Society	GM
302500	Field	Michelle	13	Illinois Psychiatric Society	GM
1007802	Gavin	Michelle	13	Illinois Psychiatric Society	GM
74936	Goldman	David	13	Illinois Psychiatric Society	GM
310224	Griffin	Marilyn	13	Illinois Psychiatric Society	GM
71414	Hartzen	Marla	13	Illinois Psychiatric Society	GM
102484	Hazaray	Emmeline	13	Illinois Psychiatric Society	GM
37892	Herrmann	Thomas	13	Illinois Psychiatric Society	LM
74437	Joyner	Claudia	13	Illinois Psychiatric Society	GM
102093	Khan	Wajid	13	Illinois Psychiatric Society	GM
1001313	Korpics	John	13	Illinois Psychiatric Society	GM
303113	Lillig	Mathias	13	Illinois Psychiatric Society	GM
305293	Meresh	Edwin	13	Illinois Psychiatric Society	GM
83775	Meyer	Kimberly	13	Illinois Psychiatric Society	GM
45514	Moody	Virginia	13	Illinois Psychiatric Society	GM
307726	Nathan	Joshua	13	Illinois Psychiatric Society	GM
1001891	Nichols	Peter	13	Illinois Psychiatric Society	GM
56085	Patras	James	13	Illinois Psychiatric Society	GM
1014160	Rao	Kalyan	13	Illinois Psychiatric Society	GM
33913	Rattan	Pradeep	13	Illinois Psychiatric Society	LM
305330	Rosenthal	Lisa	13	Illinois Psychiatric Society	GM
300433	Salinas	Esperanza	13	Illinois Psychiatric Society	GM
82684	Schell	Nancy	13	Illinois Psychiatric Society	GM
70964	Swantek	Sandra	13	Illinois Psychiatric Society	GM
1022084	Varghese	Sajoy	13	Illinois Psychiatric Society	GM
83777	Weinstein	Steven	13	Illinois Psychiatric Society	GM
304546	Williams	Adedapo	13	Illinois Psychiatric Society	GM
79147	Win	Zaw	13	Illinois Psychiatric Society	GM
67334	Bangs	Mark	14	Indiana Psychiatric Society	GM
102483	Bealke	Judith	14	Indiana Psychiatric Society	GM
67405	Borders	Philip	14	Indiana Psychiatric Society	GM
90956	Carder	Lynnea	14	Indiana Psychiatric Society	GM
306533	Chadha	Ritu	14	Indiana Psychiatric Society	GM
1016759	Dubey	Shivam	14	Indiana Psychiatric Society	GM
1016184	Khan	Mehtab	14	Indiana Psychiatric Society	GM

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1013438	Levine	Scott	14	Indiana Psychiatric Society	GM
310214	Mahmood	Ahsan	14	Indiana Psychiatric Society	GM
88029	Martinez	James	14	Indiana Psychiatric Society	GM
80142	Mueller	Rebecca	14	Indiana Psychiatric Society	GM
63560	Nicholas	Michael	14	Indiana Psychiatric Society	GM
1005042	Ricke	Amy	14	Indiana Psychiatric Society	GM
63019	Schneider	Steven	14	Indiana Psychiatric Society	GM
305889	Abdallah	Ehab	15	Idaho Psychiatric Association	GM
73023	Hines	Alan	15	Idaho Psychiatric Association	GM
1015897	Pullen	Samuel	15	Idaho Psychiatric Association	GM
84600	Ravsten	Deric	15	Idaho Psychiatric Association	GM
62771	Wait	David	15	Idaho Psychiatric Association	GM
102046	Calarge	Chadi	16	Iowa Psychiatric Society	GM
1001327	Johnson	Eric	16	Iowa Psychiatric Society	GM
302828	Kijewski	Vicki	16	Iowa Psychiatric Society	GM
77625	Muller	Philip	16	Iowa Psychiatric Society	GM
69960	Natvig	Paul	16	Iowa Psychiatric Society	GM
1037660	Simison	Michael	16	Iowa Psychiatric Society	GM
1038609	Caraballo Osorio	Patricia	17	Kansas Psychiatric Society	GM
307164	Khan	Mairaj	17	Kansas Psychiatric Society	GM
69015	Menninger	Brent	17	Kansas Psychiatric Society	GM
1061536	Rajpoot	Deepak	17	Kansas Psychiatric Society	GM
309141	Sullivant	Shayla	17	Kansas Psychiatric Society	GM
80788	Carvalho	Cletus	18	Kentucky Psychiatric Medical Association	GM
76973	Chhibber	Sunil	18	Kentucky Psychiatric Medical Association	GM
307640	Hettinger	Amanda	18	Kentucky Psychiatric Medical Association	GM
306303	Houchin	Timothy	18	Kentucky Psychiatric Medical Association	GM
9398	Johnson	Alan	18	Kentucky Psychiatric Medical Association	LM
1001023	Kwolek	Judie	18	Kentucky Psychiatric Medical Association	GM
309076	Le	Jennifer	18	Kentucky Psychiatric Medical Association	GM
33232	Moore	David	18	Kentucky Psychiatric Medical Association	GM
1013587	Rayapati	Abner	18	Kentucky Psychiatric Medical Association	GM
308024	Sallee	John	18	Kentucky Psychiatric Medical Association	GM
71025	Shelton	Charles	18	Kentucky Psychiatric Medical Association	GM
66540	Zusman	Zeev	18	Kentucky Psychiatric Medical Association	GM
302595	Aponte	Vivianne	19	Louisiana Psychiatric Medical Association	GM
79269	Borrillo	Christopher	19	Louisiana Psychiatric Medical Association	GM
305442	Drury	Stacy	19	Louisiana Psychiatric Medical Association	GM
1013065	Fluitt	Nicholas	19	Louisiana Psychiatric Medical Association	GM
1017445	Kinzie	Erik	19	Louisiana Psychiatric Medical Association	GM
1000694	Myint	Myo Thwin	19	Louisiana Psychiatric Medical Association	GM
312856	Qalbani	Mehdi	19	Louisiana Psychiatric Medical Association	GM
43567	Shervington	Denese	19	Louisiana Psychiatric Medical Association	GM
1004462	Wells	John	19	Louisiana Psychiatric Medical Association	GM
303902	Adashi	Kristen	20	Maryland Psychiatric Society, Inc	GM
1008570	Anderson	Eric	20	Maryland Psychiatric Society, Inc	GM
1068264	Armanas	Peter	20	Maryland Psychiatric Society, Inc	GM
74178	Bright	Kim	20	Maryland Psychiatric Society, Inc	GM
41832	Brynes	Glenn	20	Maryland Psychiatric Society, Inc	GM
65146	Chisolm	Margaret	20	Maryland Psychiatric Society, Inc	GM
86496	Cooke-Chen	Ayanna	20	Maryland Psychiatric Society, Inc	GM
302683	Goff	Heather	20	Maryland Psychiatric Society, Inc	GM
77150	Goldberg	Stephen	20	Maryland Psychiatric Society, Inc	GM
102683	Hall	Jo	20	Maryland Psychiatric Society, Inc	GM
308148	Hightower	Tyler	20	Maryland Psychiatric Society, Inc	GM
311431	Johnston	Meredith	20	Maryland Psychiatric Society, Inc	GM
31053	Jonas	Alan	20	Maryland Psychiatric Society, Inc	LM

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1017259	Khalid	Ovais	20	Maryland Psychiatric Society, Inc	GM
22308	Klein	Gary	20	Maryland Psychiatric Society, Inc	LM
1008196	Knight	Stephanie	20	Maryland Psychiatric Society, Inc	GM
1002771	Koola	Maju	20	Maryland Psychiatric Society, Inc	GM
304236	Lachner	Christian	20	Maryland Psychiatric Society, Inc	GM
68886	MacKinnon	Dean	20	Maryland Psychiatric Society, Inc	GM
1068345	Money	Kristina	20	Maryland Psychiatric Society, Inc	GM
21452	Padow	Rhoda	20	Maryland Psychiatric Society, Inc	LM
305351	Pirard	Sandrine	20	Maryland Psychiatric Society, Inc	GM
1015214	Puttaiah	Savitha	20	Maryland Psychiatric Society, Inc	GM
34360	Seligman	Garry	20	Maryland Psychiatric Society, Inc	LM
77745	Tomar	Elizabeth	20	Maryland Psychiatric Society, Inc	GM
303571	Tompkins	David	20	Maryland Psychiatric Society, Inc	GM
1008917	Winter	Elizabeth	20	Maryland Psychiatric Society, Inc	GM
305623	Achtyes	Eric	21	Michigan Psychiatric Society	GM
306250	Bess	Joshua	21	Michigan Psychiatric Society	GM
1001174	Coffey	M Justin	21	Michigan Psychiatric Society	GM
310858	Debiec	Jacek	21	Michigan Psychiatric Society	GM
83680	Dhatreecharan	Geetha	21	Michigan Psychiatric Society	GM
1008072	Galkine	Natalia	21	Michigan Psychiatric Society	GM
89229	Garcia	Robert	21	Michigan Psychiatric Society	GM
79556	Jawor	Katherine	21	Michigan Psychiatric Society	GM
37318	Koppenol	Carolyn	21	Michigan Psychiatric Society	GM
77456	Krause	Carey	21	Michigan Psychiatric Society	GM
78524	Lyons	Lynne	21	Michigan Psychiatric Society	GM
55429	Mahal	Surjit	21	Michigan Psychiatric Society	GM
85470	Massoumi	Lila	21	Michigan Psychiatric Society	GM
1008735	Parashar	Sunil	21	Michigan Psychiatric Society	GM
1009877	Plum	Rachel	21	Michigan Psychiatric Society	GM
72739	Rana	Lopa	21	Michigan Psychiatric Society	GM
70732	Raval	Kaushik	21	Michigan Psychiatric Society	GM
301725	Sidiropoulos	Andreas	21	Michigan Psychiatric Society	GM
63122	Van Haren	James	21	Michigan Psychiatric Society	GM
65282	Venkataraman	Sanjeev	21	Michigan Psychiatric Society	GM
1004135	Yousif	Raed	21	Michigan Psychiatric Society	GM
1008758	Anyake	Chukwuemeka	22	Minnesota Psychiatric Society	GM
1054876	Arnold	Heidi	22	Minnesota Psychiatric Society	GM
89239	Auger	R	22	Minnesota Psychiatric Society	GM
1000883	Brandenburg	Beth	22	Minnesota Psychiatric Society	GM
310859	Case	Kristen	22	Minnesota Psychiatric Society	GM
1004058	Grandt	Steven	22	Minnesota Psychiatric Society	GM
306108	Holt	Allison	22	Minnesota Psychiatric Society	GM
1014659	Johns	Brian	22	Minnesota Psychiatric Society	GM
1012819	Klapperich	Adam	22	Minnesota Psychiatric Society	GM
1011333	Kolla	Bhanu Prakash	22	Minnesota Psychiatric Society	GM
311521	LaRiviere	Lori	22	Minnesota Psychiatric Society	GM
41178	Midelfort	H	22	Minnesota Psychiatric Society	LM
1004055	Nelson	Katharine	22	Minnesota Psychiatric Society	GM
312550	Rosas	Elena	22	Minnesota Psychiatric Society	GM
59177	Setterberg	Stephen	22	Minnesota Psychiatric Society	GM
89121	Suri	Muhammad	22	Minnesota Psychiatric Society	GM
306246	Thomarios	Nickitas	22	Minnesota Psychiatric Society	GM
45886	Bishop	Andrew	23	Mississippi Psychiatric Association, Inc	GM
78965	Kumar	Parveen	23	Mississippi Psychiatric Association, Inc	GM
68977	Laizer	Janet	23	Mississippi Psychiatric Association, Inc	GM
1011827	Smith	Bridget	23	Mississippi Psychiatric Association, Inc	GM
89678	Ahmed	Masum	24	Mid-Hudson Psychiatric Society	GM

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303343	Gonsalves	Dawn	24	Mid-Hudson Psychiatric Society	GM
65367	Shriver	Kren	24	Mid-Hudson Psychiatric Society	GM
44738	Zinzuvadia	Kishor	24	Mid-Hudson Psychiatric Society	GM
84074	Angulo	Augusto	25	Greater Long Island Psychiatric Society	GM
64710	Bogdonoff	Lisa	25	Greater Long Island Psychiatric Society	GM
1019426	Cabrera	Jennifer	25	Greater Long Island Psychiatric Society	GM
26754	Carlson	Gabrielle	25	Greater Long Island Psychiatric Society	LM
305065	Hao	Howard	25	Greater Long Island Psychiatric Society	GM
62268	Kafantaris	Vivian	25	Greater Long Island Psychiatric Society	GM
1016725	Marsh	Akeem	25	Greater Long Island Psychiatric Society	GM
1008540	Martin	Danielle	25	Greater Long Island Psychiatric Society	GM
73971	Pitch	Richard	25	Greater Long Island Psychiatric Society	GM
63764	Sadikot	Susan	25	Greater Long Island Psychiatric Society	GM
1020116	Sanghani	Sohag	25	Greater Long Island Psychiatric Society	GM
33024	Sodaro	Edward	25	Greater Long Island Psychiatric Society	LM
38813	Sperber	Jacob	25	Greater Long Island Psychiatric Society	LM
309948	Arora	Lily	26	New Jersey Psychiatric Association	GM
300888	Bhandari	Pankaj	26	New Jersey Psychiatric Association	GM
40707	Bortnichak	Paula	26	New Jersey Psychiatric Association	LM
68672	Cahenzli	Christopher	26	New Jersey Psychiatric Association	GM
70983	Camacho	Brenda	26	New Jersey Psychiatric Association	GM
70767	Cantillon	Marc	26	New Jersey Psychiatric Association	GM
90218	Chen	Hong	26	New Jersey Psychiatric Association	GM
304432	Cohen	Adam	26	New Jersey Psychiatric Association	GM
68040	Cordal	Adriana	26	New Jersey Psychiatric Association	GM
1001336	Corvari	Steven	26	New Jersey Psychiatric Association	GM
306307	Dementyeva	Yuliya	26	New Jersey Psychiatric Association	GM
62056	DeWorsop	Richard	26	New Jersey Psychiatric Association	GM
308950	Dyakina	Nika	26	New Jersey Psychiatric Association	GM
63711	Francisco	Rowena	26	New Jersey Psychiatric Association	GM
306012	Ganescu	Daniela	26	New Jersey Psychiatric Association	GM
31365	Gewolb	Eric	26	New Jersey Psychiatric Association	LM
305565	Jackson	Michael	26	New Jersey Psychiatric Association	GM
306694	Juneja	Tony	26	New Jersey Psychiatric Association	GM
32600	Keyser	Joseph	26	New Jersey Psychiatric Association	LM
69823	Lieberman	Jordan	26	New Jersey Psychiatric Association	GM
307155	Lui	Gene	26	New Jersey Psychiatric Association	GM
44345	Marrero-Figarella	Arturo	26	New Jersey Psychiatric Association	GM
301430	Masry	Allen	26	New Jersey Psychiatric Association	GM
66551	Murphy	Francis	26	New Jersey Psychiatric Association	GM
306310	Nanjiani	Aijaz	26	New Jersey Psychiatric Association	GM
80942	Patel	Jayantilal	26	New Jersey Psychiatric Association	GM
1009323	Pradhan	Basant	26	New Jersey Psychiatric Association	GM
56351	Reichstein	Michele	26	New Jersey Psychiatric Association	GM
71944	Reyes	Christine	26	New Jersey Psychiatric Association	GM
66719	Samuels	Steven	26	New Jersey Psychiatric Association	GM
41512	Sanchez-Lacay	Jose	26	New Jersey Psychiatric Association	GM
66286	Sastry	Gayathri	26	New Jersey Psychiatric Association	GM
34976	Schofield	Neal	26	New Jersey Psychiatric Association	GM
1111627	Shah	Hinna	26	New Jersey Psychiatric Association	GM
307878	Sinha	Sharmila	26	New Jersey Psychiatric Association	GM
1014025	Solimine	Susan	26	New Jersey Psychiatric Association	GM
309486	Upadhyay	Shilpa	26	New Jersey Psychiatric Association	GM
20301	Van Kammen	Daniel	26	New Jersey Psychiatric Association	LM
43293	Vitolo	Joseph	26	New Jersey Psychiatric Association	GM
307828	Wei	Ronald	26	New Jersey Psychiatric Association	GM
1008057	Williams	Arnold	26	New Jersey Psychiatric Association	GM

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65388	Alfonso	Cesar	27	New York County Psychiatric Society	GM
53184	Ancona	Laura	27	New York County Psychiatric Society	GM
1152684	Bhutia	Phintso	27	New York County Psychiatric Society	GM
89581	Bienenfeld	Scott	27	New York County Psychiatric Society	GM
301828	Brajkovic	Dasen	27	New York County Psychiatric Society	GM
31966	Bukberg	Judith	27	New York County Psychiatric Society	LM
1013757	Capasso	Rebecca	27	New York County Psychiatric Society	GM
305681	Caraballo	Angel	27	New York County Psychiatric Society	GM
57774	Carbone	Joseph	27	New York County Psychiatric Society	GM
311054	Carlson	Stephan	27	New York County Psychiatric Society	GM
1005392	Casoy	Flavio	27	New York County Psychiatric Society	GM
73646	Chatterjee	Anjan	27	New York County Psychiatric Society	GM
40784	Chen	Clarence	27	New York County Psychiatric Society	LM
67176	Cherry	Sabrina	27	New York County Psychiatric Society	GM
305002	Colibazzi	Tiziano	27	New York County Psychiatric Society	GM
1010797	Cooperman	David	27	New York County Psychiatric Society	GM
300541	Davis	Glen	27	New York County Psychiatric Society	GM
1005201	Dickerman	Anna	27	New York County Psychiatric Society	GM
17784	Ellenberg	Jack	27	New York County Psychiatric Society	LM
1008579	Erlich	Matthew	27	New York County Psychiatric Society	GM
304250	Estrada	Roberto	27	New York County Psychiatric Society	GM
19451	Fay	Allen	27	New York County Psychiatric Society	LM
307062	Focht	Amanda	27	New York County Psychiatric Society	GM
33454	Freeman	Linda	27	New York County Psychiatric Society	LM
54315	Friedman	Cathy	27	New York County Psychiatric Society	GM
69201	Galynker	Igor	27	New York County Psychiatric Society	GM
72329	Goldfarb	Lisa	27	New York County Psychiatric Society	GM
312112	Gordon-Elliott	Janna	27	New York County Psychiatric Society	GM
311320	Gunther	Cary	27	New York County Psychiatric Society	GM
310334	Harding	Kelli Jane	27	New York County Psychiatric Society	GM
1000984	Hsu	Alan	27	New York County Psychiatric Society	GM
80673	Idowu	Joel	27	New York County Psychiatric Society	GM
1005813	Johnson	Amy	27	New York County Psychiatric Society	GM
1000856	Key	R.	27	New York County Psychiatric Society	GM
58045	Kleinman	Stuart	27	New York County Psychiatric Society	GM
86218	Lapetina	Graciana	27	New York County Psychiatric Society	GM
300895	Lee	Li-Wen	27	New York County Psychiatric Society	GM
312687	Lothwell	Lorraine	27	New York County Psychiatric Society	GM
304141	Malach	Stephen	27	New York County Psychiatric Society	GM
66097	Maruyama	Nancy	27	New York County Psychiatric Society	GM
92322	McAfee	Scot	27	New York County Psychiatric Society	GM
30244	Meisel	Gail	27	New York County Psychiatric Society	LM
1001921	Messing	Jacob	27	New York County Psychiatric Society	GM
1008797	Mishkin	Adrienne	27	New York County Psychiatric Society	GM
1005010	Mundy	Daniel	27	New York County Psychiatric Society	GM
73060	Nims	Chloe	27	New York County Psychiatric Society	GM
55929	Nunes	Edward	27	New York County Psychiatric Society	GM
306996	Onanuga	Jelil	27	New York County Psychiatric Society	GM
1004117	Ozga	Melissa	27	New York County Psychiatric Society	GM
311226	Palyo	Scott	27	New York County Psychiatric Society	GM
76004	Panikkar	Gopakumar	27	New York County Psychiatric Society	GM
1007755	Patterson	Aaron	27	New York County Psychiatric Society	GM
304140	Rafizadeh	Neala	27	New York County Psychiatric Society	GM
1008626	Rosenfeld	Andrew	27	New York County Psychiatric Society	GM
1037332	Samuel	Diana	27	New York County Psychiatric Society	GM
312548	Samuels	Susan	27	New York County Psychiatric Society	GM
58341	Sandberg	Larry	27	New York County Psychiatric Society	GM

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20769	Schein	Jonah	27	New York County Psychiatric Society	LM
89484	Scott	Marta	27	New York County Psychiatric Society	GM
304238	Shakibaie Smith	Shabnam	27	New York County Psychiatric Society	GM
1056986	Snyder	Carlyn	27	New York County Psychiatric Society	GM
310956	Thomas	Anil	27	New York County Psychiatric Society	GM
1017436	Tosk	Jarrett	27	New York County Psychiatric Society	GM
308167	Urban	Nina	27	New York County Psychiatric Society	GM
65369	Wachter	Eileen	27	New York County Psychiatric Society	GM
1000077	Walton	Michael	27	New York County Psychiatric Society	GM
1015774	Wei	Marlynn	27	New York County Psychiatric Society	GM
81645	Wilson	Mark	27	New York County Psychiatric Society	GM
84826	Winell	Jeremy	27	New York County Psychiatric Society	GM
312777	Yarbrough	Eric	27	New York County Psychiatric Society	GM
311574	Yusim	Anna	27	New York County Psychiatric Society	GM
1005197	Zack	Yelena	27	New York County Psychiatric Society	GM
87854	Zinberg	Adele	27	New York County Psychiatric Society	GM
84848	Zylberman	Ilana	27	New York County Psychiatric Society	GM
63956	Astill-Vaccaro	Joanne	28	New York State Capital District Branch	GM
44251	Delisle	Jeffrey	28	New York State Capital District Branch	GM
81200	Ermolenko	Guerman	28	New York State Capital District Branch	GM
88977	Perkins	Matthew	28	New York State Capital District Branch	GM
41690	Rubin	Hal	28	New York State Capital District Branch	GM
1017805	Albert	Aaron	29	North Carolina Psychiatric Association	GM
1073321	Bhatt-Mackin	Seamus	29	North Carolina Psychiatric Association	GM
84615	Boeker	Thomas	29	North Carolina Psychiatric Association	GM
306698	Bronner	Leslie	29	North Carolina Psychiatric Association	GM
1000400	Byrne	Jennie	29	North Carolina Psychiatric Association	GM
72297	Campbell	Vivian	29	North Carolina Psychiatric Association	GM
65028	Caudill	Fred	29	North Carolina Psychiatric Association	GM
305847	Dunham	Charles	29	North Carolina Psychiatric Association	GM
1016132	Feldman	Lance	29	North Carolina Psychiatric Association	GM
308061	Feldman	Zachary	29	North Carolina Psychiatric Association	GM
310164	John	Nadyah	29	North Carolina Psychiatric Association	GM
1004169	Jonnalagadda	Venkata	29	North Carolina Psychiatric Association	GM
1008002	Kaesemeyer	Nadiya	29	North Carolina Psychiatric Association	GM
1013006	Kitten	Suzanna	29	North Carolina Psychiatric Association	GM
75272	Miller	Arlene	29	North Carolina Psychiatric Association	GM
82598	Pennell	Jennifer	29	North Carolina Psychiatric Association	GM
307078	Rau	Shane	29	North Carolina Psychiatric Association	GM
307176	Romeo	Alicia	29	North Carolina Psychiatric Association	GM
21262	Rubio	Ramon	29	North Carolina Psychiatric Association	LM
310528	Salami	Saka	29	North Carolina Psychiatric Association	GM
305811	Shah	Binoy	29	North Carolina Psychiatric Association	GM
1010428	Singleton	Amy	29	North Carolina Psychiatric Association	GM
1136833	Taylor	An'Drea	29	North Carolina Psychiatric Association	GM
86491	Tolin	Kellie	29	North Carolina Psychiatric Association	GM
312515	Utterback	Reem	29	North Carolina Psychiatric Association	GM
311331	Wells Slechta	Sarah	29	North Carolina Psychiatric Association	GM
306750	Zia	Saima	29	North Carolina Psychiatric Association	GM
1121962	Auza	Michael	30	Northern California Psychiatric Society	GM
31397	Bartell	Gary	30	Northern California Psychiatric Society	LM
39083	Bernstein	Mark	30	Northern California Psychiatric Society	LM
1008981	Bhatia	Richa	30	Northern California Psychiatric Society	GM
309708	Chan	Helena	30	Northern California Psychiatric Society	GM
303471	Chou	David	30	Northern California Psychiatric Society	GM
1007080	Corriveau	Caroline	30	Northern California Psychiatric Society	GM
90154	Danielyan	Arman	30	Northern California Psychiatric Society	GM

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64081	Dong	Kathleen	30	Northern California Psychiatric Society	GM
1002372	Duvvuri	Vikas	30	Northern California Psychiatric Society	GM
44271	Edelman	Susan	30	Northern California Psychiatric Society	GM
1000354	Esguerra	Chris Edward	30	Northern California Psychiatric Society	GM
73725	Feeley	D	30	Northern California Psychiatric Society	GM
86213	Garner	Evan	30	Northern California Psychiatric Society	GM
312249	Gearhart	Lorie	30	Northern California Psychiatric Society	GM
18372	Grossi	Philip	30	Northern California Psychiatric Society	LM
86937	Harrison	Ari	30	Northern California Psychiatric Society	GM
83860	Hofmann	Virginia	30	Northern California Psychiatric Society	GM
59895	Holland	Peter	30	Northern California Psychiatric Society	GM
43318	Jeffers	Gregory	30	Northern California Psychiatric Society	GM
309870	Kalapatapu	Rajkumar	30	Northern California Psychiatric Society	GM
1007484	Kapitanski	Nina	30	Northern California Psychiatric Society	GM
102244	Khan	Farah	30	Northern California Psychiatric Society	GM
85767	Kron	Michael	30	Northern California Psychiatric Society	GM
35004	Leo	Karen	30	Northern California Psychiatric Society	LM
65111	Ljaljevic	Zorica	30	Northern California Psychiatric Society	GM
35008	Marx	Alan	30	Northern California Psychiatric Society	GM
75010	Mathews	Carol	30	Northern California Psychiatric Society	GM
306908	Moreno	Arnaldo	30	Northern California Psychiatric Society	GM
45594	Murphy	Minnette	30	Northern California Psychiatric Society	LM
37310	Paz	George	30	Northern California Psychiatric Society	LM
307566	Popescu	Ioana-Mihaela	30	Northern California Psychiatric Society	GM
43278	Prey	William	30	Northern California Psychiatric Society	GM
103264	Rho	Yanni	30	Northern California Psychiatric Society	GM
79900	Safer	Debra	30	Northern California Psychiatric Society	GM
305602	Saldanha	Charles	30	Northern California Psychiatric Society	GM
67498	Schiff	Elizabeth	30	Northern California Psychiatric Society	GM
74038	Simkovic	Suzana	30	Northern California Psychiatric Society	GM
43603	Solomon	Randall	30	Northern California Psychiatric Society	GM
81949	Sutherland	Vanna	30	Northern California Psychiatric Society	GM
79737	Takeuchi	Jason	30	Northern California Psychiatric Society	GM
1004150	Torry	Zachary	30	Northern California Psychiatric Society	GM
88050	Watters	Rebecca	30	Northern California Psychiatric Society	GM
81720	Ahn	Mary	32	Massachusetts Psychiatric Society	GM
34372	Berenbaum	Isidore	32	Massachusetts Psychiatric Society	LM
32893	Berlin	Richard	32	Massachusetts Psychiatric Society	LM
72799	Brooks	Alexis	32	Massachusetts Psychiatric Society	GM
1061913	Bush	Ashley	32	Massachusetts Psychiatric Society	GM
74746	Cimpeanu	Cezar	32	Massachusetts Psychiatric Society	GM
301817	Cohen	Wendy	32	Massachusetts Psychiatric Society	GM
34099	Davis	Aloysius	32	Massachusetts Psychiatric Society	LM
92335	Deans	Emily	32	Massachusetts Psychiatric Society	GM
313072	Donovan	Abigail	32	Massachusetts Psychiatric Society	GM
90997	Doshier	Jeffrey	32	Massachusetts Psychiatric Society	GM
304529	Fan	Xiaoduo	32	Massachusetts Psychiatric Society	GM
35163	Haines	Linda	32	Massachusetts Psychiatric Society	GM
68168	Hamkins	SuEllen	32	Massachusetts Psychiatric Society	GM
1001546	Hamoda	Hesham	32	Massachusetts Psychiatric Society	GM
311231	Harrington	Amy	32	Massachusetts Psychiatric Society	GM
65799	Heinsohn	Carmel	32	Massachusetts Psychiatric Society	GM
307692	Hopkins	John	32	Massachusetts Psychiatric Society	GM
304644	Kambampati	Vikram	32	Massachusetts Psychiatric Society	GM
69756	Kennedy	Christopher	32	Massachusetts Psychiatric Society	GM
307454	Langenfeld	Sarah	32	Massachusetts Psychiatric Society	GM
44664	Lawrence	Janet	32	Massachusetts Psychiatric Society	GM

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85852	Marsh	Wendy	32	Massachusetts Psychiatric Society	GM
313131	Maytal	Guy	32	Massachusetts Psychiatric Society	GM
79154	Moffa	Nicholas	32	Massachusetts Psychiatric Society	GM
71581	Mollod	Daniel	32	Massachusetts Psychiatric Society	GM
79232	Rediger	Jeffrey	32	Massachusetts Psychiatric Society	GM
1000237	Reed	Nancy	32	Massachusetts Psychiatric Society	GM
75776	Remmler	Saiya	32	Massachusetts Psychiatric Society	GM
305473	Somers	Nathan	32	Massachusetts Psychiatric Society	GM
311792	Trevisan	Karen	32	Massachusetts Psychiatric Society	GM
311172	Vitolo	Ottavio	32	Massachusetts Psychiatric Society	GM
1012907	Widge	Alik	32	Massachusetts Psychiatric Society	RFM
68573	Wood	Paul	32	Massachusetts Psychiatric Society	GM
1059942	Basnett	Saneer	33	Washington State Psychiatric Association	GM
1051576	Braden	Jennifer	33	Washington State Psychiatric Association	GM
102286	Bundy	Christopher	33	Washington State Psychiatric Association	GM
309536	Chao	Steven	33	Washington State Psychiatric Association	GM
59659	Cohen	Seth	33	Washington State Psychiatric Association	GM
88018	Do	Thang	33	Washington State Psychiatric Association	GM
1010525	Dowell	Amy	33	Washington State Psychiatric Association	GM
1002598	Gibson	Scot	33	Washington State Psychiatric Association	GM
1010054	Gonzalez	Benjamin	33	Washington State Psychiatric Association	GM
70941	Hakeman	Susan	33	Washington State Psychiatric Association	GM
1006570	Hein	Gretchen	33	Washington State Psychiatric Association	GM
304686	Jaffe	Craig	33	Washington State Psychiatric Association	GM
57591	King	Bryan	33	Washington State Psychiatric Association	GM
40272	Schilt	Stephen	33	Washington State Psychiatric Association	LM
1008907	Slate	Channing	33	Washington State Psychiatric Association	GM
83838	Tran	John	33	Washington State Psychiatric Association	GM
63584	Yuodelis- Flores	Christine	33	Washington State Psychiatric Association	GM
300421	Bharwani	Jawed	34	Nebraska Psychiatric Society	GM
304894	Buda	Danielle	34	Nebraska Psychiatric Society	GM
22250	Dahlke	Jane	34	Nebraska Psychiatric Society	LM
308101	Daughton	Joan	34	Nebraska Psychiatric Society	GM
53002	Fromm	Janine	34	Nebraska Psychiatric Society	GM
30543	Gutnik	Bruce	34	Nebraska Psychiatric Society	LM
310532	Obatusin	Tayo	34	Nebraska Psychiatric Society	GM
1008500	Ojha	Rashmi	34	Nebraska Psychiatric Society	GM
304158	Ramaswamy	Sriram	34	Nebraska Psychiatric Society	GM
32597	Bobba	Sharda	35	Ohio Psychiatric Association	LM
1009405	Brojmohun	Archana	35	Ohio Psychiatric Association	GM
102278	Cabatan	Edgardo	35	Ohio Psychiatric Association	GM
307133	Cerny	Cathleen	35	Ohio Psychiatric Association	GM
90866	Chaturvedi	Anand	35	Ohio Psychiatric Association	GM
310588	Deoras	Ketan	35	Ohio Psychiatric Association	GM
1008050	Dlugosz	Heather	35	Ohio Psychiatric Association	GM
41715	Doukides	Panagiotis	35	Ohio Psychiatric Association	GM
302044	Gao	Keming	35	Ohio Psychiatric Association	GM
86851	Gentile	Julie	35	Ohio Psychiatric Association	GM
1017816	Hackman	Daniel	35	Ohio Psychiatric Association	GM
1017515	Igboeli	Blessing	35	Ohio Psychiatric Association	GM
82596	Jefferson Wilson	Lena	35	Ohio Psychiatric Association	GM
80235	Johnson	John	35	Ohio Psychiatric Association	GM
301472	Khawam	Elias	35	Ohio Psychiatric Association	GM
44277	King	Steven	35	Ohio Psychiatric Association	GM
89222	Kostrzewski	Maria	35	Ohio Psychiatric Association	GM
307969	Lackamp	Jeanne	35	Ohio Psychiatric Association	GM
310740	Markley	Laura	35	Ohio Psychiatric Association	GM

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1010508	McCutcheon	Samar	35	Ohio Psychiatric Association	GM
1006790	Nagle-Yang	Sarah	35	Ohio Psychiatric Association	GM
306119	Palumbo	Todd	35	Ohio Psychiatric Association	GM
72037	Patel	Harish	35	Ohio Psychiatric Association	GM
66950	Sales	Gary	35	Ohio Psychiatric Association	GM
302106	Schuermeyer	Isabel	35	Ohio Psychiatric Association	GM
1011334	Zaraa	Solomon	35	Ohio Psychiatric Association	GM
1017240	Crawford	Benjamin	36	Oklahoma Psychiatric Physicians Association	GM
312187	Deshpande	Swapna	36	Oklahoma Psychiatric Physicians Association	GM
1014156	Doyle	Jonathan	36	Oklahoma Psychiatric Physicians Association	GM
62142	Geis	Heather	36	Oklahoma Psychiatric Physicians Association	GM
1008769	Jawed	Farhan	36	Oklahoma Psychiatric Physicians Association	GM
21123	Jurkowicz	Abel	36	Oklahoma Psychiatric Physicians Association	LM
1010284	Vanderlip	Erik	36	Oklahoma Psychiatric Physicians Association	GM
69392	Allain	Suzanne	37	Ontario District Branch	GM
89473	Bail	Monte	37	Ontario District Branch	GM
309768	Barrett	Elizabeth	37	Ontario District Branch	GM
72801	Besir	Mirjana	37	Ontario District Branch	GM
1014272	Brown	Cara	37	Ontario District Branch	GM
306702	Chad	Larry	37	Ontario District Branch	GM
70660	Collins	Peter	37	Ontario District Branch	GM
76180	Corona	Alfonso	37	Ontario District Branch	GM
1015051	El Saidi	Mohammed	37	Ontario District Branch	GM
84838	Elbaz	Zeinab	37	Ontario District Branch	GM
310351	Goldstein	Benjamin	37	Ontario District Branch	GM
1001147	Gopidasan	Balaji	37	Ontario District Branch	GM
90947	Gulati	Meena	37	Ontario District Branch	GM
87417	Ismail	Aden	37	Ontario District Branch	GM
86142	Jetly	Rakesh	37	Ontario District Branch	GM
1107220	Jwely	Ahmed	37	Ontario District Branch	GM
70348	Koczorowska	Maria	37	Ontario District Branch	GM
19287	Kugelmass	Michael	37	Ontario District Branch	LM
305137	Lee	Elliott	37	Ontario District Branch	GM
309506	Lorberg	Gunter	37	Ontario District Branch	GM
59166	Margittai	Katalin	37	Ontario District Branch	GM
1255716	Mehta	Gaurav	37	Ontario District Branch	GM
61860	Milin	Robert Paul	37	Ontario District Branch	GM
1001840	Naidu	Mary	37	Ontario District Branch	GM
1044129	Pallen	Alphie	37	Ontario District Branch	GM
1193295	Singh	Amarendra	37	Ontario District Branch	GM
1016385	Srivastava	Amresh	37	Ontario District Branch	GM
63125	Weerasekera	Priyanthy	37	Ontario District Branch	GM
83212	Wiebe	Patricia	37	Ontario District Branch	GM
307207	Ajayi	Olayinka	38	Pennsylvania Psychiatric Society	GM
1004848	Angelini	Renata	38	Pennsylvania Psychiatric Society	GM
76381	Buzogany	Joseph	38	Pennsylvania Psychiatric Society	GM
87944	Chaudhry	Rashid	38	Pennsylvania Psychiatric Society	GM
77202	Coffman	Peter	38	Pennsylvania Psychiatric Society	GM
63816	Dhopesh	Vasant	38	Pennsylvania Psychiatric Society	GM
1000493	Diller	Kathleen	38	Pennsylvania Psychiatric Society	GM
68467	Felins	Kelly	38	Pennsylvania Psychiatric Society	GM
304512	Gluck	Natalie	38	Pennsylvania Psychiatric Society	GM
92294	Good	Candace	38	Pennsylvania Psychiatric Society	GM
1005840	Javid	Zeeshan	38	Pennsylvania Psychiatric Society	GM
1000489	Kannan	Muralidhar	38	Pennsylvania Psychiatric Society	GM
1031707	Khan	Amanullah	38	Pennsylvania Psychiatric Society	GM
62345	Levine	Martha	38	Pennsylvania Psychiatric Society	GM

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1037434	Lobach	Liudmila	38	Pennsylvania Psychiatric Society	GM
1005275	Mai	Evelyn	38	Pennsylvania Psychiatric Society	GM
307411	Matta	Mark	38	Pennsylvania Psychiatric Society	GM
307485	Miceli	Kurt	38	Pennsylvania Psychiatric Society	GM
1016554	Mohammed	Anseruddin	38	Pennsylvania Psychiatric Society	GM
63151	Montaner	Jose	38	Pennsylvania Psychiatric Society	GM
78814	Nelson	Robert	38	Pennsylvania Psychiatric Society	GM
1014193	Neog	Amit	38	Pennsylvania Psychiatric Society	GM
1015666	Paing	Wynn	38	Pennsylvania Psychiatric Society	GM
86702	Pan	Raymond	38	Pennsylvania Psychiatric Society	GM
1004533	Posner	Imran	38	Pennsylvania Psychiatric Society	GM
74496	Prescott	Theresa	38	Pennsylvania Psychiatric Society	GM
84162	Rauh	Donald	38	Pennsylvania Psychiatric Society	GM
35424	Rueda-Vasquez	Eduardo	38	Pennsylvania Psychiatric Society	GM
1016128	Rushing	Susan	38	Pennsylvania Psychiatric Society	GM
41423	Saul	Marjorie	38	Pennsylvania Psychiatric Society	GM
1000258	Sedhain	Suresh	38	Pennsylvania Psychiatric Society	GM
1008205	Shukla	Neeraj	38	Pennsylvania Psychiatric Society	GM
89148	Srinivasa	Raghavendra	38	Pennsylvania Psychiatric Society	GM
303860	Togias	Nickolas	38	Pennsylvania Psychiatric Society	GM
311573	Tripp	Adam	38	Pennsylvania Psychiatric Society	GM
311795	Ugwuoke	Emmanuel	38	Pennsylvania Psychiatric Society	GM
87821	Verma	Sunil	38	Pennsylvania Psychiatric Society	GM
76815	Vitali	Ariel	38	Pennsylvania Psychiatric Society	GM
309050	Volfson	Elena	38	Pennsylvania Psychiatric Society	GM
82031	Waxmonsky	James	38	Pennsylvania Psychiatric Society	GM
59350	Weerasinghe	Chandra	38	Pennsylvania Psychiatric Society	LM
1000483	Widroff	Jacob	38	Pennsylvania Psychiatric Society	GM
73460	Zulovich	Linda	38	Pennsylvania Psychiatric Society	GM
1097746	Alatishe	Moses	39	Quebec & Eastern Canada District Branch	GM
85912	Amirali	Evangelia	39	Quebec & Eastern Canada District Branch	GM
310904	Bordeaux	Patrick	39	Quebec & Eastern Canada District Branch	GM
1186408	Calkin	Cynthia	39	Quebec & Eastern Canada District Branch	GM
1015909	Godbout	Sylvie	39	Quebec & Eastern Canada District Branch	GM
312783	Hechtman	Lily	39	Quebec & Eastern Canada District Branch	GM
88458	Lapointe	Marc	39	Quebec & Eastern Canada District Branch	GM
72499	Martel	Julie	39	Quebec & Eastern Canada District Branch	GM
83352	Walsh	Anthony	39	Quebec & Eastern Canada District Branch	GM
302671	Akhter	Aafaque	40	Queens County Psychiatric Society	GM
72658	Konnikow	Boris	40	Queens County Psychiatric Society	GM
306029	Ogunlesi	Christianah	40	Queens County Psychiatric Society	GM
309286	Peteru	Sachidanand	40	Queens County Psychiatric Society	GM
1041556	Singh	Deepan	40	Queens County Psychiatric Society	GM
303915	Williams	Michelle	40	Queens County Psychiatric Society	GM
78217	Young	Richard	40	Queens County Psychiatric Society	GM
309287	Christopher	Paul	41	Rhode Island Psychiatric Society	GM
1013659	Hartselle	Stephanie	41	Rhode Island Psychiatric Society	GM
74011	Rosenzweig	Andrew	41	Rhode Island Psychiatric Society	GM
1008145	Asper	Mari	42	South Carolina Psychiatric Association	GM
1000750	Beckert	David	42	South Carolina Psychiatric Association	GM
1017351	Scarff	Jonathan	42	South Carolina Psychiatric Association	GM
1037659	Sharma	Taral	42	South Carolina Psychiatric Association	GM
307997	Aminzadeh	Arastou	43	Southern California Psychiatric Society	GM
1014478	Amrami	Binyamin	43	Southern California Psychiatric Society	GM
1109742	Ashley	Robert	43	Southern California Psychiatric Society	GM
18997	Bloch	Sheldon	43	Southern California Psychiatric Society	LM
1011750	Cho	Hyong Jin	43	Southern California Psychiatric Society	GM

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1017098	Cohen	Marc	43	Southern California Psychiatric Society	GM
310199	Danovitch	Itai	43	Southern California Psychiatric Society	GM
73021	Elliott	Andrew	43	Southern California Psychiatric Society	GM
1001165	Eslao	Omar Anthony	43	Southern California Psychiatric Society	GM
83594	Farooqi	Mubashir	43	Southern California Psychiatric Society	GM
309170	Ford	Christina	43	Southern California Psychiatric Society	GM
31754	Fukushima	Susan	43	Southern California Psychiatric Society	LM
42855	Galarnyk	Ihor	43	Southern California Psychiatric Society	GM
43591	Gray	Gregory	43	Southern California Psychiatric Society	GM
64189	Hanft	Alan	43	Southern California Psychiatric Society	GM
72953	Koo	Martha	43	Southern California Psychiatric Society	GM
102216	Little	Zeb	43	Southern California Psychiatric Society	GM
311015	Mehta	Michelle	43	Southern California Psychiatric Society	GM
61049	Patel	Bipin	43	Southern California Psychiatric Society	GM
79012	Ruiz Graves	Amanda	43	Southern California Psychiatric Society	GM
60941	Sangdahl	Christopher	43	Southern California Psychiatric Society	GM
43393	Schaefer	Daniel	43	Southern California Psychiatric Society	GM
42024	Wang	Andrew	43	Southern California Psychiatric Society	GM
33185	Bhateja	Renu	45	Tennessee Psychiatric Association	LM
1008194	Elder	Agnes	45	Tennessee Psychiatric Association	GM
1013685	Huddleston	William	45	Tennessee Psychiatric Association	GM
310970	McDuffie	Everett	45	Tennessee Psychiatric Association	GM
310645	Moturi	Sricharan	45	Tennessee Psychiatric Association	GM
1004658	Peters	Todd	45	Tennessee Psychiatric Association	GM
65197	Propper	Michael	45	Tennessee Psychiatric Association	GM
76254	Rajpura	Bhupendra	45	Tennessee Psychiatric Association	GM
1021178	Rodriguez	Juan	45	Tennessee Psychiatric Association	GM
81476	Taylor	Warren	45	Tennessee Psychiatric Association	GM
1008892	Vashist	Amit	45	Tennessee Psychiatric Association	GM
307318	Wilson	Jerry	45	Tennessee Psychiatric Association	GM
1008391	Alonso-Katzowitz	Julie	46	Texas Society of Psychiatric Physicians	GM
30920	Arumugham	Bagyalakshmi	46	Texas Society of Psychiatric Physicians	LM
85556	Balderas	Teresita	46	Texas Society of Psychiatric Physicians	GM
1017490	Balfanz	Phillip	46	Texas Society of Psychiatric Physicians	GM
311661	Ball	Valdesha	46	Texas Society of Psychiatric Physicians	GM
67972	Banks	Kathleen	46	Texas Society of Psychiatric Physicians	GM
69442	Brown	Michael	46	Texas Society of Psychiatric Physicians	GM
1013500	Cannon	Holly	46	Texas Society of Psychiatric Physicians	GM
103431	Casey	Sara	46	Texas Society of Psychiatric Physicians	GM
40950	Cassidy	John	46	Texas Society of Psychiatric Physicians	GM
313223	Chapman	Meredith	46	Texas Society of Psychiatric Physicians	GM
311632	Dani	Radhika	46	Texas Society of Psychiatric Physicians	GM
92261	Doyle	Emily	46	Texas Society of Psychiatric Physicians	GM
59242	Eddins-Folensbee	Florence	46	Texas Society of Psychiatric Physicians	GM
1018962	Garber	Nicole	46	Texas Society of Psychiatric Physicians	GM
90421	Garvin	Jason	46	Texas Society of Psychiatric Physicians	GM
54526	Goyal	Manju	46	Texas Society of Psychiatric Physicians	GM
312075	Haider	Kanwal	46	Texas Society of Psychiatric Physicians	GM
65315	Hendrickse	William	46	Texas Society of Psychiatric Physicians	GM
59884	Hicks	Paul	46	Texas Society of Psychiatric Physicians	GM
90595	Hurd	Cheryl	46	Texas Society of Psychiatric Physicians	GM
71264	Illich	Melanie	46	Texas Society of Psychiatric Physicians	GM
312371	Johnson	Sylvia	46	Texas Society of Psychiatric Physicians	GM
1008478	Jones	Kenyatta	46	Texas Society of Psychiatric Physicians	GM
1102686	Keenmon	Corinna	46	Texas Society of Psychiatric Physicians	GM
82345	Kim	Thomas	46	Texas Society of Psychiatric Physicians	GM
72087	Krishna	Gollavelli	46	Texas Society of Psychiatric Physicians	GM

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304312	Listengarten	Dmitry	46	Texas Society of Psychiatric Physicians	GM
1013965	Lynx	Matthew	46	Texas Society of Psychiatric Physicians	GM
59066	Marsh	Laura	46	Texas Society of Psychiatric Physicians	GM
312538	McClam	Michael	46	Texas Society of Psychiatric Physicians	GM
303889	Nichols	Michelle	46	Texas Society of Psychiatric Physicians	GM
1013549	Nix	Bobby	46	Texas Society of Psychiatric Physicians	GM
81164	Onuoha	Bernadette	46	Texas Society of Psychiatric Physicians	GM
301027	Patel	Tushar	46	Texas Society of Psychiatric Physicians	GM
68416	Rivera	Cynthia	46	Texas Society of Psychiatric Physicians	GM
12481	Rodriguez	Francisco	46	Texas Society of Psychiatric Physicians	LM
303706	Shiekh	Michael	46	Texas Society of Psychiatric Physicians	GM
1001425	Shrestha	Shree	46	Texas Society of Psychiatric Physicians	GM
303685	Snyder	Karen	46	Texas Society of Psychiatric Physicians	GM
77397	Soares	Jair	46	Texas Society of Psychiatric Physicians	GM
301722	Szmuk	Eleonora	46	Texas Society of Psychiatric Physicians	GM
305462	Thomas	Lia	46	Texas Society of Psychiatric Physicians	GM
1061368	Thompson	Alexander	46	Texas Society of Psychiatric Physicians	GM
63158	Trivedi	Sandhya	46	Texas Society of Psychiatric Physicians	GM
66452	Weinstein	Lawrence	46	Texas Society of Psychiatric Physicians	GM
57460	Young	Patrick	46	Texas Society of Psychiatric Physicians	GM
311134	Bankole	Azziza	47	Psychiatric Society of Virginia, Inc	GM
1016788	Brinker	Henrike	47	Psychiatric Society of Virginia, Inc	GM
69468	Dameron	Zachariah	47	Psychiatric Society of Virginia, Inc	GM
311686	Hines	Neil	47	Psychiatric Society of Virginia, Inc	GM
310913	Hneich	Nesly	47	Psychiatric Society of Virginia, Inc	GM
31861	Ignacio	Luis	47	Psychiatric Society of Virginia, Inc	LM
1117681	Jafri	Rabia	47	Psychiatric Society of Virginia, Inc	GM
310659	Lee	Jonathan	47	Psychiatric Society of Virginia, Inc	GM
17382	Lovko	Kenneth	47	Psychiatric Society of Virginia, Inc	LM
74365	Morse	Jeffrey	47	Psychiatric Society of Virginia, Inc	GM
76355	Mustafa	Shaheen	47	Psychiatric Society of Virginia, Inc	GM
311849	Paluvoi	Sobha	47	Psychiatric Society of Virginia, Inc	GM
308390	Sapra	Mamta	47	Psychiatric Society of Virginia, Inc	GM
1049499	Senu-Oke	Maxwell	47	Psychiatric Society of Virginia, Inc	GM
1014033	Singh	Gagandeep	47	Psychiatric Society of Virginia, Inc	GM
41572	Templeton	Hilda	47	Psychiatric Society of Virginia, Inc	LM
310469	Tennyson	Colleen	47	Psychiatric Society of Virginia, Inc	GM
59509	Akil	Mayada	48	Washington Psychiatric Society	GM
78435	Ali	Syed	48	Washington Psychiatric Society	GM
312742	Amin	Farooq	48	Washington Psychiatric Society	GM
78240	Atdjian	Sylvia	48	Washington Psychiatric Society	GM
1064326	Bammidi	Nora	48	Washington Psychiatric Society	GM
16660	Churchill	Stephen	48	Washington Psychiatric Society	LM
312781	Dankovich	Megan	48	Washington Psychiatric Society	GM
311243	Dewar	Amy	48	Washington Psychiatric Society	GM
307202	Elamin	Yasir	48	Washington Psychiatric Society	GM
70845	Hammill	Maria	48	Washington Psychiatric Society	GM
86708	Johannesen	Erin	48	Washington Psychiatric Society	GM
1000819	Khin Khin	Eindra	48	Washington Psychiatric Society	GM
1001149	Klein	Carolina	48	Washington Psychiatric Society	GM
310864	Malik	Aditi	48	Washington Psychiatric Society	GM
1012294	Masuood	Sirosh	48	Washington Psychiatric Society	GM
1006919	Mian	Ayesha	48	Washington Psychiatric Society	GM
310236	Miller	Ashley	48	Washington Psychiatric Society	GM
1008216	Okezie	Ihuoma	48	Washington Psychiatric Society	GM
1007337	Oni	Emmanuel	48	Washington Psychiatric Society	GM
304572	Rich	Susan	48	Washington Psychiatric Society	GM

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308053	Shah	Renu	48	Washington Psychiatric Society	GM
307869	Singh	Sarabjit	48	Washington Psychiatric Society	GM
1016751	Singh	Tejpal	48	Washington Psychiatric Society	GM
312534	Stevens	KyleeAnn	48	Washington Psychiatric Society	GM
1012533	Uzoma	Hyacinth	48	Washington Psychiatric Society	GM
311739	Zinnes	Anca	48	Washington Psychiatric Society	GM
36954	Bhatty	Mansukh	49	Psychiatric Society of Westchester County, Inc	LM
1000789	Caneva	Elishka	49	Psychiatric Society of Westchester County, Inc	GM
1062549	Ervin	Katherine	49	Psychiatric Society of Westchester County, Inc	GM
45126	Hyler	Irene	49	Psychiatric Society of Westchester County, Inc	GM
306349	Kelly	Robert	49	Psychiatric Society of Westchester County, Inc	GM
1013391	Lalonde	Mary	49	Psychiatric Society of Westchester County, Inc	GM
64333	Loebel	Antony	49	Psychiatric Society of Westchester County, Inc	GM
306540	Nowillo	Jessica	49	Psychiatric Society of Westchester County, Inc	GM
59171	Perry	Bradford	49	Psychiatric Society of Westchester County, Inc	GM
310122	Sanchez-Barranco	Pablo	49	Psychiatric Society of Westchester County, Inc	GM
1011343	Saeed	Mohammad	51	Western New York Psychiatric Society	GM
1040296	Christian	Christopher	52	Wisconsin Psychiatric Association	GM
307242	Hale-Richlen	Barbara	52	Wisconsin Psychiatric Association	GM
71134	Lehrmann	Jon	52	Wisconsin Psychiatric Association	GM
89127	Mostaghimi	Ladan	52	Wisconsin Psychiatric Association	GM
36040	Musunuru	Jagadeeswara	52	Wisconsin Psychiatric Association	LM
1008338	Opaneye	Bababo	52	Wisconsin Psychiatric Association	GM
305618	Peterson	Michael	52	Wisconsin Psychiatric Association	GM
311718	Plante	David	52	Wisconsin Psychiatric Association	GM
18641	Rhoades	Bruce	52	Wisconsin Psychiatric Association	LM
76363	Rolli	Martha	52	Wisconsin Psychiatric Association	GM
75523	Scallon	Peggy	52	Wisconsin Psychiatric Association	GM
311735	Schoen	Justin	52	Wisconsin Psychiatric Association	GM
300702	Schroederus	Jennifer	52	Wisconsin Psychiatric Association	GM
40579	Simon	Jeffrey	52	Wisconsin Psychiatric Association	GM
311859	Thrasher	Tony	52	Wisconsin Psychiatric Association	GM
76371	Trueman	Laurence	52	Wisconsin Psychiatric Association	GM
1004509	Wahlen	Kelly	52	Wisconsin Psychiatric Association	GM
88623	Weisensel	Nicolette	52	Wisconsin Psychiatric Association	GM
73147	White	Herbert	52	Wisconsin Psychiatric Association	LM
1011999	Aldandashi	Samer	53	Western Canada District Branch	GM
1005380	Alghamdi	Mohammad	53	Western Canada District Branch	GM
102661	Balachandra	Krishna	53	Western Canada District Branch	GM
84851	Brink	Johann	53	Western Canada District Branch	GM
1005220	Hibbard	Katharine	53	Western Canada District Branch	GM
77236	Jani	Aarti	53	Western Canada District Branch	GM
1005527	Lari	Harris	53	Western Canada District Branch	GM
80951	Lint	Donald	53	Western Canada District Branch	GM
59039	Milliken	A.	53	Western Canada District Branch	LM
1073433	Okonkwo	Cletus	53	Western Canada District Branch	GM
1038958	Pirlot	Tyler	53	Western Canada District Branch	GM
80518	Robertson	Heather	53	Western Canada District Branch	GM
75418	Tewfik-Moussa	Laila	53	Western Canada District Branch	GM
302360	Tham	Chun	53	Western Canada District Branch	GM
1061045	Vila-Rodriguez	Fidel	53	Western Canada District Branch	GM
73424	Casdorph	Mark	54	West Virginia Psychiatric Association	GM
1017844	Hackman	Michael	54	West Virginia Psychiatric Association	GM
92133	Halasz	Mirela	54	West Virginia Psychiatric Association	GM
64221	Holroyd	Suzanne	54	West Virginia Psychiatric Association	GM
43133	Kelly	Lawrence	54	West Virginia Psychiatric Association	GM
1013715	Lluberes-Rincon	Nubia	54	West Virginia Psychiatric Association	GM

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1001686	Melhem	Imad	54	West Virginia Psychiatric Association	GM
1009557	Nazha	Hani	54	West Virginia Psychiatric Association	GM
1000144	Antar	Laura	55	West Hudson Psychiatric Society	GM
69422	Belzie	Louis	55	West Hudson Psychiatric Society	GM
1090249	Tobe	Russell	55	West Hudson Psychiatric Society	GM
1014366	Hargrave	Teresa	56	Central New York District Branch	GM
1017152	Ramanathan	Seethalakshmi	56	Central New York District Branch	GM
83086	Weiss	Anthony	56	Central New York District Branch	GM
63066	Baumann	Susan	57	Arizona Psychiatric Society	GM
1016503	Bindal	Ankur	57	Arizona Psychiatric Society	GM
76976	Campbell	Melissa	57	Arizona Psychiatric Society	GM
1004691	Cattelino	Amanda	57	Arizona Psychiatric Society	GM
91485	Chern	Darwyn	57	Arizona Psychiatric Society	GM
74417	Friedman	Dennis	57	Arizona Psychiatric Society	GM
43264	Gazda	Thomas	57	Arizona Psychiatric Society	GM
313073	Kaempf	Aimee	57	Arizona Psychiatric Society	GM
308614	Kawamoto	Yukari	57	Arizona Psychiatric Society	GM
1007860	Kumar	Shubha	57	Arizona Psychiatric Society	GM
71345	Levitt	Gwen	57	Arizona Psychiatric Society	GM
77223	Pequeno	Juan	57	Arizona Psychiatric Society	GM
1005349	Segal	Roland	57	Arizona Psychiatric Society	GM
81527	Taylor-Desir	Monica	57	Arizona Psychiatric Society	GM
90982	Venter	Jacob	57	Arizona Psychiatric Society	GM
1058682	Wicklund	Sarah	57	Arizona Psychiatric Society	GM
1002275	Woerner	Shabnam	57	Arizona Psychiatric Society	GM
1000472	Blekic	Amela	58	Oregon Psychiatric Physicians Association	GM
86235	Dunaway	Kristen	58	Oregon Psychiatric Physicians Association	GM
305758	Lakhani	Carmel	58	Oregon Psychiatric Physicians Association	GM
312143	Lockey	Christopher	58	Oregon Psychiatric Physicians Association	GM
305395	Monteverdi	Anthony	58	Oregon Psychiatric Physicians Association	GM
1015674	Pareek	Pallav	58	Oregon Psychiatric Physicians Association	GM
40758	Sogn	Richard	58	Oregon Psychiatric Physicians Association	GM
1004523	Soller	Marie	58	Oregon Psychiatric Physicians Association	GM
1005129	Asar	Mariam	59	Northern New York District Branch	GM
1008887	Birur	Badari	60	Alabama Psychiatric Physicians Association	GM
38292	Lindsay	Trevor	60	Alabama Psychiatric Physicians Association	LM
72003	Montgomery-Barefi	Laura	60	Alabama Psychiatric Physicians Association	GM
1015711	Nimmagadda	Janaki	60	Alabama Psychiatric Physicians Association	GM
306017	Penherski	Peter	60	Alabama Psychiatric Physicians Association	GM
307662	Sadler	Bradley	60	Alabama Psychiatric Physicians Association	GM
1008229	Vemuluri	Ramakanth	60	Alabama Psychiatric Physicians Association	GM
1017156	Wang	Baowu	60	Alabama Psychiatric Physicians Association	GM
1014251	Annadata	Satish	61	Utah Psychiatric Association	GM
40959	Dewey	Larry	61	Utah Psychiatric Association	LM
83305	Grissom	Janet	61	Utah Psychiatric Association	GM
306417	Holmes	Kevin	61	Utah Psychiatric Association	GM
68364	Pantziris	Nancy	61	Utah Psychiatric Association	GM
1004491	Williams	Ryan	61	Utah Psychiatric Association	GM
87215	Bilotti	Edward	62	Maine Association of Psychiatric Physicians	GM
82459	Cutler	Melanie	62	Maine Association of Psychiatric Physicians	GM
31520	Prentice	Glenn	62	Maine Association of Psychiatric Physicians	LM
312235	Capan	Michael	63	North Dakota Psychiatric Society	GM
63917	Kenney	Emmet	63	North Dakota Psychiatric Society	GM
92563	Camacho	Alvaro	64	San Diego Psychiatric Society	GM
69448	Carroll	Matthew	64	San Diego Psychiatric Society	GM
302243	Irwin	Scott	64	San Diego Psychiatric Society	GM
1159790	Kistler	Jonathan	64	San Diego Psychiatric Society	GM

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20615	Kline	Neal	64	San Diego Psychiatric Society	LM
1013428	Koh	Steve	64	San Diego Psychiatric Society	GM
311227	Lanouette	Nicole	64	San Diego Psychiatric Society	GM
1007438	Lauzon	Vanessa	64	San Diego Psychiatric Society	GM
1004495	Milazzo	Yvette	64	San Diego Psychiatric Society	GM
304658	Paul	Robindra	64	San Diego Psychiatric Society	GM
91065	Rehan	Ghazala	64	San Diego Psychiatric Society	GM
30833	Saben	Laurence	64	San Diego Psychiatric Society	LM
74687	Smith	Barbara	64	San Diego Psychiatric Society	GM
1013772	Tsai	Gary	64	San Diego Psychiatric Society	GM
21652	Berggren	Jean	66	Vermont Psychiatric Association	LM
305542	Boutin	Paul	66	Vermont Psychiatric Association	GM
43754	Jacobson	James	66	Vermont Psychiatric Association	GM
37448	Linder	Robert	66	Vermont Psychiatric Association	LM
32322	Cohen	Kenneth	68	New Hampshire Psychiatric Society	LM
1012979	Davis	Matthew	68	New Hampshire Psychiatric Society	GM
29125	Evans	Michael	68	New Hampshire Psychiatric Society	LM
312138	Gunning	Michele	68	New Hampshire Psychiatric Society	GM
81458	Mistler	Lisa	68	New Hampshire Psychiatric Society	GM
62490	Potenza	Daniel	68	New Hampshire Psychiatric Society	GM
311274	Powell	Steven	68	New Hampshire Psychiatric Society	GM
1014805	Vita	Anthony	68	New Hampshire Psychiatric Society	GM
21789	Lu	Leighmin	70	Puerto Rico Psychiatric Society	LM
84122	McCarthy	Vilma	70	Puerto Rico Psychiatric Society	GM
87566	Mendez-Buso	Carla	70	Puerto Rico Psychiatric Society	GM
63107	Sabate	Nuria	70	Puerto Rico Psychiatric Society	GM
79383	Sanchez	Antonio	70	Puerto Rico Psychiatric Society	GM
74787	Walton	April	71	Alaska District Branch	GM
89809	Weeks	Bruce	71	Alaska District Branch	GM
69624	Green	Joan	73	Montana Psychiatric Association	GM
1000593	Stiles	Troy	73	Montana Psychiatric Association	GM
1017034	Khurana	Sapandeep	74	Nevada Psychiatric Association	GM
1005645	Magsalin	Rhanda Marie	74	Nevada Psychiatric Association	GM
38304	Nussbaum	Larry	74	Nevada Psychiatric Association	GM
311210	Still	Jonathan	74	Nevada Psychiatric Association	GM
92414	Taccir-Macias	Claudia	74	Nevada Psychiatric Association	GM
1002438	Collison	Jason	75	Wyoming Association of Psychiatric Physicians	GM
1000606	Mehra	Abhishek	75	Wyoming Association of Psychiatric Physicians	GM
1004634	Sohi	Sukhpreit	75	Wyoming Association of Psychiatric Physicians	GM
90373	Alexander	Marya	76	Orange County Psychiatric Society	GM
1008861	Faziola	Lawrence	76	Orange County Psychiatric Society	GM
1011454	Huffman	Charles	76	Orange County Psychiatric Society	GM
67183	Sandhu	Sarabjit	76	Orange County Psychiatric Society	GM
67614	Teddy	Virginia	76	Orange County Psychiatric Society	GM
312246	Vasa	Monisha	76	Orange County Psychiatric Society	GM
1013873	Vo	Ngoctram Staci	76	Orange County Psychiatric Society	GM
1001380	Agius	Matthew	77	Society of Uniformed Services Psychiatrists	GM
1005904	Alfonzo	Chris	77	Society of Uniformed Services Psychiatrists	GM
81426	Bailey	Michael	77	Society of Uniformed Services Psychiatrists	GM
303845	Campbell	Christine	77	Society of Uniformed Services Psychiatrists	GM
1006508	Chatigny	Ashley	77	Society of Uniformed Services Psychiatrists	GM
1005720	Clark	Edmund	77	Society of Uniformed Services Psychiatrists	GM
1008468	Dailey	Jason	77	Society of Uniformed Services Psychiatrists	GM
75608	Doyle	Michael	77	Society of Uniformed Services Psychiatrists	GM
1005100	Duda	Roger	77	Society of Uniformed Services Psychiatrists	GM
1016081	Eader	Scott	77	Society of Uniformed Services Psychiatrists	GM
65660	Engel	Charles	77	Society of Uniformed Services Psychiatrists	GM

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1006960	Flores-Carrera	Aidith	77	Society of Uniformed Services Psychiatrists	GM
1017120	Ford	Shannon	77	Society of Uniformed Services Psychiatrists	GM
1017605	Gale	Anthony	77	Society of Uniformed Services Psychiatrists	GM
310445	Ghurani	Sawsan	77	Society of Uniformed Services Psychiatrists	GM
86196	Grammer	Geoffrey	77	Society of Uniformed Services Psychiatrists	GM
1014053	Groom	Rhianon	77	Society of Uniformed Services Psychiatrists	GM
1236520	Gunther	Jenifer	77	Society of Uniformed Services Psychiatrists	GM
308571	Houck	Kelly	77	Society of Uniformed Services Psychiatrists	GM
1004116	Hutcheson-Tipton	David	77	Society of Uniformed Services Psychiatrists	GM
1004102	Kim	Michael	77	Society of Uniformed Services Psychiatrists	GM
1001961	Kovell	Judy	77	Society of Uniformed Services Psychiatrists	GM
1013710	Lam	Sherrell	77	Society of Uniformed Services Psychiatrists	GM
312938	Leasure	William	77	Society of Uniformed Services Psychiatrists	GM
77578	Lyszczarz	John	77	Society of Uniformed Services Psychiatrists	GM
1015137	McKinnon	Nicholas	77	Society of Uniformed Services Psychiatrists	GM
88878	McLay	Robert	77	Society of Uniformed Services Psychiatrists	GM
90467	Millegan	Jeffrey	77	Society of Uniformed Services Psychiatrists	GM
305701	Morganstein	Joshua	77	Society of Uniformed Services Psychiatrists	GM
75154	Reeves	James	77	Society of Uniformed Services Psychiatrists	GM
1066494	Rumayor	Christina	77	Society of Uniformed Services Psychiatrists	GM
1004637	Sargent	Paul	77	Society of Uniformed Services Psychiatrists	GM
311592	Schultheiss	C Christopher	77	Society of Uniformed Services Psychiatrists	GM
311072	Shibley	Heather	77	Society of Uniformed Services Psychiatrists	GM
1010257	Smith	Earl	77	Society of Uniformed Services Psychiatrists	GM
311556	Stenback	Karis	77	Society of Uniformed Services Psychiatrists	GM
305658	Terhakopian	Art	77	Society of Uniformed Services Psychiatrists	GM
306630	Weis	Daniel	77	Society of Uniformed Services Psychiatrists	GM
1000220	White	Dennis	77	Society of Uniformed Services Psychiatrists	GM
1073059	Whiting	William	77	Society of Uniformed Services Psychiatrists	GM
307716	Williams	Scott	77	Society of Uniformed Services Psychiatrists	GM
300220	Williams	Michael	77	Society of Uniformed Services Psychiatrists	GM
1008876	Young	Lisa	77	Society of Uniformed Services Psychiatrists	GM
Total	**n=1057**				

Country/Applicant Name	Member ID#
ARGENTINA	
Luis L Albalustri M.D.	89818
Sebastian A Alvano, MD	91672
Matias Bonanni, MD	1011294
Gustavo F Carlsson M.D.	302765
Guillermo M Delmonte M.D.	103080
Maria Isabel Diaz M.D.	89855
Gerardo M Garcia-Bonetto, MD	90041
Federico O Livi M.D.	103724
Luis Ignacio Mariani, MD	87087
Luisa B Martin, MD, PhD	92401
Alfredo Ortiz Fragola, MD	312825
Jaime José Pahissa, MD	91978
Cesar Angel Rios, MD	87128
Juan Cristobal Tenconi, MD	92040
Javier M Usandivaras, MD	87148
AUSTRALIA	
Sameh Tharwat Anis, FRANZCP	1105749
Sivasankaran Balaratnasingam, MBBS	1247246
Michael Beech M.D.	308636
Tom Bell, MD	1105175
Samir Benjamin M.D.	101982
Rosemary Campbell, MBBS	1213745
Geeta Chaudhary, MBBS	1225777
Robyn L Cross, MD	1031419
Gordon Robert Davies, MD	1040164
Hector Gregorio R Divinagracia, MD	1185155
Spencer Duke, MD	1046442
Alby Elias, MD	1240160
David C Furrows M.D.	92224
Angelos Giannakoureas BMBS, FRANZCP	1203581
Gregory P Hugh, MD	1016946
Salam Hussain, MD	1204939
Rakesh Khanna, MBBS	1012085
Jon-Paul K Khoo, MBBS	1227283
Fatma H Lowden M.D.	87080
Julian Parmegiani, MBBS	1139779
Ajit Selvendra, MBBS	1240895
Ivan Siklich, MD	1005432
Carol L Silberberg, MBBS	1034987
Jeffery D Thompson, MD	305490
John A Wardell, MB ChB	1103218
Roger W Wenden M.D.	90734

Country/Applicant Name	Member ID#
AUSTRIA	
Christoph Silberbauer, MD	1139715
Christian Simhandl MD, PhD.	308996
BANGLADESH	
Helal Uddin Ahmed, MD	1255232
Abdus Salam Miah, MBBS	1220213
Jhunu S Nahar, MD	1000994
Syed Faheem Shams, MBBS, MD	1221640
BELGIUM	
Paul de Keyzer MD,PharmD	91152
Samuel J Leistedt, MD PhD	1019184
Mihaela Luminita M Staicu, MD	1112688
Joseph Kueta Suykerbuyk, MD, PhD	1165787
BERMUDA	
Chantelle M Simmons M.D.	313155
BRAZIL	
Chisleine F Abreu, MD	1016426
Daniel Fortunato Burgese, MD	1224896
Bruno Mendonca Coêlho, MD	1076662
Jose Eduardo Milori Cosentino, MD	1015192
Vanessa F Favaro, MD	1026920
Marcelo Fleck M.D.	91154
Celso Garcia Jr, MD	1136000
Wagner Gesser, MD	1081188
Moyses Aron Gotfryd, MD	28270
Jacson Hubner, MD	1217204
Henrique A Imthurn M.D.	91159
Luis A Lacerda, MD	91412
Beny Lafer M.D.	85043
Paula Melin, MD	300100
Alexander Moreira-Almeida, MD	1098228
Danilo De Andrade Nader, MD	1160814
Hercilio Pereira Oliveira Jr, MD	1230446
Luiz Fernando Pedroso, MD	310565
Camilla Moreira De Sousa Pinna, MD	1213904
Andre De Mattos Salles, MD	1123905
Almir R Tavares Jr, MD, PhD	60996
Maria Troster, MD	310572

Country/Applicant Name	Member ID#
CHILE	
Sergio M Gloger M.D.	80768
COLUMBIA	
Adolfo Federico Ahumada, MD	1007452
Soraya Aparicio, MD	1040002
Pablo Alberto Chalela Mantilla, MD	1130661
Roberto E Chaskel M.D.	91797
Jorge A Franco Lopez, MD	1012508
Patricio Garcia Caro M.D.	309936
Efrain Noguera, MD	1041380
Luis F Orozco-Cabal, MD, PhD	1230680
Alexander Pinzon, MD	1016074
Jorge E Tellez-Vargas M.D.	87145
COSTA RICA	
Luis A Meza M.D.	305508
CROATIA (HRVATSKA)	
Ninoslav Mimica, MD	1007459
CZECH REPUBLIC	
Jiri Raboch, MD	1005270
DOMINICAN REPUBLIC	
Mirlan De Los Santos, MD	1012520
Cesar Mella Mejias M.D.	85045
Nelson Tabar Garcia, MD	1007414
ECUADOR	
Carlos Eduardo Freire, MD	1017149
Carlos Leon-Andrade M.D.	62866
Dr. Juan Varas, MD	1012632
EGYPT	
Hafez Amin, MD	1015613
Mohammad Mohammad Mohammad Ba	1247245
Kamal Abdel Mohsen El Fawal, MD	1012516
Mohammed A Elmahdy, MD	1240554
Amany H El-Mougy M.D.	92206
Mahmoud A Hammouda, MD	1118939
Karim Hussein Kotkata, MD	1017869
Refaat Mahfouz Mahmoud	103703
Ahmed Mubarak M.D.	92266
Tawfik Narouz, MD, PhD.	308988

Country/Applicant Name	Member ID#
FINLAND	
Heikki Tuomas Vartiainen, MD	1001792
FRANCE	
Gisele Apter, MD, PhD	307748
Jean Cottraux M.D.	310548
Daniel J Delcroix, MD	87042
Jean-Michel Delile, MD	1026145
Fabrice Duval M.D.	63444
Jean-Christophe Hureaux, MD	1011462
Nicole Parant-Lucena M.D.	311927
Denis Vabre M.D.	90006
GERMANY	
Bernhard Joosten Connemann, MD	1127100
Karel Joachim Frasch, MD	1218292
Robert E Gebhard, MD	311914
Bernhard Kis, MD	1009892
Frank Schneider, MD, PhD	77470
Ulrich Schweiger, MD	1091740
Christiane Tholen-Rudolph M.D.	306529
GUATEMALA	
See-King E Quinto-Barrera, MD	308630
HONDURAS	
Carlos J Mutjoz Mazzoni, MD	1118937
HONG KONG	
Roger Man Kin Ng, MD	1089421
Fankwong David Tsang, MBBS	1149123
ICELAND	
Halldor Kolbeinsson M.D.	300103
Mike Scully, MB	1241311

Country/Applicant Name	Member ID#
INDIA	
Bimalkumar Radheshayam Agrawal, MD	45362
Madan Lal Agrawal, MD	1238349
Dipesh Bhagabati, MBBS	1006489
Suresh Chakravarty, MD	1012156
Dean Agnel Creado, MBBS	1112687
Abhay Kumar De, MD	1011815
Lakshman S Dutt, MD	43236
Padmaja Gaddamanugu, MD	1018775
Parshotam Dass Gargi, MBBS	1117334
Philip John, MD	1016477
Bharath Bhushan Mahesh, MBBS	1011376
Thirunavukarasu Manickam, MD	312582
Ashwin Mohan, MBBS	1016538
Susanta Kumar Padhy, MD	1113089
Debanjan Pan, MD	1006550
Shailesh Vasudeo Pangaonkar, MD	1101824
Rajan Shridhar Prabhu, MBBS	1228908
Sanjeev Prasad, MBBS	1198256
Daniel Saldanha, MBBS, MD	1132840
Shakil Singh, MBBS	1045059
Padma Sudhakar Thatikonda, MD	1010408
Kuruvilla Thomas, MBBS	63461
Mrugesh Vaishnav, MBBS	1006502
Sandeep Verma, MD	1065545
INDONESIA	
Oely Adhyasantie, MD	1012492
Cokorda Bagus Jaya Lesmana, MD	1115530
Siti Hisnaniah Sempurna Djaja, MD	1001869
IRAN (Islamic Republic Of)	
Parviz Mazaheri, MD	1012126
Mehdi Tehranidoost, MD	300106
IRAQ	
Fatih Al-Khalidi, MD	1014280
ISRAEL	
Guy A Farber M.D.	91839
Haim Knobler M.D.	76088

Country/Applicant Name	Member ID#
ITALY	
Lodovico E Berra M.D.	85034
Massimo Biondi M.D.	73394
Aristotele Hadjichristos, MD	1007029
Stefano Pallanti, MD, PhD	1012679
JAMAICA	
Loraine Barnaby, MD	1016951
JAPAN	
Masatake Kurita, MD, PhD	1238356
Kenji Narushima, M.D.,Ph.D.	312823
Masatomo Suetsugi, MD	1005465
Kazuyo Yoshiyama, MD	1234350
KENYA	
Anna N Nguithi, MD	1016315
Frank G Njenga M.D.	302344
KOREA, REPUBLIC OF	
Geon-Ho Bahn, MD	87017
Young-In Chung, MD	89027
Jihye Sophy Ha, MD	1009888
Se-Joong Oh, MD	87113
Young-Woo Park, MD, PhD	1015980
LITHUANIA	
Darius S. Dirzys, MD	1228144
MALAYSIA	
Benjamin Teck Ming Chan, MBBS	1014211
Chandra Mohan Panchadcharam, MD	1227687
Chin Hong Yap, MD	1205433
MEXICO	
Gabriel J Alejo, MD	1007383
Sergio Enrique Duarte Lobato, MD	312846
Leonardo Gomez, MD	1070272
Ignacio Ruiz Lopez, MD	91551
Andrea Sada, MD	1139713
Rafael Jesus Salin-Pascual, PhD, MD	1008607
MOROCCO	
Kamal Raddaoui, MD	1138516

Country/Applicant Name	Member ID#
NETHERLANDS	
Rene A Achilles M.D.	85032
Ahmed Mohammed Ahmed, MD	1159137
Nicolaas Hendricus Bouman, MD	1188750
Victor Buwalda M.D.	307758
Job de Jonge M.D.	92484
Irma Dwarkasing, MD	1152094
Paul Hodiamont, MD,PhD	83473
Robertus J.M. Mooren M.D.	307752
Tjoe Ing Oei, MD	103301
Eugene Schouten M.D.	309650
Barbara Strack van Schijndel-Garofoli, M	1138803
Nicolas J Van Der Wee Ph.D.	306949
Marcel H B Vonk M.D.	90011
Ieneke (W.J.) Vos, MD	312493
Roel H S Witte, MD	309658
Martin Wiznitzer, MD	311954
NETHERLANDS ANTILLES	
Guillermo Amaro M.D.	307356
Mercedes Grullon M.D.	307358
NEW ZEALAND	
Nadezda Baba-Milkic M.D.	91675
Nicholas Hoeh M.D.	91444
Sanu Pal M.D.	304189
NIGERIA	
Maymunah Kadiri, MD	1002604
Jude Uzoma Ohaeri, MD	1004004
Osamuede Belle Ojo, MBBS	1108669
NORWAY	
Valborg Helene Helseth, MD	1214522
Katalin Juhasz, MD	1095158
PAKISTAN	
Abdul Malik Achakzai, MBBS, MCPS, MD,	1102410
Moin Ahmad Ansari, MBBS	1131678
Muhammad Amjad Chaudhry, MD	1094802
Qazi Rashid Hamid, MD	1065060
Muhammad Irfan, MBBS	1221671
Muhammad Sharif Khan, MBBS	1240773
Mohan Luhano, MD	1104656

Country/Applicant Name	Member ID#
PAKISTAN (continued)	
Ahsan Ul Haq, MD	1016204
Mian Mukhtar Ul Haq, MBBS	1133636
PARAGUAY	
Josè Antonio Arias Mañotti, MD	90912
PERU	
Enrique Bojorquez Giraldo M.D.	312999
PHILIPPINES	
Beverly Azucena, MD	309205
Carlo V Banaag, MD	1012524
Maria Victoria Briguela M.D.	301222
Mary Agnes Llamas Busuego, MD	1203583
Maria Monica V Cardinez-Tan M.D.	301989
Alden C Cuyos, MD	312272
Constantine D Della, MD	1045058
Romeo Yu Enriquez M.D.	313179
Benjamin Rodrigo C Go, MD	1042457
Lovie Hope Ong Go, MD	311764
Mariano Sobrevega Hembra, MD	1233964
Elaine Leynes, M.D.	1004700
Bihildis C Mabunga, MD	103307
Jacqueline Te Sy, MD	306952
PORTUGAL	
Virgilio Kasprzykowski M.D.	87067
SAUDI ARABIA	
Magdi Ishag Ahmed, MD	1138783
SINGAPORE	
Arthur K Lee M.D.	87070
SOUTH AFRICA	
Solomon Rataemane, MD	1016483

Country/Applicant Name	Member ID#
SPAIN	
Maria Fe Bravo M.D. Ph.D.	89829
Antonio Bulbena M.D.	79114
Pablo Gotor Diaz, MD	1171454
Juan J Lopez-Ibor M.D.	69998
Carlos Mur de Viu, MD, PhD	1012923
Nestor Szerman M.D.	91869
Eduard Vieta M.D.,Ph.D.	87153
SUDAN	
Fathia Hussein Shabo, MD	1218354
SWITZERLAND	
Peter J Drescher M.D.	90038
Francois P Ferrero M.D.	67458
Rolf H Koester, MD	101949
Rudolf N Kunz M.D.	76135
Wayne Macfadden M.D.	59129
SYRIAN ARAB REPUBLIC	
Khaldoun I Marwa, MD	1240814
THAILAND	
Worrawat Chanpattana, MD	89840
Pairat Pruksachatkunakorn M.D.	86132
Pramod M Shyangwa, MD	1087070
TRINIDAD AND TOBAGO	
Hazel A Othello, MD	1002352
TURKEY	
Oguz Karamustafalioglu M.D.	92227
Ismet Kirpinar, MD	304980
Ertugrul H Koroglu, MD	313011
Bengi Semerci, MD	313174
Nevzat K Tarhan, MD	1000464
Mehmet Hakan Turkcapar, MD, PhD	1012106
UNITED ARAB EMIRATES	
Yousef-Abou Allaban	76783
Seyed Davood Hosseini, MD	300083
Muraleedharan Kattuvila Kumaran, MD	71524
Padmaraju Varrey M.D.	300650

Country/Applicant Name	Member ID#
UNITED KINGDOM	
Oghenevwoke Eguono Akpubi, MD	1089362
Jegatheesan Aravinthan, MBBS	1225159
Oyedeji A Ayonrinde M.D.	306288
Massimo Bernini, MD	1040362
Marcelo Camprubi M.D. MRCPsych	310109
Luiz Dratcu, MD, PhD	1240989
Sophia Frangou, MD	1012549
Peter Heinl, MD	1091741
Chetan Bangra Kuloor, MD	1093066
Teodor Lerescu, MD	1209296
Daryoush Malekniazi, MD	1095276
Jide Morakinyo, MD	1002468
Ramin Nilforooshan, MD	1196260
Zoran C Simic, MD	1095456
Total = 282	

2014 Distinguished Fellow Nominations - Approved
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Member ID	Name	Member Class	District Branch
67038	Dinesh Mittal M.D.	FE	Arkansas Psychiatric Society
301943	Andreea L Seritan, MD	FE	Central California Psychiatric Society
310220	Melinda S Motes M.D.	GM	Colorado Psychiatric Society
305377	Kimberly D Nordstrom MD JD	FE	Colorado Psychiatric Society
69190	Lori E Raney, MD	GM	Colorado Psychiatric Society
307396	Brian A Rothberg M.D.	GM	Colorado Psychiatric Society
301407	Rajesh R Tampi MD MS	FE	Connecticut Psychiatric Society
88357	Andrew William Donohue, DO	FE	Psychiatric Society of Delaware
303759	Dawn-Christi M Bruijnzeel, MD	FE	Florida Psychiatric Society
77687	Manal M Durgin, MD	GM	Florida Psychiatric Society
38156	Laura Jane Elder, MD	GM	Florida Psychiatric Society
18298	M Khaled El-Yousef M.D.	LF	Florida Psychiatric Society
78356	Cheryl L Gonzales-Nolas, MD	GM	Florida Psychiatric Society
65753	Christine A Grissom M.D.	FE	Florida Psychiatric Society
306146	Jacqueline A Hobbs M.D.	FE	Florida Psychiatric Society
77046	F Andrew Kozel, MD	FE	Florida Psychiatric Society
89322	Juandalyn R Peters M.D.	FE	Florida Psychiatric Society
71462	Caryn B Schorr, MD	FE	Florida Psychiatric Society
81883	Oscar M Villaverde M.D.	FE	Florida Psychiatric Society
73603	Farzana M Bharmal M.D.	GM	Georgia Psychiatric Physicians Association, Inc
79079	Ann C Schwartz, MD	FE	Georgia Psychiatric Physicians Association, Inc
33754	William Frank Thorneloe M.D.	LF	Georgia Psychiatric Physicians Association, Inc
78619	Chad Y Koyanagi M.D.	FE	Hawaii Psychiatric Medical Association
67016	Junji Takeshita, MD	FE	Hawaii Psychiatric Medical Association
74868	Ryan D Finkenbine, MD	GM	Illinois Psychiatric Society
62369	Atul R Mahableshwarkar M.D.	GM	Illinois Psychiatric Society
79002	Daniel B Martinez M.D.	FE	Illinois Psychiatric Society
57517	Ralph Michael Orland M.D.	FE	Illinois Psychiatric Society
57577	Robert C Sharpe M.D.	FE	Illinois Psychiatric Society
61316	Robert B. Shulman M.D.	FE	Illinois Psychiatric Society
61188	Carl M Wahlstrom, MD	GM	Illinois Psychiatric Society
45810	Gregory Barclay M.D.	FE	Iowa Psychiatric Society
90316	Laurie M McCormick, MD	FE	Iowa Psychiatric Society
37903	Paul Ray Kensicki M.D.	FE	Kentucky Psychiatric Medical Association
70462	Marc Fishman M.D.	GM	Maryland Psychiatric Society, Inc
88259	Nancy K Wahls M.D.	FE	Maryland Psychiatric Society, Inc
18291	Phillip Louis Edwardson M.D.	LM	Minnesota Psychiatric Society
300569	Joel V Oberstar, MD	FE	Minnesota Psychiatric Society
64530	Philip Louis Scurria, MD	FE	Mississippi Psychiatric Association, Inc
55311	Risa Levenson Gold, MD	FE	Greater Long Island Psychiatric Society
42260	Sashi Shukla M.D.	FE	Greater Long Island Psychiatric Society
74776	Mary F Beirne M.D.	GM	New Jersey Psychiatric Association
72476	Linda M Brzustowicz M.D.	FE	New Jersey Psychiatric Association
39468	Kenneth Roland Kaufman, MD	FE	New Jersey Psychiatric Association
80999	Narsimha R Pinninti M.D.	GM	New Jersey Psychiatric Association
29161	Paul Edward Rosenberg M.D.	LF	New Jersey Psychiatric Association
102785	Fatimah A Tahil MD MPH	FE	New Jersey Psychiatric Association
91842	Anthony C Tamburello, MD	FE	New Jersey Psychiatric Association
30756	Michael R Zornitzer M.D.	LF	New Jersey Psychiatric Association

67949	Stewart L Adelson M.D.	FE	New York County District Branch
74950	Marianne T Guschwan M.D.	FE	New York County District Branch
28632	Barry Reisberg, MD	LF	New York County District Branch
72619	Stephan F Baum M.D.	GM	North Carolina Psychiatric Association
85321	Daniel W Bradford M.D.	FE	North Carolina Psychiatric Association
71834	Brian Andrew Farah M.D.	FE	North Carolina Psychiatric Association
73469	Manish A Fozdar M.D.	GM	North Carolina Psychiatric Association
30286	Arthur Evans Kelley M.D.	LM	North Carolina Psychiatric Association
64738	Winston Earl Lane, MD	GM	North Carolina Psychiatric Association
82361	Omar S Manejwala, MD	FE	North Carolina Psychiatric Association
86646	Mehul V Mankad, MD	FE	North Carolina Psychiatric Association
83881	John M Santopietro M.D.	FE	North Carolina Psychiatric Association
64572	Philip Marget Spiro M.D.	FE	North Carolina Psychiatric Association
43576	Pamela J Wright-Etter, MD	FE	North Carolina Psychiatric Association
66965	Ronald Craig Albucher M.D.	FE	Northern California Psychiatric Society
20408	Basil G Bernstein, MD	LF	Northern California Psychiatric Society
69285	James Alan Bourgeois M.D.	FE	Northern California Psychiatric Society
78794	Jacquelyn B Chang M.D.	FE	Northern California Psychiatric Society
18259	John Kenneth Darby M.D.	LF	Northern California Psychiatric Society
87311	Khurram K Durrani M.D.	FE	Northern California Psychiatric Society
71930	Kewchang Lee M.D.	FE	Northern California Psychiatric Society
75010	Carol A Mathews M.D.	GM	Northern California Psychiatric Society
64412	Adam Phillip Nelson, MD	FE	Northern California Psychiatric Society
38948	Zena Cathryn Potash M.D.	GM	Northern California Psychiatric Society
71840	Steven V Fischel MD PhD	GM	Massachusetts Psychiatric Society
77829	David L Mintz M.D.	GM	Massachusetts Psychiatric Society
62495	Marilyn Price MD CM	GM	Massachusetts Psychiatric Society
56972	Mary Anna Sullivan, MD	GM	Massachusetts Psychiatric Society
71482	Christopher J Kratochvil M.D.	FE	Nebraska Psychiatric Society
33509	Steven W Jewell, MD	LF	Ohio Psychiatric Association
102300	William J Resch, DO	FE	Ohio Psychiatric Association
57718	Ana Maria Bautista-Gutierrez M.D.	FE	Oklahoma Psychiatric Physicians Association
73142	Jimmie D McAdams, DO	FE	Oklahoma Psychiatric Physicians Association
33646	Leslie Tamas Kiraly M.D.	LF	Ontario District Branch
72478	Gilles Chamberland M.D.	GM	Quebec & Eastern Canada District Branch
311771	Daphne Rocha Marussi, MD	GM	Quebec & Eastern Canada District Branch
70692	France Proulx M.D.	GM	Quebec & Eastern Canada District Branch
68131	Stuart Gitlow MD MPH	FE	Rhode Island Psychiatric Society
102173	Robert James Dasher M.D.	GM	Southern California Psychiatric Society
301742	Eric M Levander MD MPH	FE	Southern California Psychiatric Society
303363	Joseph R Simpson, MD PhD	GM	Southern California Psychiatric Society
71189	Timothy R Jennings M.D.	FE	Tennessee Psychiatric Association
68088	Melissa Gail Inga Eshelman, MD	FE	Texas Society of Psychiatric Physicians
305237	Dawnelle J Schatte M.D.	GM	Texas Society of Psychiatric Physicians
58512	Jordan Yee M.D.	GM	Texas Society of Psychiatric Physicians
69440	W. Gregory Briscoe, MD	GM	Psychiatric Society of Virginia, Inc
102051	Varun Choudhary M.D.	FE	Psychiatric Society of Virginia, Inc
76672	Adam T Kaul M.D.	FE	Psychiatric Society of Virginia, Inc
84023	Christine K Steinhagen M.D.	FE	Psychiatric Society of Virginia, Inc
21386	Ann C Birk, MD	LF	Washington Psychiatric Society

2014 Distinguished Fellow Nominations - Approved
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54556	James Lamont Griffith, MD	FE	Washington Psychiatric Society
59908	Janice Gertrude Hutchinson M.D.	FE	Washington Psychiatric Society
91603	Grace E Inyang M.D.	GM	Washington Psychiatric Society
76139	Daniel Z Lieberman M.D.	FE	Washington Psychiatric Society
304572	Susan D Rich MD, MPH	GM	Washington Psychiatric Society
77685	Mary E Salcedo M.D.	FE	Washington Psychiatric Society
87344	Karen G Gennaro M.D.	FE	Psychiatric Society of Westchester County, Inc
43416	Jon Scott Berlin, MD	GM	Wisconsin Psychiatric Association
304255	Jerry L Halverson M.D.	FE	Wisconsin Psychiatric Association
45506	Joseph Bernard Layde MD JD	FE	Wisconsin Psychiatric Association
83794	Angelique D Goodhue M.D.	FE	Western Canada District Branch
63620	Chris Paul Gorman, MD	FE	Western Canada District Branch
1000643	Dhanapal Natarajan, MD	FE	Western Canada District Branch
78716	Colleen J Northcott, MD	FE	Western Canada District Branch
68311	James L Megna M.D.,Ph.D.	GM	Central New York District Branch
63187	Emerson B Bueno M.D.	FE	Arizona Psychiatric Society
301863	Tolulope T Aduroja, MD MPH	FE	Alabama Psychiatric Physicians Association
36881	Frederick C Goggans M.D.	LF	Maine Association of Psychiatric Physicians
40752	Joan Schaap Leitzer M.D.	LM	Maine Association of Psychiatric Physicians
87664	Michael Price M.D.	GM	Maine Association of Psychiatric Physicians
86844	Karl M Jacobs M.D.	FE	San Diego Psychiatric Society
90208	Anoop Karippot M.D.	FE	San Diego Psychiatric Society
58914	Arvin Mirow M.D.	GM	San Diego Psychiatric Society
88435	DeeAnn Yuk-Han Wong, MD	FE	San Diego Psychiatric Society
73312	Matthew B Stanley, DO	FE	South Dakota Psychiatric Association
84728	Lisa Ann Durette, MD	FE	Nevada Psychiatric Association
303567	Laura J Dardashti M.D.	GM	Orange County Psychiatric Society
42782	Thomas Hiroshi Okamoto M.D.	FE	Orange County Psychiatric Society
305665	John A Van Slyke, DO	FE	Society of Uniformed Services Psychiatrists

n=128 approved
n=1 deferred Dr. Delano Heard (DB26)

Distinguished Fellow Nomination
Deferred - Confidential

Member ID #	Name	Member Class	District Branch
28102	Delano R Heard DO	Life Fellow	New Jersey Psych Assn

n=1

International Distinguished Fellow Nomination
Approved - Confidential

Member ID #	Name	Member Class	Country
1063686	Gabriel Obukohwo Ivbijaro, MD	International Member	United Kingdom

n=1

Resignations
August 1, 2014 - October 31, 2014

Member ID	Label Name	Member Class	DB #	DB Name	Reason
78984	Sumathi Balaraman, DO	General Member	DB43	Southern California	Economic reasons
44384	Mark S Bauer M.D.	Distinguished Fellow	DB32	Massachusetts	Not Provided
1017755	Rebecca Birnbaum MD	General Member	DB20	Maryland	Not Provided
1005155	Gina M Borugian Ostermann, MD	General Member	DB43	Southern California	Dues too high
28442	Neil David Carr M.D.	Life Member	DB20	Maryland	Not Provided
88384	James G Carter M.D.	General Member	DB11	Georgia	Not Provided
21684	Nathan Cohen M.D.	Life Member	DB30	Northern California	Not Provided
1013571	Robert William Ellis III, MD	General Member	DB21	Michigan	Not Provided
78601	Rosemary A Horstmann M.D.	General Member	DB38	Pennsylvania	Not Provided
44124	Chris Richard Howlett M.D.	General Member	DB21	Michigan	Not Provided
45928	Denise Ann Ingham M.D.	General Member	DB46	Texas	Not Provided
86763	Samina Juneja M.D.	General Member	DB18	Kentucky	Not Provided
37298	David Allan Koch, MD	Life Member	DB33	Washington State	Not Provided
10167	William Kornfeld M.D.	Life Member	DB18	Kentucky	Retired
1052872	David F Mays II, MD	General Member	DB11	Georgia	Career Change
32147	L Marlene Payne, MD	Distinguished Life Fellow	DB48	Washington	Not Provided
1005540	Carla M Reese, MD	General Member	DB20	Maryland	Not Provided
72727	Martin T Ryan M.D.	General Member	DB35	Ohio	Not Provided
21275	Sherman Wayne Severson, MD	Life Member	DB63	North Dakota	Not Provided
311248	Dan R Tzuang, MD	General Member	DB76	Orange County	Not Provided
81174	Daniel F Villarreal M.D.	General Member	DB46	Texas	Not Provided
71290	Leo Villar Yason M.D.	General Member	DB10	Florida	Not Provided

n = 22

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1163785	Abdul-Karim, Yasmeen
1136481	Abegaz, Mezgebe
1060275	Abraham, Jacob
1205484	Adame, John
1111869	Adams, Carson
1131397	Adebayo, Adewale
1056535	Aderholt, Andie
1253735	Adigun, Ayodola
1093934	Adkins, Matthew
1162960	Aguilar, Stephanie
1133033	Ahmed, Suleman
1140139	Akasaka, Kento
1133525	Akinkugbe, Alan
1162986	Alamgir, Mohammad
1163197	Ali, Shad
1056508	Ali, Yasmin
1157568	Allan, Elizabeth
1131382	Allan, Hillary
1115505	Allen, Nick
1133008	Amadu, David
1137178	Andersen, Matthew
1065571	Ankeny, Daniel
1060053	Arens, David
1122013	Arnett, Mawusi
1138129	Arvidson, Megan
1140105	Ash, David
1133523	Aylsworth, Kelly
1276194	Badillo, Monica
1244947	Bahadoor, Kevin
1152157	Bajrovic, Emina
1103051	Baker, Paul
1152186	Barbour, Meredith
1140120	Barratt, Jeffrey
1137186	Barrera, Fernando
1114634	Barrett, Richard
1097993	Barusch, Nathaniel
1158469	Bastiaens, Jesse
1233679	Bates, Nicole
1097428	Bautista, Tricia
1156745	Beattie, Ashley
1159083	Beaty, Natalie
1167179	Beaulieu, Nicolas
1126074	Calnan, Sarah
1220426	Campbell, Liana
1162978	Capili, Emlyn
1156765	Capitano, Mario
1133521	Carpenter, Conor
1163203	Carroll, Joshua
1129397	Carter, Jeffrey
1131079	Cartier, Earnestine

Member #	Name
1056511	Begovic, Jovan
1234476	Bekker, Yana
1135235	Bell, Patrick
1133007	Bender, Daniel
1113358	Bennink, Justin
1167315	Benton, Amber
1056551	Berg, Lindsey
1056055	Bergfeld, Nicholas
1135236	Berrios, Jaclismar
1115920	Berry, Benjamin
1163731	Berthelot, Jessica
1220330	Bhurgri, Ashhar
1056558	Bishop, Jacob
1135225	Black, Jason
1059967	Blackburn, Kyle
1111894	Blechinger, Derek
1121995	Bleck, Ryan
1216613	Blocker, Janelle
1162802	Bocock, John
1134643	Bodenhamer, Lisa
1238273	Bodnar, Tetyana
1113011	Bonavitacola, Patrick Joseph
1056507	Bornstein, Ethan
1155397	Borreggine, Kristin
1235761	Bowen, Lynneice
1155255	Bowen, Michael
1152861	Bowser, Kelli
1163734	Bozhdaraj, Durim
1005085	Brakken-Thal, Christina
1055055	Braus, Benjamin
1133369	Bridges, Amber
1118004	Britton, William
1115041	Brom, Jacqueline
1060048	Brown, Adam
1140094	Buchalter, Erica
1158493	Budde, Kristin
1167208	Bui, Brian
1129399	Burke, Michael
1137566	Burley, Ruth
1234138	Burnett, Sharlena
1133371	Buzza, Colin
1193809	Callinan, Nora
1238426	Daly, Nadia
1008368	Daniels, Jeremy
1056503	Daraei, Pedram
1133375	Darakjian, Ara
1163789	Daunis, Daniel
1160347	Davis, Michael
1140103	Davis, Ryan
1221778	Dawson, Antoinette

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1131078	Cartier, William
1133011	Casey, Brian
1090950	Castater, A. Christine
1253732	Chadalavada, Sridhar
1056509	Chang, Alison
1147684	Charlot, Christopher
1163818	Chaudhari, Sumit
1140116	Chauhan, Neeraj
1229220	Chen, Clark
1147711	Chi, Tiffany
1129389	Chikvashvili, Irina
1114010	Choi, Kwang
1138135	Ciobanu, Cosmina
1063978	Clark, Abigail
1152130	Clements, Elizabeth
1137184	Cline, Garred
1073127	Cochran, Deanna
1151547	Cohen, Abigail
1194158	Cole, Lesley-Ann
1201062	Colon Colon, Edwin
1221783	Contreras, Luz
1134645	Cooper, Ayden
1157600	Cordero Sam, Cesar
1126064	Cornelius, Julia
1158480	Coshal, Shana
1225821	Courtright, Alanna
1119659	Covington, Ashley
1163816	Cox, Mike
1221544	Craig, Cassandra
1137176	Cranford, Melissa
1060047	Cummins, John
1160379	Cyzeski, Kelley-Anne
1163798	Dabolt, Richard
1093846	Dakay, Katarina
1136473	Ervin, Elizabeth
1135747	Espejo, Gemma
1220338	Fairbairn, Jonathan
1056062	Farin, Casey
1155236	Farmer, Derrick
1126067	Farrell, Michael
1131950	Fauq, Irfan
1133029	Fenn, Eric
1138858	Flores, Melanie
1161192	Fox, Michael
1147682	Fragoso-Vazquez, Ivonne
1135528	Gauer, Elliott
1056512	Gebrelul, Naomi
1193646	Gekhman, Dmitriy
1056515	Gensler, Lauren
1119663	Gentile, Natalie
1162943	De Jesus, Miranda
1157572	Debrey, Sarah
1152666	DeHaan, Jonathan
1239209	Deleva, Vasilka
1162955	Deng, Yi
1056514	Derkits, Elena
1056521	Desai, Megan
1131461	Deyoung, David
1071040	Dias, Valeria
1201059	DiGenova, Patrick
1193820	Diomi, Pierre
1156752	Distler, Margaret
1114045	Do, David
1137171	Dodard Friedman, Anise
1152863	Donoghue, Anna
1102393	Douillard, Jelena
1219637	Dowling, Tyler
1149900	Dragonetti, Joseph
1193239	Drouin, Marlene
1065591	Dudley, Brittney
1014875	Duncan, Ellen
1151573	Dunn, Kelly
1138479	Durand-Hollis, Gabriel
1147382	Ee, Jessica
1229128	Eid, Laeticia
1060042	Elisha, Adam
1140118	Ellington, Thomas
1193771	Elliott, Alicia
1119662	Ellis, Amanda
1115496	Elperin, Anna
1093928	Elswick, Benjamin
1103071	Embry, Faneece
1158479	Emmanuel, Geraldine
1238281	Erck, Daniel
1103294	Griffith, Paula
1200982	Grossman, Aaron
1158485	Guo, Sharon
1133012	Habeshian, Kaiane
1121987	Hadeed, George
1059960	Hadlock, Jennifer
1113030	Hall, Matt
1163199	Halperin, Marc
1162806	Handler, Elliot
1233641	Harneja, Sonal
1138854	Harper, Kari
1151564	Hassanyeh, Ruby
1149923	Hathaway, Taylor
1129353	Haynes, Nichelle
1056530	Hayslett, Drew
1160350	He, Bei

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1101186	Georges, Michelle
1093848	Gerdner, Oscar
1133528	Gergelis, Kristyn
1159194	Gerson, Adam
1113359	Ghobadimanesh, Alexander
1167373	Giddings, Robert
1147677	Gill, Jacquelyn
1159065	Gill, Kristin
1135749	Gimbel, Harrison
1140502	Girgis, Jacob
1126079	Glaser, Alessandra
1152070	Gold, Jessica
1137198	Gomez, Andres
1091223	Gomez, Aurora
1097226	Gomez, Rebecca
1134061	Gongireddy, Divyasri
1115487	Gonzalez, Daniel
1099124	Gonzalez, Wilfredo
1137180	Gould, Jennifer
1155216	Granda, Melissa
1050889	Gray, Lorian
1113995	Gray, Royce
1114028	Green, Karen
1131374	Greenfeder, Alison
1136477	Gregory, Jonathan
1229142	Grewal, Smrita
1133370	Izraelit, Asya
1009532	Jackson, Shawn
1122001	Jagadish, Sneha
1160351	Jaitly, Nina
1240969	James, Brenda
1060784	Janopaul-Naylor, Elizabeth
1201038	Jaspal, Hardeep
1155200	Jetmalani, Asha
1160371	Jewell Burks, Erin
1220311	Jimenez, Alfonso
1121999	Jimenez, Monica
1163819	Johnson, Erik
1134642	Johnson, James
1133526	Johnson, Keith
1159062	Johnson, Kevin
1240961	Jones, Dylan
1129409	Jones, Katherine
1119652	Jones, Tarrell
1235414	Joseph, Susan
1134639	Jouni, Ali
1114035	Jucan, Ioana
1135532	Kapoor, Shuchi
1140238	Katuwapitiya, Shehan
1218987	Katz, Judith
1103224	Heim, Leah
1140076	Heldt, Jonathan
1056532	Henry, George
1133365	Hernandez, Steffi
1135828	Hiatt, Elizabeth
1159181	Hicks, Hamilton
1103237	Hocko, Alex
1163196	Hodzic, Vedrana
1008919	Hoftman, Gil
1134169	Hollett, Brock
1167357	Hong, Joe
1122370	Horton, Renette
1167344	Hosker, Daniel
1140098	Hossain, Sumaiya
1152171	Howard, Camille
1065572	Hsieh, Wei-Jen
1129396	Hughes, Matthew
1134665	Hundley, Esther
1136478	Hurlbert, Lori
1094046	Husko, Christopher
1076916	Huynh, Margaret
1060308	Igoe, Sarah
1193740	Ilaria, Shawen
1155174	Inouye, Daniel
1114268	Irwin, Lacy
1234151	Isom, Jessica
1155187	Kucherer, Shelly
1129357	Kuckel, Daniel
1114315	Kuiper, Brandon
1102818	Kupersmit, Daniel
1140311	Kuster, Kael
1109795	La Bril, Robert
1098823	La Pointe, Michael
1193241	Lai, Karen
1201067	Lane, Chadrick
1167264	Larochelle, Matthieu
1134648	Latef, Nauf
1152150	Latorre, Samantha
1122379	Lau, Wai
1154634	Laurent, John
1129355	Lee, Anna
1158489	Lee, Catherine
1065574	Lee, Daewoong
1160345	Lee, Dane
1193583	Lee, Daniel
1160403	Lee, Grace
1131443	Lee, Jena
1147687	Lee, Jon Yong
1159077	Leon, Michael
1152173	Leonpacher, Anne

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1161182	Keating, Patrick
1065570	Kelly, Kathleen
1151549	Kennis, Samantha
1140096	Khan, Mahfuzul
1056505	Khoury, Lanya
1167216	Kim, Jae
1163201	Kim, Jenice
1160375	Kim, Joyce
1160440	Kim, Jungjin
1152537	Kim, Thomas
1129473	Kin, Sarah
1070228	Klein, Maximilian
1089821	Kline, David
1065579	Kooperkamp, Hannah
1149929	Koshy, Stanley
1129354	Kositsawat, Juthamas
1240201	Koskey, Jesse
1163795	Kravitz, Evan
1158474	Mangal, Jed
1115489	Marin, Isennia
1193826	Marin, Lea
1060295	Maris, Emily
1065575	Marr, Joshua
1151552	Martin, Leisel
1157574	Marut, Allison
1069621	Masterson, Haley
1275267	Mathew, Chrissy
1135539	Maung, Zaw
1194172	Mazurek, Matthew
1140442	McCormick, Cyndi
1140109	McGarvey, Jonathan
1140110	McIntyre, Lucas
1152172	Mendrano, Benjamin
1133615	Meshman, Michelle
1060306	Meyer, Dana
1133014	Mills, Christina
1129364	Moharari, Gazelle
1111919	Mond, Yehuda
1155204	Monestime, Jim
1131656	Monterrey, Julio
1156758	Moore, Brian
1059966	Moore, Cassandra
1121996	Moore, Iris
1056541	Moore, Mary
1162808	Moore, Samantha
1062312	Moraites, Eleni
1140123	Morales, Wilnelya
1122003	Morris, Kylie
1160365	Morrison, Matthew
1136202	Moss, Stephanie
1118007	Li, Annette
1138140	Li, Luming
1059965	Li, Winston
1133832	Lin, Hua-Fang
1094008	Liu, Mike
1070210	Livingston, Briana
1060305	Loewenstein, Scott
1140137	LoGrotta, Christine
1163204	Lorenzo, Aileen
1093842	Lozada Montanez, Militza
1216617	Lugo, Esteban
1131384	Luoma, Tyson
1103222	Lwin, Wai Wai
1133372	Lyu, Hee-Sang
1233655	MacKenzie, Robert
1136108	Maddox, Birrilla
1224665	Maeng, Soobin
1167185	Mahler, John
1151237	Nelson, Sarah
1129393	Nemani, Katlyn
1131654	Ng, Stephanie
1137188	Nguyen, Mai-Thao
1133016	Nguyen, Thai
1060277	Nichols, Stephen
1134224	Norat, Bradley
1068716	Nykiel, Jennifer
1073460	O'Brien, Alyxandra
1193795	O'Leary, Patrick
1093927	Odumade, Oludare
1152665	Oh, James
1159176	Ojeda, Edgardo
1133376	Olivetti, Pedro
1116674	Oroskar, Anand
1131398	Ostler, Peter
1111951	Ostrovsky, Dmitry
1129387	Ottiniano, Emily
1056557	Pace, Benjamin
1129356	Pack, Valerie
1140102	Pak, Kichul
1133367	Palmer, Robert
1216561	Pangle, Leslie
1134651	Park, Francine
1116673	Park, Timothy
1103076	Patel, Neil
1151561	Paul, Derek
1056533	Paulk, Dennis
1093840	Payne, Laurel
1149901	Peecher, Jenevieve
1129385	Pelleg, Ayla
1151554	Perez, Alejandro

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1056517	Mott, Brian
1163202	Mou, David
1218342	Moylan, Swathi
1023467	Muelly, Emilie
1131380	Muetzel, Joshua
1131951	Murante, Tessa
1079661	Murphy, Amy
1140122	Nagarkatti-Gude, David
1201061	Nageeb, Maysaa
1151246	Narasimhan, Varsha
1135228	Puckett, Judith
1108166	Pytell, Jarratt
1282147	Quinones, Leisha
1156228	Radoeva, Petya
1163813	Rafferty, Erin
1162998	Rajani, Mohsin
1167350	Raleigh, Brendan
1282145	Ramzi, Raymond
1129386	Ratemo, Brenda
1076931	Redovian, Michael
1167221	Reed, Jeffrey
1147685	Reinhardt, Jason
1136104	Reinstein, Sarah
1135745	Rettenmier, Monica
1140106	Reyna, Lorena
1140079	Richardson, Matthew
1167338	Riddle, Megan
1159178	Riggs, Shane
1135540	Riva, Katherine
1056538	Rivero, Julie
1056528	Roberts, Allison
1140135	Robinson, Diana
1111913	Rodriguez, Tonantzin
1152184	Rodriguez, Vanessa
1111896	Rogg, Rebecca
1159193	Rojas, Javier
1147728	Rojchanakasetchai, Tanida
1140114	Rolle, Pharez
1133366	Roraff, David
1223074	Rosoff, Eric
1091191	Ross, Lela
1163814	Rubinchik, Yakov
1140136	Ruege, Andrew
1129403	Russ, James
1115510	Rutledge, Shanika
1155499	Ryder, John
1147383	Salah, Yusuf
1162167	Salcido, Crystal
1137569	Samikoglu, Ali
1114029	Samran, Karandeep
1062319	Pesquera Molinaris, Jorge
1133517	Peterson, Robert
1167194	Piatz, Christopher
1149890	Pierce, Donald
1221774	Pikard, Jennifer
1103225	Pike, Emily
1102827	Pires, Charity
1149898	Powell, Karen
1133028	Pratt, Howard
1136102	Price, Amber
1151245	Sanders, Donald
1163187	Sandver, Justin
1056516	Sangha, Thalvinder
1101185	Sannesy, Seema
1232125	Sansfaçon, Jeanne
1152170	Santin, Ryan
1236127	Sarhani, Reda
1133917	Saul, Joel
1225028	Saunders, Amber
1155215	Saunders, David
1159067	Schleger, William
1216002	Schneider, Brandon
1135538	Schultz, Amanda
1221773	Schultz, Autumn
1056547	Scoggin, Darren
1126054	Seaton, Kathleen
1119653	Selpides, Pocholo Jose
1133524	Semenova, Yelena
1282146	Shah, Nishith
1239648	Shah, Rian
1282158	Shah, Sunny
1111898	Shahid, Jawad
1056054	Shamma, George
1115504	Shapter, Christine
1068714	Shaw, Samantha
1111872	Sheehan, Meghan
1118009	Sheikh, Mohammed
1155212	Sherhart, Rachel
1056534	Sherrill, Cameron
1137195	Shwarts, Erik
1167169	Siedler, Robert
1089823	Silberschmidt, Amy
1118473	Simon, Kevin
1135227	Simpson, Monique
1056510	Singh, Davin
1138130	Singh, Navendra
1274765	Siskind, Ilana
1138133	Smith, Ashley
1160376	Smith, Casey
1135774	Smith, Christopher

Medical Students Whose Memberships Expire 12/31/2014
(Graduated-Not Eligible for MS Membership)

Member #	Name
1133519	Sanchez, Gabriela
1111924	Sanchez, Melissa
1126078	Smith, Sean
1129398	Smith, Shaun
1155217	Smolcic, Elyse
1114042	Sobowale, Kunmi
1167379	Soonthornpong, Nathan
1129404	Sorrell, Larry
1118016	Soued, Valerie
1102360	Sreshta, Nina
1159064	St. Louis, Joshua
1135530	Stack, Colleen
1126070	Stacy, Benjamin
1090949	Staudt, Michael
1254252	Stephens, Izzy
1077098	Stone, Laura
1155211	Stovall, Jessica
1159082	Stram, Alyssa
1114050	Strong, Christian
1131372	Sutton, Nathan
1129360	Sweat, Christopher
1073138	Tai, Sean
1147735	Talaat, Sherine
1162799	Talley, Megan
1136111	Taneja, Ekta
1065573	Tannenbaum, Jessica
1147730	Tapias, Rafael
1131391	Tarver, Leslie
1063977	Taufique, Zahrah
1095145	Taylor, Erin
1114026	Taylor, Mia
1104411	Tehrani, Diana
1240087	Theriault, Caroline
1162990	Thomas, Jason
1219383	Thomson, Michael
1070229	Tobon, Amalia
1151562	Trammell, June
1102397	Tschang, Jane
1122011	Tucciarone, Jason
1151560	Turkmani, Sophia
1067871	Twiggs, Elliot
1133041	Unger, Marcia
1234044	Ursani, Aneel
1059402	Vana, George
1163735	Zito, Michael
1129395	Zuern, Ashley
1134638	Zulueta, John
1056548	Smith, Erin
1151566	Smith, Pauline
1114011	VanToai, Anna
1138110	Varigonda, Anjali
1129369	Varner, Bradley
1131657	Vaughan, Freddie
1160363	Velez, Merill
1155197	Wachtel, Amanda
1129351	Waggel, Stephanie
1122348	Wahba, Noha
1060293	Walsh, Brian
1134641	Walsh, Jeffrey
1147678	Ward, Eric
1131459	Wasserman, Brian
1160418	Weathers, Eric
1056549	Weaver, Courtney
1151546	Weaver, Lauren
1056529	Wells, Ashley
1136203	Wells, Devin
1159189	Wenzinger, Michael
1154635	Wheat, Ian
1218310	White, Jacob
1236413	Wilber, Charles
1230459	Wilson, Andy
1113062	Windon, Annika
1093947	Wingert, Valerie
1118018	Winn, Aubrey
1161143	Wojcicki, Lucy
1043057	Wong, Wai Chong
1076917	Woods, Jeremy
1056531	Wright, Crystal
1149908	Xiong, Willa
1097150	Xu, Jie
1159180	Yanchar, Elena
1104785	Yang, Andrew
1056513	Yang, Yihan
1114041	Yee, Tracy
1138659	Yoshimatsu, Kei
1232081	Yusuf, Rafi
1102376	Zagrabbe, Kathryn
1133004	Zanitsch, Brendan
1138132	Zeger, Nicholas
1126062	Zhao, Bailey
1149936	Zhuang, David

n = 591

ID#	Name	Mbr Cls	DB Name	Reason
36669	Neal Howard Adams M.D.	DLF	Northern California	APA Dues Non-Payment
1007415	Manuel Aguilar Saens MD	Intl Mbr		APA Dues Non-Payment
308383	Oliver Abbas Ahmadpour MD	GM	San Diego	APA Dues Non-Payment
1231865	S. M. Anwar Ahmed MD	GM	Genesee Valley	APA Dues Non-Payment
59512	Mohammed Younus Alam MD	GM	Illinois	APA Dues Non-Payment
1005061	Hernan E Alvarez MD	GM	New Mexico	APA Dues Non-Payment
1009326	Mona Amini MD	GM	Arizona	Failure to Meet GM Req
34911	Douglas Burtman Anderson MD	LM	Northern California	APA Dues Non-Payment
92514	Sharon P Andrews MD	GM	Florida	APA Dues Non-Payment
1245413	Rebecca Melissa Arana MD	RFM	Florida	APA Dues Non-Payment
301873	Abila F Awan M.D.	GM	Oklahoma	APA Dues Non-Payment
31396	William Steven Baker M.D.	LM	Kansas	APA Dues Non-Payment
305723	Carolyn Oates Ballantine MD	GM	North Carolina	APA Dues Non-Payment
68941	Stewart Barnett MD	GM	North Carolina	APA Dues Non-Payment
1163709	Farzana Begum MD	GM	Connecticut	APA Dues Non-Payment
60510	Ward E Bein M.D.	GM	Massachusetts	APA Dues Non-Payment
77971	Michael D Bernot M.D.	GM	Greater Long Island	APA Dues Non-Payment
89581	Scott I Bienenfeld MD	GM	New York County	APA Dues Non-Payment
85406	Bernard J Biermann MD PhD	GM	Michigan	APA Dues Non-Payment
61943	Rodney S Birney M.D.	GM	Oregon	APA Dues Non-Payment
311192	Nancy M Bivens MD PhD	GM	New York County	APA Dues Non-Payment
310449	Daniel Bober DO	GM	Florida	APA Dues Non-Payment
36272	Federico C Boehringer M.D.	GM	Bronx	APA Dues Non-Payment
1058736	Scott Borkenhagen MD	RFM	Wisconsin	APA Dues Non-Payment
1001955	Andrea E Bowen MD	GM	Pennsylvania	APA Dues Non-Payment
85321	Daniel W Bradford M.D.	FE	North Carolina	APA Dues Non-Payment
310918	Jill Bradshaw M.D.	GM	West Virginia	APA Dues Non-Payment
63994	Jo Ellen Brainin-Rodriguez M.D.	GM	Northern California	APA Dues Non-Payment
1082495	Joel Breen MD	GM	Oregon	Failure to Meet GM Req
75678	Patrick C Brown MD	GM	Central California	APA Dues Non-Payment
304006	Eddy S Bruno MD	GM	Ohio	APA Dues Non-Payment
67750	Debra Lynne Bunger MD	GM	Northern California	APA Dues Non-Payment
70641	Mary T Burns MD	FE	Georgia	APA Dues Non-Payment
83849	Jean Rankin Butterfield MD	GM	Massachusetts	APA Dues Non-Payment
59624	David Arthur Carlson MD	GM	Connecticut	APA Dues Non-Payment
1216317	Edouard Cattan MD	GM	Ontario	APA Dues Non-Payment
1098862	Cori Chase DO MPH	RFM	Michigan	APA Dues Non-Payment
1120661	Goshawn Chawla MD	RFM	North Carolina	APA Dues Non-Payment
304584	Eran Chemerinski M.D.	GM	New York County	APA Dues Non-Payment
72305	Charles D M Clemetson M.D.	GM	Maine	APA Dues Non-Payment
1230539	Janetta Dominic Cureton MD	GM	Florida	APA Dues Non-Payment
1199647	Dean Julian Cutillar DO	GM	Uniformed Services	APA Dues Non-Payment
40657	Robert Allan Dahmes M.D.	DLF	Louisiana	APA Dues Non-Payment
71222	Alison F Dancer MD	GM	Oklahoma	APA Dues Non-Payment
90735	Rita-Kay Mabine Davis MD	GM	North Carolina	APA Dues Non-Payment
74205	Daniel J Dees MD	GM	Iowa	APA Dues Non-Payment
1013883	Namita Dhiman MD	GM	Virginia	Failure to Meet GM Req
65632	Lourdes M Dominguez M.D.	GM	New York County	APA Dues Non-Payment
1027765	Matt S Duncan MD	GM	New Hampshire	APA Dues Non-Payment
300907	Natalia Eisenberg MD	GM	Washington DC	APA Dues Non-Payment
31648	Stuart James Eisendrath M.D.	DLF	Northern California	APA Dues Non-Payment
89076	Marcelo R Eizner M.D.	GM	New Mexico	APA Dues Non-Payment

64094	Mohamed Hamed El-Gabalawy M.D	GM	Southern California	APA Dues Non-Payment
1001118	Claudia A Epelbaum MD	GM	Massachusetts	APA Dues Non-Payment
89135	Katherine Marie Erdwinn MD	GM	Arizona	APA Dues Non-Payment
1018230	Mia S Everett MD	GM	New York County	APA Dues Non-Payment
40216	Janet Lauren Feigelson M.D.	GM	Colorado	APA Dues Non-Payment
84138	Jeffrey A Feola M.D.	FE	Brooklyn	APA Dues Non-Payment
84625	Rena K Ferguson MD	GM	Greater Long Island	APA Dues Non-Payment
1016982	Jessaka Bailey Fife MD	GM	Alabama	APA Dues Non-Payment
35315	Linda Figen M.D.	LM	Indiana	APA Dues Non-Payment
91499	Kathryn J Flegel M.D.	FE	Oregon	APA Dues Non-Payment
84022	Stephanie J Forbes DO	GM	Oklahoma	APA Dues Non-Payment
40545	Emily Kukula Forcade MD	LM	Illinois	APA Dues Non-Payment
64670	Kathleen M Fouche-Brazzle MD	GM	Michigan	APA Dues Non-Payment
92314	Malcolm R Freedman DO	GM	Connecticut	APA Dues Non-Payment
77661	Gary W Frick M.D.	GM	Florida	APA Dues Non-Payment
22269	Stephen Howard Frye MD	LM	Nevada	APA Dues Non-Payment
1014129	Amy Fuglei MD	GM	Hawaii	Failure to Meet GM Req
1006378	Michael K Fullar MD	GM	Brooklyn	APA Dues Non-Payment
57568	Mindy Jennifer Fullilove MD	GM	New York County	APA Dues Non-Payment
103881	Leigh A Gaines MD	GM	Ohio	APA Dues Non-Payment
1004931	Magdalene Diana Garza MD	GM	Texas	APA Dues Non-Payment
34586	Anselm George MD	LF	Western NY	APA Dues Non-Payment
54462	Debra Ann Glitz M.D.	GM	Michigan	APA Dues Non-Payment
1013673	Danielle Goerke DO	GM	Minnesota	Failure to Meet GM Req
82700	Hagop Gorgissian M.D.	FE	Queens	APA Dues Non-Payment
45254	Jeffrey H Gottlieb M.D.	GM	Connecticut	APA Dues Non-Payment
310969	Rashida N Gray M.D.	GM	Virginia	APA Dues Non-Payment
304229	Rickey C Gray MD	GM	Colorado	APA Dues Non-Payment
1053317	Alexander E Graypel MD	RFM	Missouri	APA Dues Non-Payment
307891	Ayodele Kamila Green MD	GM	Mid-Hudson	APA Dues Non-Payment
1014054	Stacy L Greeter MD	GM	Illinois	APA Dues Non-Payment
1008137	Elisha Rebecca Greggo MD	GM	South Carolina	APA Dues Non-Payment
305397	Rikki Lynn Halavonich MD	GM	Tennessee	APA Dues Non-Payment
310219	Linda Green Harvey MD	GM	Georgia	APA Dues Non-Payment
67101	Richard Lee Hauser MD	GM	Iowa	APA Dues Non-Payment
1243733	Marcel Hediger MB	GM	Western Canada	APA Dues Non-Payment
54693	Roberta Natalie Hellman MD	GM	Queens	APA Dues Non-Payment
1245417	Jehan Helmi MD	RFM	Florida	APA Dues Non-Payment
1266783	Helga Reyne Herold DO	RFM	Queens	APA Dues Non-Payment
1002786	Daniel Hertzman MD	GM	Ontario	APA Dues Non-Payment
68986	David Walter Hiott M.D.	FE	South Carolina	APA Dues Non-Payment
1007941	Barry J Hoffman MD	GM	Pennsylvania	APA Dues Non-Payment
1105962	Hooman Hormozian MD	GM	Nevada	APA Dues Non-Payment
1009337	Maryam Hosseini MD	GM	Georgia	APA Dues Non-Payment
42489	Charita Cherylle Hoyle MD	GM	New York County	APA Dues Non-Payment
307034	Andrew W Hunt MD	GM	Ohio	APA Dues Non-Payment
302627	Tina C James M.D.	GM	Kentucky	APA Dues Non-Payment
303313	Samar Aisha Jasser MD	GM	Pennsylvania	APA Dues Non-Payment
68843	Neil Johnston M.D.	GM	Georgia	APA Dues Non-Payment
1207976	Robert Johnston MD	GM	Massachusetts	APA Dues Non-Payment
83432	Mirlande Jordan M.D.	GM	West Hudson	APA Dues Non-Payment
80987	Joel C Julian MD	GM	Oregon	APA Dues Non-Payment
1007420	Patricia Junquera MD	FE	Florida	APA Dues Non-Payment

73360	Savithri Kamakshi M.D.	GM	New Jersey	APA Dues Non-Payment
54969	Michael Miller Kaplan MD	FE	Wisconsin	APA Dues Non-Payment
72357	Neal Stuart Kass M.D.	GM	Massachusetts	APA Dues Non-Payment
68241	Melpomeni Kavadella M.D.	GM	Michigan	APA Dues Non-Payment
58608	Edward McDonnell Kendall M.D.	FE	South Carolina	APA Dues Non-Payment
62869	Lauren R Kern M.D.	GM	Illinois	APA Dues Non-Payment
1007266	Nicole M King MD	GM	Georgia	APA Dues Non-Payment
1266309	Shawn Kirby DO	RFM	Florida	APA Dues Non-Payment
1132203	Sobia Kirmani-Moe MD	GM	Wisconsin	Failure to Meet GM Req
102700	Alla Kirshner M.D.	GM	Western Canada	APA Dues Non-Payment
1001235	Gayle S Klein MD	GM	Connecticut	APA Dues Non-Payment
311840	Deborah L Knudson Gonzalez MD	GM	Massachusetts	APA Dues Non-Payment
1231940	Jamal Kobeissi MD	GM	New York County	APA Dues Non-Payment
1077432	Urszula S Kopec MD	GM	Westchester	APA Dues Non-Payment
42388	S Alexanndra Kreps MD	FE	Pennsylvania	APA Dues Non-Payment
1137151	Mercedes Kwiatkowski MD	GM	Ohio	Failure to Meet GM Req
1001837	Alyssa S Kwon MD	GM	New Jersey	APA Dues Non-Payment
61234	Gina Elisa Laite MD	GM	Indiana	APA Dues Non-Payment
30044	Julia Kit L Lam M.D.	LM	Southern California	APA Dues Non-Payment
89115	Jennifer T Lange M.D.	GM	Uniformed Services	APA Dues Non-Payment
301083	Richard M Lasarow M.D. Ph.D.	GM	Southern California	APA Dues Non-Payment
1106385	Saima Latif MD	GM	New Jersey	Failure to Meet GM Req
67254	Regina Y Le Verrier MD	GM	Colorado	APA Dues Non-Payment
305197	Uma Lerner MD	GM	Northern California	APA Dues Non-Payment
38756	Robert Bennett Levin M.D.	GM	Northern California	APA Dues Non-Payment
1229207	Xiaoping Liu MD PhD	RFM	Queens	APA Dues Non-Payment
310194	Adi Loebl MD	GM	New York County	APA Dues Non-Payment
73507	Bret W Logan M.D.	FE	Tennessee	APA Dues Non-Payment
303771	Tracy S Loper MD	GM	Oklahoma	APA Dues Non-Payment
91057	Julie Y Low M.D.	GM	New York County	APA Dues Non-Payment
305563	Joseph Z Lux MD	FE	New York County	APA Dues Non-Payment
63079	Joan Patricia Lynch MD	GM	Illinois	APA Dues Non-Payment
1017416	Lissette Madrigal MD	GM	South Carolina	APA Dues Non-Payment
1005645	Rhanda Marie M Magsalin MD	GM	Nevada	APA Dues Non-Payment
67848	Pamela Sue Martell M.D.	GM	Central California	APA Dues Non-Payment
304964	Michael L Martin M.D.	GM	Connecticut	APA Dues Non-Payment
85853	Anthony Joseph Mascola MD	GM	Idaho	APA Dues Non-Payment
83147	Jose L Massa M.D.	GM	Puerto Rico	APA Dues Non-Payment
60054	Leslie Ann Matsukawa M.D.	GM	Hawaii	APA Dues Non-Payment
1013781	Darrick May MD	RFM	Idaho	APA Dues Non-Payment
66026	Anne Clare Mazonson M.D.	FE	Washington DC	APA Dues Non-Payment
63341	Gregory Smith McFadden M.D.	FE	San Diego	APA Dues Non-Payment
37402	Mary Lou Meyers MD	DF	Genesee Valley	APA Dues Non-Payment
85576	Aidaspahic S Mihajlovic MD	FE	Illinois	APA Dues Non-Payment
1254940	Pawel W Miklaszewicz MD	Intl Mbr		APA Dues Non-Payment
1230234	Elana Monchar MD	GM	New Jersey	APA Dues Non-Payment
77781	Karen D Monroe M.D.	GM	Massachusetts	APA Dues Non-Payment
308707	Sara L Montgomery M.D.	GM	New Mexico	APA Dues Non-Payment
91991	Ricardo A Mujica MD	GM	Massachusetts	APA Dues Non-Payment
1000713	Indroneil Mukerji MD	GM	Greater Long Island	APA Dues Non-Payment
1001890	Muhammad I Munawar MD	GM	Connecticut	APA Dues Non-Payment
91056	Mauricio Murillo M.D.	FE	New York County	APA Dues Non-Payment
1117738	Muhammad A Muzaffar MD	GM	Virginia	APA Dues Non-Payment

306010	Calya Myint M.D.	GM	Washington DC	APA Dues Non-Payment
1043804	Georgia Nagel	GM	Texas	Failure to Meet GM Req
90329	Syed S Naqvi MD	DF	Southern California	APA Dues Non-Payment
90898	Shah Nawaz M.D.	FE	Connecticut	APA Dues Non-Payment
308847	Chandan Nayak MD	GM	Illinois	APA Dues Non-Payment
83110	Linda R Neale DO	GM	Georgia	APA Dues Non-Payment
301727	Christine E Negendank MD	GM	Michigan	APA Dues Non-Payment
69944	Kathryn A Neraas M.D.	FE	Washington State	APA Dues Non-Payment
306370	Elizabeth W Newlin M.D.	GM	Texas	APA Dues Non-Payment
33092	Michael A Newton M.D.	LM	Ohio	APA Dues Non-Payment
77628	Cynthia M Nguyen MD	GM	Northern California	APA Dues Non-Payment
1246179	Robina Hameed Niazi MD	GM	Maryland	APA Dues Non-Payment
1016792	Elizabeth Smith Nicholson MD	GM	North Carolina	APA Dues Non-Payment
79008	Julie A Niedermier MD	GM	Ohio	APA Dues Non-Payment
301746	Jason Louis Niksch MD	GM	Northern California	APA Dues Non-Payment
1107744	Anthony Njoku MBBS	GM	Quebec & E Canada	APA Dues Non-Payment
33566	Robert B Olsen M.D.	DLF	Washington State	APA Dues Non-Payment
63138	Julie Anne Otten MD PC	GM	Nebraska	APA Dues Non-Payment
85706	Jagoda Pasic MD PhD	GM	Washington State	APA Dues Non-Payment
1101580	Alkesh Navin Patel MD	GM	New Jersey	APA Dues Non-Payment
1114624	Karnika Patel MD	RFM	New York County	APA Dues Non-Payment
311337	Nicole A Pearl DO	GM	Florida	APA Dues Non-Payment
78047	Charles A Perkel M.D.	GM	Brooklyn	APA Dues Non-Payment
1049196	Laron Phillips MD	GM	Illinois	APA Dues Non-Payment
300942	Rebecca S Phillips MD	GM	Western NY	APA Dues Non-Payment
1050549	Jessica Ann Pineda MD	RFM	Ohio	APA Dues Non-Payment
26380	Melvin K Pisetzner M.D.	DLF	Genesee Valley	APA Dues Non-Payment
41026	Edward Pontius MD	DF	Maine	APA Dues Non-Payment
1009681	Julie Poulin MD	GM	Pennsylvania	APA Dues Non-Payment
1232788	Srikanth Prayaga MD	RFM	Queens	APA Dues Non-Payment
1239395	Samuel L Preston DO	GM	Hawaii	APA Dues Non-Payment
1021004	Manoj Puthiyathu MD	GM	New Jersey	Failure to Meet GM Req
83652	Yifang Qian MD PhD	GM	Northern California	APA Dues Non-Payment
84110	Sohail A Rana MD	FE	New Jersey	APA Dues Non-Payment
75148	Prabhakaran Rangaswamy M.D.	GM	New Jersey	APA Dues Non-Payment
1004539	Beverly A Reader MD	GM	Washington DC	APA Dues Non-Payment
78762	Alan J Reis M.D.	GM	Pennsylvania	APA Dues Non-Payment
1042262	Joseph Ronald Richards MD	GM	Uniformed Services	APA Dues Non-Payment
301791	Carol M Rockhill M.D. Ph.D.	GM	Washington State	APA Dues Non-Payment
302674	Shahna G Rogosin MD	GM	Northern California	APA Dues Non-Payment
1004928	Nils Rosenbaum MD	GM	New Mexico	APA Dues Non-Payment
67302	Ellen A Rosenblatt M.D.	GM	Ohio	APA Dues Non-Payment
75073	Wayne C Ross DO	GM	Georgia	APA Dues Non-Payment
1245658	Kaushik Roy MD	RFM	Queens	APA Dues Non-Payment
309089	Duke J Ruktanonchai MD	GM	Texas	APA Dues Non-Payment
40270	Astrid N Rusquellas M.D.	GM	Northern California	APA Dues Non-Payment
1010186	Sneha Sastry MD	GM	Michigan	APA Dues Non-Payment
64520	Erica Schiffman M.D.	GM	New Jersey	APA Dues Non-Payment
303120	Corbett A Schimming MD	GM	Bronx	APA Dues Non-Payment
66710	Hebe E. Schultz MD	GM	Central California	APA Dues Non-Payment
1001182	Miriam N Schultz MD	GM	Northern California	APA Dues Non-Payment
40356	Janice M Scott M.D.	GM	Kansas	APA Dues Non-Payment
64532	Margaret Sellers-Bok M.D.	GM	Alabama	APA Dues Non-Payment

1052351	Carmen R Serpa MD	GM	Michigan	APA Dues Non-Payment
81574	Joseph C Shanklin M.D.	GM	Florida	APA Dues Non-Payment
307796	Xiaoping Shao M.D.	GM	Washington DC	APA Dues Non-Payment
1017368	Rifat M Sharif MD	GM	Massachusetts	APA Dues Non-Payment
56725	Vinod Sharma MD	LM	Ohio	APA Dues Non-Payment
43287	Earle Hillel Shugerman MD	GM	Colorado	APA Dues Non-Payment
85173	Eva M Sikora MD	FE	North Carolina	APA Dues Non-Payment
1067259	Karamjit Singh MD	GM	Virginia	APA Dues Non-Payment
1043429	Darryl Smith MD MPH	GM	Washington DC	APA Dues Non-Payment
1009545	Michael J Sorna MD	GM	Florida	APA Dues Non-Payment
1012924	Renee V Spitzer MD	GM	Uniformed Services	APA Dues Non-Payment
1238172	Anil Srivastava MD	GM	Ontario	APA Dues Non-Payment
1099051	Diane St. Fleur MD	RFM	Central New York	APA Dues Non-Payment
1017702	Evelynn Marie Stephens DO	GM	Missouri	APA Dues Non-Payment
31076	Ronald Murray Sterling M.D.	GM	Washington State	APA Dues Non-Payment
103602	Kimberly A Stigler M.D.	GM	Indiana	APA Dues Non-Payment
1092574	Ashish Tambar MD	RFM	Western NY	APA Dues Non-Payment
34624	Isabel Tolentino-Mirasol MD	FE	Greater Long Island	APA Dues Non-Payment
79351	Carol L Trippitelli M.D.	DF	Washington DC	APA Dues Non-Payment
1009000	Napatia Moree Tronshaw MD	GM	Illinois	APA Dues Non-Payment
1265295	Marina Tsoy-Podosenin MD PhD	RFM	Queens	APA Dues Non-Payment
60422	Archer Kilbourne Tullidge Jr MD	GM	Texas	APA Dues Non-Payment
1008480	Susannah A Tung MD	GM	Connecticut	APA Dues Non-Payment
64618	Mariann K Turato MD	GM	Westchester	APA Dues Non-Payment
80311	Michael T Unger MD	GM	Ohio	APA Dues Non-Payment
75316	Mary C Uricchio MD	GM	Greater Long Island	APA Dues Non-Payment
1245419	Monica Lynn Vega MD	RFM	Florida	APA Dues Non-Payment
1240885	Carmencita Vicencio MD	GM	Bronx	APA Dues Non-Payment
305012	Jose L Villaluz M.D.	GM	New York County	APA Dues Non-Payment
78428	Lynn A Villemaire M.D.	GM	New Hampshire	APA Dues Non-Payment
36540	Richard Virgil M.D.	LM	Washington DC	APA Dues Non-Payment
91605	Katalin Vladar M.D.	FE	Washington DC	APA Dues Non-Payment
34598	Henry Chester Waite M.D.	LF	Ohio	APA Dues Non-Payment
310724	Imani Jehan Walker DO	GM	Southern California	APA Dues Non-Payment
83466	John Wallace MD JD	GM	North Carolina	APA Dues Non-Payment
66443	Theodore J Wander MD	GM	Utah	APA Dues Non-Payment
41765	R Mark Webb MD	FE	Pennsylvania	APA Dues Non-Payment
86835	Barry C Weed M.D.	GM	North Carolina	APA Dues Non-Payment
41473	Paul Irving Weiss M.D.	GM	Massachusetts	APA Dues Non-Payment
74782	Lawrence P Widman M.D.	GM	Nebraska	APA Dues Non-Payment
1016931	Robert Burton Wieck DO	GM	Texas	APA Dues Non-Payment
63932	Marcella Maria Wilson M.D.	DF	San Diego	APA Dues Non-Payment
85541	Phone M Win M.D.	GM	West Hudson	APA Dues Non-Payment
78113	Mariusz Wirga M.D.	GM	Southern California	APA Dues Non-Payment
75784	Sierra-Doreen Wong MD	GM	Arizona	APA Dues Non-Payment
43053	Jonathan Hugh Woodcock M.D.	GM	Colorado	APA Dues Non-Payment
79419	Mark S Wright M.D.	GM	Kentucky	APA Dues Non-Payment
89790	Junzhe Xu MD	DF	Western NY	APA Dues Non-Payment
67004	Asa Greenwood Yancey MD	GM	Colorado	APA Dues Non-Payment
300933	Tammy S Yuen MD	GM	Illinois	APA Dues Non-Payment
31496	Martha Ellen Zuehlke M.D.	LM	Illinois	APA Dues Non-Payment

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Dropping Members
Membership Terminated by District Branches

Member #	Name	Member Class	DB	Reason
301870	Josefina S Antonio, MD	General Member	DB25 - Greater Long Island	Nonpayment of local dues
1012963	Candyce Joy DeLoatch, MD	General Member	DB20 - Maryland	Nonpayment of local dues
312732	Mehera C Halliwell, MD	General Member	DB43 - Southern California	Nonpayment of local dues
1001739	Louis R Taylor, DO	General Member	DB46 - Texas	Nonpayment of local dues

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New International Membership Applications
August 1, 2014 - October 31, 2014

Member ID#	Label Name	Country	Country Income Category
1280489	Parashar Koirala, MD	Nepal	Lower Income

n = 1

1284381	Gautam Anand, MD	India	Lower Middle Income
1284899	Simon Melvin Das Chagas E Silva, MBB	India	Lower Middle Income
1282763	Dinesh Dua, MD	India	Lower Middle Income
1271620	Gihan Medhat Elnahas, MBBS	Egypt	Lower Middle Income
1274676	Andrii Gorbunov, MD	Ukraine	Lower Middle Income
1266896	Baba Awoye Issa, MBBS	Nigeria	Lower Middle Income
1291998	Sameer Sudhakar Kulkarni, MBBS	India	Lower Middle Income
1284439	Olutinka Emmanuel Majekodunmi, MBB	Nigeria	Lower Middle Income
1271666	Idowu Oladujoye Malomo, MBBS	Nigeria	Lower Middle Income
1267584	Ajay Kumar Nihalani, MD	India	Lower Middle Income
1284387	Chijioke N Nwakanma, MBBS	Nigeria	Lower Middle Income
1284440	Adetunji Obadeji, MBBS	Nigeria	Lower Middle Income
1271629	Debasish Sanyal, MBBS, MD	India	Lower Middle Income
1276826	Malaya Kant Singh, MD	India	Lower Middle Income
1280616	Jayathi Bihan Kamalrathna Tuduwage D	Sri Lanka	Lower Middle Income
1284433	Abdullah D Yussuf, MBBS	Nigeria	Lower Middle Income

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1280501	Mauricio Nicolas Battafarano, MD	Argentina	Upper Middle Income
1284435	Gerhard P Grobler, MBCHB, MMED	South Africa	Upper Middle Income
1284436	Hongbo He, MD, PhD	China	Upper Middle Income
1284441	Albert Bernard Janse van Rensburg, MM	South Africa	Upper Middle Income
1290136	Arfat Hussein Kadhir, MD	Iraq	Upper Middle Income
1280556	Andre G.J. Pellizzari, MD	Brazil	Upper Middle Income
1284442	Mvuyiso Talatala, MBCHB, MMED	South Africa	Upper Middle Income

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1265405	Abdulaziz Abdullah Al-Zamil	Saudi Arabia	Upper Income
1221425	Ingenet Anoff Kwafo, MD	Netherlands	Upper Income
1284438	Gerben A De Boer, MD	Netherlands	Upper Income
1281754	Catherine Elizabeth Egan, MD	Australia	Upper Income
1284437	Ettore Guaia, MD	Australia	Upper Income
1293331	Riccardo Guglielmo, MD	Italy	Upper Income
75618	Peyton H Hurt, MD	Italy	Upper Income
1029541	Sanjay Khanna, MBBS	Australia	Upper Income
1280260	Husam Aldeen Saleem Mohammad, MD	Saudi Arabia	Upper Income
1284380	Maite Teresa Morato Guinchard, MD	Spain	Upper Income
1268616	Ovidiu Pomian, MD	France - Metropolita	Upper Income
1287338	Erin M Redmond, MBBS	Australia	Upper Income
1293330	Sanjay Sinha, MBBS	Australia	Upper Income
1284898	Akindele Adeola Sorinmade, MD	Ireland	Upper Income
1291383	Theodore John Turpin, MD	Australia	Upper Income

n = 15

Dues Relief Requests - Confidential

Dues Waivers - Approved

Member #	Name	Member Class	District Branch
86538	Bassam A Amawi MD MPH	Fellow	Florida Psychiatric Society
1005543	Marissa H Kaminsky, MD	General Member	New York County Psychiatric Society
20706	Philip Joseph Parker M.D.	Life Member	Michigan Psychiatric Society
89018	Marthel Elena Parsons, MD	General Member	Missouri Psychiatric Association
31520	Glenn David Prentice M.D.	Life Member	Maine Assn of Psychiatric Physicians
88617	Anne Niemiro Robinson, MD	General Member	Psychiatric Society of Virginia Inc
75027	Augusta S Roth M.D.	Fellow	Oregon Psychiatric Physicians Association
33678	Ana Maria Soto M.D.	Distinguished Life Fellow	Missouri Psychiatric Association
82789	James G Trantham M.D.	Inactive Member	Washington State Psychiatric Association

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Dues Reductions - Approved

Member #	Name	Member Class	District Branch Name
306267	Ashley D Bone M.D.	General Member	Maryland Psychiatric Society Inc
64021	Araceli Gonzalez Casso M.D	General Member	Texas Society of Psychiatric Physicians
74777	Doris M Iarovici M.D.	Distinguished Fellow	North Carolina Psychiatric Association
74472	Kimberly Toland Jones M.D.	Distinguished Fellow	Pennsylvania Psychiatric Society
1002864	Janet C Kennedy MD	General Member	Massachusetts Psychiatric Society
67848	Pamela Sue Martell M.D.	General Member	Central California Psychiatric Society
312245	Susan S Pyatetsky M.D.	General Member	Illinois Psychiatric Society
41219	Muntzra Khatoon Qadri, MD	Life Member	Ohio Psychiatric Physicians Association
30394	Harley Glenn Rubens, MD	Life Member	Illinois Psychiatric Society
306552	Lisa M Seufert M.D.	General Member	Pennsylvania Psychiatric Society
1018559	Erica R Tsai, MD	General Member	Rhode Island Psychiatric Society
58691	Mahmoud Mohamed Wahba, MI	Distinguished Fellow	Missouri Psychiatric Association
31933	Lloyd Allan Wells, MD	Distinguished Fellow	Minnesota Psychiatric Society

n=13

Permanent Inactive Status - Approved

Member #	Name	Member Class	District Branch Name
42364	Imtiaz Siraj Basrai, MD	Fellow	Orange County Psychiatric Society
71326	Marie T Kelly, MD	General Member	Texas Society of Psychiatric Physicians
28931	Richard D May, MD	Life Member	Psychiatric Soc of Westchester County
32401	Jack Nass M.D.	Distinguished Life Fellow	Greater Long Island Psychiatric Society
32929	Kumari Verghese M.D.	General Member	North Carolina Psychiatric Association
7267	Robert Buie M.D.	Distinguished Life Fellow	Ontario District Branch
73833	Maya A Koopman, MD	General Member	Washington State Psychiatric Association
30129	Barry Rossman Zitin, MD	Life Member	Massachusetts Psychiatric Society
60465	Jane C Wells M.D.	General Member	Montana Psychiatric Association

n=9

Report to the APA Board of Trustees
Finance and Budget Committee
Alan Schatzberg, MD, Chair

ACTION #1
Travel Policies: Will the Board of Trustees approve the proposed amendment to the travel policy to allow "an upgrade to the next class of service" when air time exceeds 12 hours, and to the Officers Reimbursement policy when air time is greater than 5 hours?

ACTION #2
Travel Policy: Will the Board of Trustees approve the proposed amendment to the travel policy to allow reimbursement of costs associated with upgraded economy class seats when no other seat is available?

ACTION #3
Lump Sum Dues: Will the Board of Trustees approve the establishment of a lump sum dues program for International Members, with rates as proposed?

ACTION #4
Lump Sum Dues: Will the Board of Trustees approve the establishment of a lump sum dues program for Canadian Members, with rates as proposed?

ACTION #5
Lump Sum Dues: Will the Board of Trustees approve the adjustment of the lump sum dues amounts for US Members, as proposed?

ACTION #6
Reserve Spending Policy: Will the Board of Trustees approve the APA Reserve Spending Policy as proposed?

ACTION #7
Reserve Spending Policy: Will the Board of Trustees allow the use of the June 30 balance of the prior year as the base for calculations for budget years 2015-2017, with the three year averaging to begin in 2018 budget year?

Report to the APA Board of Trustees
Finance and Budget Committee
Alan Schatzberg, MD, Chair

In order for the APA administration to enhance membership value, engage in meaningful and strong partnerships, develop a well-respected political and policy presence, and create a communications infrastructure to ensure that our message is heard loud and clear, the APA must be willing to invest the necessary financial resources. The 2015 proposed budget was developed based on a thorough analysis of the APA's capabilities to implement a vision of membership, partnerships, and strategic issues. The proposal contained support for initiatives and resources that will promote APA membership and member value, enhance and leverage partnerships with critical stakeholders, develop effective communication strategies and infrastructure, and position the APA as a thought leader in mental health at the state and national level.

The Finance & Budget Committee met on November 18 – 19 to review the Administration's proposed budget and will continue its review and deliberations on a phone call that will be held prior to the December 13-14 Board meeting. The Committee supported the CEO's request for additional resources and proposes to invest in the organization's future through a planned use of the reserve - a 4% spending rate would allow the APA to bring $2.8M into operations for 2015.

The Committee also reviewed the American Psychiatric Foundation's request and will complete its consideration of that budget prior to the December Board meeting.

Additional information and budgetary details will be provided after December 7 subsequent to the upcoming Finance & Budget Committee conference call.

At that time, the Committee will be submitting the following actions:

ACTION #8
Capital Budget: Will the Board of Trustees approve the 2015 Capital budget as proposed?

ACTION #9
American Psychiatric Foundation Operating Budget: Will the Board of Trustees approve the 2015 Foundation Operating Budget as proposed?

ACTION #10
APA Operating Budget: Will the Board of Trustees approve the 2015 APA Operating Budget as proposed?

Travel Policy Amendments

Consistent with the Board-approved policy, APA requires travelers use the lowest practical non-refundable transportation. The policy does allow the cost associated with upgraded travel in very limited circumstances (documented medical necessity or where the cost is less than economy travel). Business class tickets may be used when air time exceeds 12 hours. With changes in the travel industry, we are finding that domestic airlines have essentially eliminated the business class seats so that travelers can select either coach (with individual seat upgrades) or first class. The Finance & Budget Committee recommends that the policy be amended to allow the use of the next class of service when air time exceeds 12 hours.

The Officers Reimbursement policy provides for a travel advance for the President, President-Elect, Speaker, Speaker-Elect and currently precludes first class travel. It does allow an upgrade to business class for flights that are 5 hours or more. The Finance & Budget Committee recommends that policy be amended similarly, to allow the use of the next class of service when air time is 5 hours or more.

Finally, the Finance & Budget Committee approved a recommendation to allow the reimbursement of economy class seat upgrades when no other seat is available.

ACTION:

Will the Board of Trustees approve the proposed amendment to the travel policy to allow "an upgrade to the next class of service" when air time exceeds 12 hours, and to the Officers Reimbursement policy when air time is greater than 5 hours?

Will the Board of Trustees approve the proposed amendment to the travel policy to allow reimbursement of costs associated with upgraded economy class seats when no other seat is available?

Note: We are required to report first class travel on the tax form 990.

Lump Sum Dues Amounts

Proposed Increases for U.S.

(New rates for Canadians and Internationals)

We have updated the values for the Lump Sum Dues program, following the same methodology as has been done in the past. Because it had been many years since it was reviewed when we last updated the values, there are discrepancies between the Current and Proposed amounts. When we made the changes in 2012, it was decided to phase-in the variance, rather than doing it at one time. We propose adjustments be made to fully address the differences that are less than $1,000 and to reduce the Life 60+ to its proposed value. The other variances (50-69 categories) could be made at one time or transitioned in.

The proposals for the Canadian and International categories are based on the same methodology as has been used in the past.

At its recent meeting, the Membership Committee discussed the establishment of a Lump Sum Dues program for international members. They will recommend that the BOT approve the "concept" of offering lump sum to internationals, with specific amounts to come from the Finance & Budget Committee. The Committee also reviewed the proposal to offer the program to Canadian members, but did not take action other than to suggest that the Finance & Budget Committee should weigh in on the proposed amounts. Finally, the Membership Committee reviewed the new calculations for the current US member program, and, likewise, suggested that the Finance & Budget Committee weigh in on the proposed changes.

The Finance & Budget Committee voted to recommend the lump sum dues as proposed.

ACTIONS:

Will the Board of Trustees approve the establishment of a lump sum dues program for International Members, with rates as proposed?

Will the Board of Trustees approve the establishment of a lump sum dues program for Canadian Members, with rates as proposed?

Will the Board of Trustees approve the adjustment of the lump sum dues amounts for US Members, as proposed?

	U.S. Members			Canadian	International			
Age	**Current**	**Proposed**	**Change**	**Proposed**	**$50**	**$130**	**$180**	**$210**
30-39	12,500	12,750	250	7,745	1,130	2,930	4,075	4,740
40-44	12,000	12,075	75	7,345	1,075	2,785	3,850	4,500
45-49	10,500	11,475	975	6,980	1,025	2,650	3,675	4,275
50-54	9,500	10,750	1,250	6,545	975	2,475	3,430	4,000
55-59	8,000	9,875	1,875	6,000	875	2,274	3,150	3,675
60-64	6,000	8,800	2,800	5,350	780	2,025	2,800	3,275
65-69	4,500	7,500	3,000	4,565	665	1,725	2,400	2,800
70+	4,000	4,800	800	2,925	425	1,100	1,525	1,790
Life 60+	5,500	4,410	(1,090)	2,665	-	-	-	-

Note:

Age projection increased to 85 since the most recent actuarial information from the federal government and actuarial societies support that age (previously factored age 75).

The change in Life 60+ is due to the lower rates for Life status (which was not factored in before).

American Psychiatric Association – Spending Policy

Reserve Target:

In December 2006, the APA Board of Trustees approved a reserve target to build its unrestricted, undesignated reserve to equal to 100% of operating expenses for a calendar year. The unrestricted reserve will be available to accommodate normal cash flow timing differences, unexpected emergencies; unanticipated opportunities to replace or improve capital assets, subject to the specific approval of the Finance and Budget Committee and APA Board of Trustees. Any portion of a projected or actual surplus not otherwise designated by the Board for current or future activities will be assigned to the reserve replenishment fund, until it reaches 100% of unrestricted operating expenses. The fund was fully reserved in early 2014.

Funding Status

At September 30, the APA has $72.7M in cash and investments, of which $50M are encumbered as either externally or internally restricted. Board Designated funds are internally restricted for specific purposes, e.g. Reserve Replenishment Fund ($48.8M), Lindemann Disaster Fund ($30K), Area Block Grant Carryover ($157K), Presidential initiative funds ($50K). Temporarily restricted funds are externally restricted ($754K). Undesignated/ unrestricted funds total $22.8M.

	$000
APA's Long-Term Portfolio	72,724
Net Operating Cash	69
Available Funds	72,793
Temporarily Restricted	754
Permanently Restricted	0
Board Designated	49,276
Encumbered	50,030
Undesignated/Unrestricted	22,763

Spending Plan

Nonprofit organizations that are fully reserved (as defined by the Board of the organization), typically establish spending policies to enable use of reserve funds for identified purposes. A survey of 10 medical societies revealed that 9 of the 10 have some form of reserve spending policy. Of those 9, four use the funds for general operations and five use them for emergencies or one-time programmatic activities.

Typically a spending level is set at some percentage of a rolling (3-year) average unrestricted reserve balance, and spending policies are developed to preserve the corpus of the reserve. This is consistent with the policy established for the APF Legacy Fund. An average is used as it smooth out the ups and downs of the market, and allows a more predictable flow into the operating budget. If investment returns are strong, spending will increase slowly and the fund will continue to grow. If losses are incurred, spending will be reduced, again slowly.

In some organizations, the formula represents a floor, and the amount may be adjusted upward if the average earnings over the rolling time frame exceeds the long term investment target (for APA, it is 7.35% annually). APA's advisors suggested that a 4% target is reasonable in this marketing environment, assuming an average long term return rate of 7.35%.

The Finance & Budget Committee recommends the following Reserve Spending Policy for the APA:

> APA may use 4% of the June 30 three-year rolling average net unrestricted reserve balance (total long term investment portfolio less externally restricted funds) to supplement operations. If the average return over the three-year time frame exceeds the long-term investment target by greater than 100 basis points, the amount may be adjusted upward for the budget year under consideration.

ACTION:

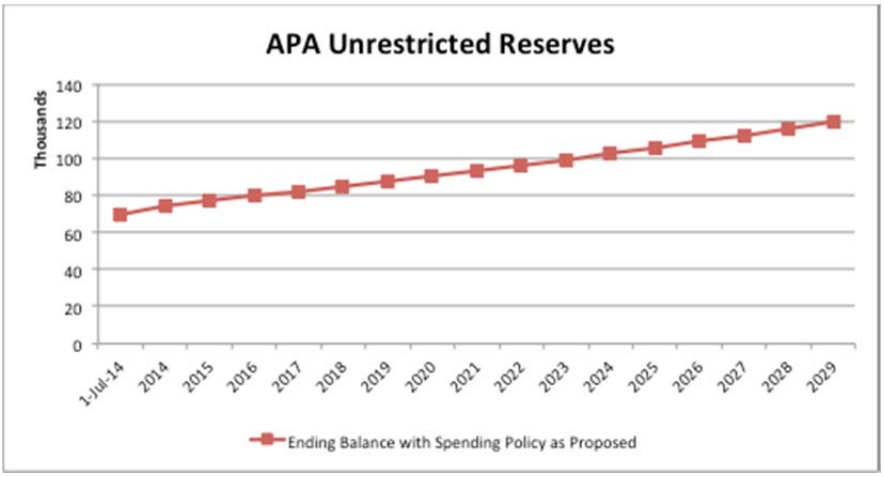
> **Will the Board of Trustees approve the Reserve Spending Policy as proposed?**

Due to the lower pre-DSM5 balance, the Committee recommends that for 2015-7, the APA use the June 30 balance of the prior year as the base and begin the three year averaging in 2018.

- At June 30, 2014, the net unrestricted reserve balance was $69.5M. A 4% spending rate would allow the APA to bring **$2.8M** into operations for 2015.
- The average return rate for APA in the three year period was 6%. As it does not exceed the long term target, the amount would not be adjusted upward for 2015.

ACTION:

> **Will the Board of Trustees allow the use of the June 30 balance of the prior year as the base for calculations for budget years 2015-2017, with the three year averaging to begin in 2018 budget year?**


APA Unrestricted Reserves
Thousands
140
120
100
80
60
40
20
0
1-Jul-14
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
Ending Balance with Spending Policy as Proposed

Report to the APA Board of Trustees
Finance and Budget Committee
Alan Schatzberg, MD, Chair

ACTION #6
Capital Budget: Will the APA Board of Trustees approve the 2015 Capital budget as proposed?

ACTION #7
Foundation Operating Budget: Will the APA Board of Trustees approve the 2015 Foundation Operating Budget as proposed?

ACTION #8
APA Operating Budget: Will the APA Board of Trustees approve the 2015 APA Operating Budget as proposed?

APA Operating Budget

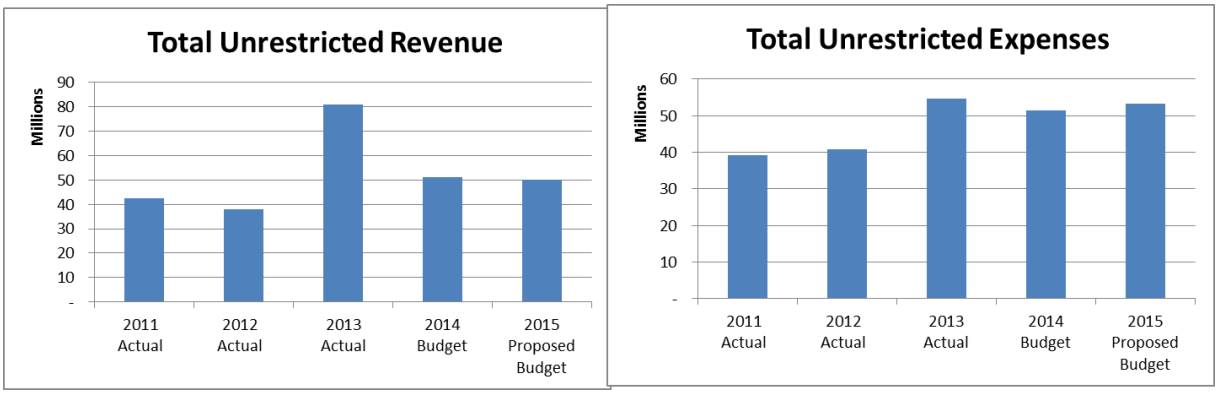
At its recent meeting, the Finance & Budget Committee reviewed the budget presented by the Administration. The budget was developed based on a thorough analysis of the APA's capabilities to implement a vision of membership, partnerships, and strategic issues. The proposal contained support for initiatives and resources that will promote APA membership and member value, enhance and leverage partnerships with critical stakeholders, develop effective communication strategies and infrastructure, and position the APA as a thought leader in mental health at the state and national level.

Comparative Review of 2014 & 2015 Budgets

	2014 Approved	2015 Proposed	Change
		$M	
Unrestricted Revenue	51.1	50.0	(1.1)
Unrestricted Expense	51.3	53.1	1.8
Net Income (Deficit)	(0.2)	(3.1)	(2.9)
DSM Net Income *(included above)*	7.9	7.3	(0.6)

Unrestricted Revenue: Revenue is expected to decrease $1.1M due primarily to the CME and Annual Meeting ($1.6M). The decreases are offset by increases in DSM sales ($278K) and

membership related receipts ($108K). DSM 5 revenues are expected to continue at a higher level than normal, but the initial surge continues the downward trend.



Unrestricted Expenses: The 2015 budget request is $2.9M greater than 2014 and includes:

Major Decreases:

- Annual Meeting costs are lower than 2014 due to the location of the meeting ($302K)
- Estimates for corporate insurance and bank fees have been reduced ($110K)
- A placeholder has been included to align travel costs for the Board, Assembly, and Components more closely with historical actuals. ($330K. This has no impact on the structure and number of attendees at meetings; it is an alignment to historical actuals.)
- Cancellation of the Federal Advocacy Leadership Conference due to a change in the Congressional calendar ($200K)
- Elimination or reduction in certain staff salaries ($300K)
- Completion or shift to 2015 of several nonrecurring activities (~ $1.2M)
    - Strategic Planning activities
    - Communications consultation (primarily GYMR) due to enhancement of in-house capabilities
    - Recruiting and consulting costs for the CEO transition
    - Legal fees

Major Increases:

- ***Membership***
    - Membership expenses are higher by $107K primarily due to the shift of one FTE to the Division.
- A***dvocacy***
    - The APA's government relations function is being urgently reorganized and reinvigorated by an experienced new DGR Chief. Our candid assessment is that the APA has an inadequate footprint on Capitol Hill and within the White House. With important changes in the external environment, it is time to significantly invest in externally-focused advocacy activities. Particularly with the growing threats to reimbursement and with Congressman Murphy driving comprehensive reform, we

believe it is imperative for psychiatry to quickly develop much greater influence and a higher-level leadership role in the Federal government. We propose to do this by reorganization and by the addition of two senior lobbyists who are trusted, known entities able to make an immediate impact, as well as by supplementing our in-house experts with select heavyweight political consultants. While the consulting talent would be prohibitively expensive for APA to bring in-house, they are more than cost-effective for the value they add to the overall lobbying effort to protect our reimbursement and drive our appropriations and other policy goals. Funding is requested to develop advocacy-oriented policy papers. We also ask for incremental funds to grow the PAC, to expand the Congressional Fellowship program, and for establishing a competitive internship program. ($750K)
    - Addition of the State Advocacy Meeting, approved in 2014 for implementation in 2015 ($225K)
    - Funding to support AMA activities is higher than 2014 due to travel and related expenses ($27K)

- ***Communications***
    - Public Education Outreach - This request is for funding to engage a public relations firm to conduct the Board approved action to launch a nationwide public education campaign that would include paid and earned advertising, a possible new website, TV, and print PSAs, blogger outreach, and social media activities to help alleviate stigma surrounding psychiatry and individuals with mental illness. ($60K)
    - Consultant Fees (Rep. Kennedy) - Funding for the continuation of a relationship with Patrick Kennedy, to serve as Senior Advisor and Spokesperson for the APA to help alleviate stigma and counter anti-psychiatry, and to obtain advice/guidance on government relations. ($120K)
    - Branding Project - Placeholder funding for consultant fees of $218k to hire an agency to conduct an APA brand audit that would facilitate the update and design of the APA logo. ($218K)

- ***Publishing***
    - Psych News and OCPA have requested a shared FTE to write articles with emphasis on government, articles and new features relevant to APA members in the areas of advocacy news, legislation, and regulation ($96K)
    - Increases in sales commissions related to proposed increase in advertising revenue ($68k)
    - DSM5 costs are increased related to the forecasted increase in revenue ($899K)

- ***Policy, Programs, & Partnerships***
    - OHSF is requesting additional funding for consultants to assist with ongoing work with the RUC, CPT Editorial Panel and CMS on new coding proposals in development and routine review of existing codes as part of the RUC process, stipends for APA's representatives to the RUC, and a consultant for other products

and services to build out an advocacy program that focuses on financing and payment models at the state level ($98K)

- State Health Care Reform activities - This request includes funding to cover salary and fringe expenses for one employee, travel and related expenses and consulting fees to establish activities to address healthcare policy at the state level. Most of the emerging developments concerning health reform initiatives (eg; integrated care arrangements, health exchanges, Medicaid expansion, parity law enforcement) are shaped by decision making by state legislators, regulators and the prevalent commercial insurers in each respective locale. The issue and policy questions embedded in these matters are complex and require levels of expertise not typically available at the state association/DB level. The APA objective will be to provide sophisticated technical assistance and other resources to aide its affiliates in dealing with these issues. ($115K)
- The Office of Research budget reflects an increase of ($418k), a realignment of budgets following the placeholder reduction in 2014.
- Funding is requested to successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before health care reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join forces in a coordinated fashion nationwide. These plans contemplate selecting multiple large states, and some more consumer friendly small states, and launching attacks on the same day at the same time with attendant press and coverage that will put pressure on companies to comply. The request would cover a cross functional strategy, including Legal, OHSF, Communications, DGR, and the APF. Using the unspent funds from the previously approved funding for the "Anthem legal fees" activity. Funding is needed for additional personnel, outside consultants, contract labor, travel, communications needs, toolkit preparation, printing, and telephone costs. ($250K)
- Research Workgroup - In the aftermath of the successful completion and launch of DSM-5, a DSM Advisory Work Group comprised of experts in psychiatric research and clinical psychiatry was convened to provide guidance to the APA Board of Trustees (BOT) on how to manage the DSM going forward. The DSM Advisory Work Group presented its report at the BOT meeting 3/9/14. The BOT accepted the report and approved proceeding with the implementation of its recommendations. The first step in this process is the appointment of a Steering Committee. The committee will be charged with monitoring developments in biomedical research and clinical psychiatry that might warrant revision of the disorders and/or the criteria which define them, and determine if and how to do so; to review proposals for DSM changes submitted to APA; to determine how best to coordinate the DSM with ICD-10-CM code planning and harmonization with ICD-11, and alignment with RDoCs development; and to participate in developing a process by which the DSM can be iteratively updated as developments in the field of psychiatric medicine warrant. The

steering committee will have one in person meeting per year and monthly conference calls, budgeted at $15,000 per year.

- Research Consultation - Consultation in the areas of DSM-5, including as it relates to the International Classification of Diseases (ICD) 10-CM, DSM-5 harmonization with the forthcoming World Health Organization's (WHO) ICD-11, education about DSM-5, completion of grants awarded to the American Psychiatric Foundation and past research about health care reform and mental health parity insurance coverage, and in transitioning functions to APA staff. ($100K)

- ***Meetings***
  - Annual Meeting - Space for Additional Group Meetings - This would cover the cost of assignment of four spaces at the Annual Meeting where some component and allied groups such as Women, MUR, international and seniors can meet. Four groups are anticipated at an estimate of $5K per group. Funding for space for RFM and ECP groups is in the base budget. ($20K)

- ***Operations***
  - Addition of 2 part-time FTEs in the call center to maintain quality and response time for member and customer calls ($80K)
  - IT depreciation, maintenance, and licensing costs are greater in the 2015 budget. The Allbooks upgrade, AJP Mobile App, Advantage and the financial reporting system are due to be implemented in 2015 ($340K)

- ***Administration***
  - There is an estimated 15% increase for employee health benefit insurance and a placeholder for a 3.5% merit increase

- ***Org-wide Costs***
  - Staff Strategic Planning (BOT delayed to FY15) - Funding to support the continuation of the strategic planning exercise in 2015. Funds were requested in 2014 to support the implementation planning at the staff level, as well to provide leadership training. The Board asked staff to resubmit as part of the 2015 budget. ($25K)

  - Board Strategic Planning (Previously approved – carryover) - Funds are included to continue the Strategic Planning activities. The request represents the estimated unspent funding approved in 2014. ($100K)

- ***Governance & Components***
  - Insurance Workgroup - Funding to support workgroup meetings and consultation to review, recommend, and negotiate the Malpractice Insurance Program and associated implementation activities. ($60K)

- Real Estate Workgroup - Funding to support workgroup meetings, consultation, and attorney fees to review, and recommend the lease or purchase of a Headquarters facility. ($87K)

- ***Assembly Request*** - The initial request was for $223.5K; the Finance & Budget Committee revised the amount to $100K, with details to be determined by the AEC.

  Funding for the DB Dep Reps to attend the Fall Assembly meeting – Initial request at $78,000 - There are 52 small DBs which have one Rep and one Dep Rep. This is viewed as a leadership training slot. These members participate at the Area Councils and at the May Assembly. Since they are not invited to the Fall Assembly they have a year round second class status.

  Increase in Assembly travel caused by restoring the DB delegations - Initial request at $6,000 - The size of the Assembly was substantially reduced from historic levels during the lean years. This was accomplished by reducing the number of members traveling to the fall meeting and treating the multi-DB states differently. This proposal restores the Representatives from the District Branches in CA and NY. This will result in a net increase of 4 members in the Assembly.

  Increase in funding to the Area Councils - Initial request at $13,000 - The Area Councils meet twice each year and at the Assembly. The travel has been paid through a grant process based on the best estimate of the cost. Increases in airfare and hotel costs have impacted the Areas long travel distance.

  Innovation fund - Initial request at $35,000 - The Area Councils have provided important training for their members and DB leaders at their meetings. Area 1 and Area 4 have had formal advocacy training using APA staff. Area 5 has funded travel for the RFMs from each DB in the Area for leadership training. Area 3 has taken provided leadership training for their DBs. The ability to provide this training has been uneven because of the difference in travel costs across the Areas. A grant process would encourage specific projects with known costs. Successful projects could be repeated in other Areas.

  Deputy Representatives from the MUR groups - Initial request at $10,500 - Funding for 7 Dep. Reps. to attend the Fall meeting. These members of the Assembly should have funding for their travel separate from the Area Councils.

  Representatives from the Allied Organizations - travel to the Area Council meetings and Fall Assembly - Initial request at $81,000 - The Assembly has invited representatives from 18 Allied Organizations. Those members of the

Assembly have funded their own travel to the Area Councils and fall Assembly. They have the same responsibilities as other members of the Assembly and many have taken the lead on projects important to the APA.

The Assembly Executive Committee at its July 2014 meeting 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

Summary – APA

As part of the long term financial plan, the Board passed a policy to maintain in reserves an amount equal to 100% of the operating reserves. Once this target was achieved, the APA would establish a spending policy to access the reserves in a planned way, while protecting the corpus. For 2015, a 4% spending policy would allow a drawdown of $2.8M. The Administration's budget proposal includes funding for several new initiatives, including advocacy, communications, healthcare reform and parity implementation, and other activities, and requires a drawdown of $3.1M, about $343K above the target.

APF Operating Budget

At its October, 2014 meeting, the Board of the American Psychiatric Foundation approved a budget requesting a reserve drawdown of $3.8M, compared to $3.6M in 2014. The most significant driver of the increase in the drawdown is the loss of external funding for APF program activities – the Partnership for Workplace Mental Health and the Office of HIV Psychiatry. The Finance & Budget Committee reviewed the proposal and asked the Foundation to reduce its drawdown request to be less than that approved for 2014.

Comparative Review of 2014 & 2015 Budgets

	2014 Approved	2015 Proposed	Change
		$000	
Unrestricted Revenue	1,680	1,739	59
Unrestricted Expense	5,240	5,258	19
Net Income (Deficit)	(3,560)	(3,519)	(41)

The 2015 proposed unrestricted operating budget reflects use of the reserves in the amount of $3.5M, which is slightly lower than requested in 2014. As part of the overall strategy behind the 2010 reorganization, the APF, with the concurrence of the APA, is structured to use a portion of these funds annually. Thus, the annual operating budget allows expenditures in excess of that year's forecasted revenues, reflecting the planned spend down of the reserve.

Funding Sources

The proposed budget for 2015 contemplates external revenue of $3.0M ($1.7M from unrestricted sources, including federal grants, and $1.3M from private awards). This is lower than the 2014 budget ($3.6M), due primarily to a decline in federal funding for research activities.

Expenditures

Expenditure requests for 2015 total $7.1M, of which $1.8M is funded from restricted awards. It is about $636K less than the 2014 budget, primarily due to a reduction in externally funded activity.

Summary – APF

With the fine-tuning changes, the 2015 proposed budget reflects a net operating loss of $3.5M, which is approximately $41K less than the drawdown in 2014.

Capital Budget

The 2015 proposed budget for capital request includes $852k of new requests and $125k of operating expenses including license fees, maintenance and other user related expenses. The total request is $977k.

		2015 Operating Expense			
2015 Capital Budget New Request	**Capital Cost**	*License Fee*	*Maintenance*	*Other Expense*	**Op Exp Subtotal**
Allbooks Upgrade	30,000	*15,000*	-	-	**15,000**
Server Infrastructure Upgrade	105,000	-	-	-	**-**
SharePoint Upgrade	60,000	-	-	*5,000*	**5,000**
AJP Mobile App	90,000	-	-	-	**-**
Advantage Upgrade	125,000	-	-	-	**-**
Personify Upgrade	355,000	*40,000*	*3,000*	*8,500*	**51,500**
Advantage System Business Intelligence Module	37,000	*20,000*	*3,500*	*5,000*	**28,500**
Financial Reporting System Upgrade	50,000	*20,000*	*3,000*	*2,000*	**25,000**
TOTAL	**852,000**	***95,000***	***9,500***	***20,500***	**125,000**

Description of Projects

1. **Allbooks Upgrade -** The Allbooks Upgrade project is designed to update APA's Books publishing software, Filemaker Pro and the Allbooks database. The Allbooks database maintains the metadata for all APP book products. The data is used by Editorial, Production, and Marketing departments and it is pushed daily to the APA ecommerce site and to our distributors. The Allbooks database converts APP data into an industry standard format, ONIX Book Standard. APA is currently using ONIX 2.0. By the end of 2014 the all publishing industry must use ONIX 3.0 (since ONIX 2.0 will no longer be supported).

2. **Server Infrastructure Upgrade** - Some of APA's current server infrastructure relies on hardware that is over five years old with server infrastructure support which ended in between end-2010 thru 2013. These servers need to be replaced since the support and warranty ended. During the replacement process, some of the applications supported by those servers can be optimized by migrating to a virtual environment using Windows 2012 as an Operating System. This upgrade would also facilitate future migration from on-premise to cloud/hosted environments. This project is intended to support the

transition to an up-to-date datacenter having all the servers under warranty as well as minimizing the rack space by consolidating the servers.

3. **SharePoint Upgrade** -The APA's current SharePoint websites are based on SharePoint 2007. This version of SharePoint is now seven years old and is no longer supported by Microsoft. This project is to upgrade our environment and the SharePoint sites we host to the latest version, SharePoint 2013.

4. **AJP Mobile App** - Mobile use of online content is increasing, and medical practitioners are high-volume concurrent users of smartphones (for drug information) and tablets (for accessing research). Subscribers to The American Journal of Psychiatry have access to journal content online via the journal's website but that is at the moment its only digital presence. Mobile access is available only in a wifi-enabled location and through a recognized IP address. The American Journal of Psychiatry mobile app will allow members and subscribers to access psychiatric knowledge offline in a display attuned to the print version yet enhanced by standalone app features and functionality. This app would be available to APA members at no or minimal cost, and would be perceived as a benefit of membership as well as an added value to a journal subscription. The app would also provide digital advertising opportunities, promote traffic and discoverability of our content, and allow us to identify previously anonymous institutional users.

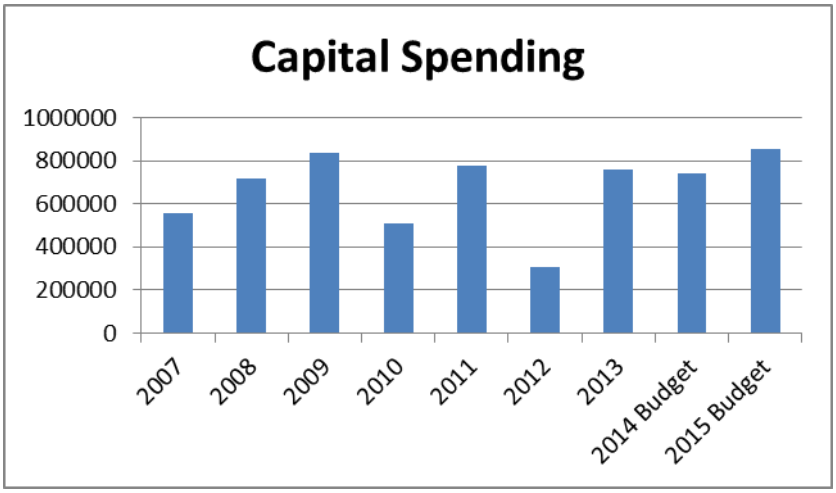
5. **Advantage Upgrade** - This project supports a request from American Psychiatric Publishing to upgrade the existing subscription management system, Advantage, to the latest software version release: 2014R1 or 2015R1 (to be determined prior to upgrade). Advantage is a business critical application which provides functionality to manage all APPI publication/journal sales and subscriptions, fulfillment, invoicing and related financial reconciliation activities. This project will ensure that the latest software fixes and enhancements are available to support APPI operations.

6. **Personify Upgrade** - The Personify Upgrade project is designed to update APA's Association Management System to the latest released version. The Personify system is developed by Personify Corp (formerly TMA Resources) and is used across the APA for business critical association and member management activities. The software version currently deployed is now several releases old. The upgrade will also support new feature enhancements and technical fixes not available in the current version. This upgrade project will also include the implementation of the Personify Single Sign-On feature and Outlook email integration.

7. **Advantage System Business Intelligence Module** - The Advantage Business Intelligence Module has the following: a separate data warehouse, an OLAP cube for reporting, pivot table report templates and sample SSRS reports. The system is easily navigable, accommodates custom data, isolates the reporting and operational databases, and can serve as an enterprise warehouse.

8. **Financial Reporting System Upgrade** - Our current web reporting system has become outdated. Unfortunately it's not very user-friendly therefore staff has stopped using it and depends on finance staff to provide them with monthly reports. This can sometimes create a backlog within the Finance Dept, which can lead to missed deadlines.

The graph below shows the budget increasing in 2015–due primarily to the Personify Upgrade. Spending was at a similar level in 2009 due to the cost of implementation of the Association Management System, Space expansion and floor remodeling, publishing website and server virtualization project and storage area network implementation. Spending in 2012 was lowest due to the completion of the Psych.org visual refresh and the Association Management System.



Attachments:

APA 2015 Budget
APA 2015 Budget - Contribution Margin
APF 2015 Budget

American Psychiatric Association
C6 Only Statement of Activities

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
UNRESTRICTED REVENUE:						
Membership						
Membership Dues	9,575,516	9,536,060	9,712,559	9,690,000	9,765,000	75,000
Insurance Program	1,500,000	1,447,246	1,625,000	1,500,000	1,500,000	-
Membership Affinity Programs	127,444	98,629	109,700	81,000	95,000	14,000
APA Job Bank	568,848	511,024	659,879	650,000	700,000	50,000
APA Store	5,895	5,625	11,294	11,000	-	(11,000)
List Sales	112,946	83,185	50,441	80,000	60,000	(20,000)
Membership Subtotal	***11,890,649***	***11,681,769***	***12,168,873***	***12,012,000***	***12,120,000***	***108,000***
Advocacy						
PAC	7,299	7,553	6,282	7,000	7,500	500
Advocacy Leadership Conference	17,140	15,060	19,245	14,500	16,250	1,750
Healthcare System & Financing	-	-	52,581	-	-	-
Advocacy Subtotal	***24,439***	***22,613***	***78,108***	***21,500***	***23,750***	***2,250***
Communications						
OCPA - Let's Talk Facts	31,726	36,129	38,103	46,000	-	(46,000)
Communication Subtotal	***31,726***	***36,129***	***38,103***	***46,000***	***-***	***(46,000)***
Publishing						
American Journal of Psychiatry	5,003,632	4,794,412	5,118,143	5,272,150	5,098,900	(173,250)
Journal of Psychiatric Services	755,340	707,689	805,610	900,225	905,900	5,675
Psychiatric News	4,085,146	3,227,849	3,344,242	3,187,175	3,602,800	415,625
Books	4,913,219	4,092,535	4,803,414	5,684,000	5,637,200	(46,800)
Specialty Journals	462,108	456,064	564,023	350,850	321,050	(29,800)
Legacy Content	112,083	48,636	22,555	50,000	25,000	(25,000)
Psychiatry Online	2,253,299	2,600,093	3,137,569	3,400,000	3,600,000	200,000
Electronic Publishing	433,722	409,015	210,475	425,000	500,000	75,000
Allocation of Epubs and POL	(2,666,795)	(2,966,537)	(3,334,031)	(3,825,000)	(4,100,000)	(275,000)
Publishing Subtotal	***15,351,754***	***13,369,756***	***14,672,000***	***15,444,400***	***15,590,850***	***146,450***

American Psychiatric Association
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	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
DSM						
DSM IV	6,057,105	3,791,243	707,290	20,000	-	(20,000)
DSM 5	-	-	41,384,143	11,602,093	11,900,000	297,907
DSM Subtotal	***6,057,105***	***3,791,243***	***42,091,433***	***11,622,093***	***11,900,000***	***277,907***
Continuing Medical Education						
Annual Meeting	7,107,225	7,565,513	9,414,233	10,126,395	7,995,000	(2,131,395)
CME Products and Accreditation	138,518	219,705	794,859	230,000	415,000	185,000
Institute on Psychiatric Services	496,120	449,851	393,317	350,000	482,000	132,000
Focus Journal	803,381	907,116	1,272,044	1,132,300	1,335,900	203,600
Continuing Medical Education Subtotal	***8,545,244***	***9,142,185***	***11,874,453***	***11,838,695***	***10,227,900***	***(1,610,795)***
Research						
Practice Guidelines	131,696	67,982	83,606	80,000	106,500	26,500
Research Subtotal	***131,696***	***67,982***	***83,606***	***80,000***	***106,500***	***26,500***
Other Income						
Miscellaneous Income	385,888	9,630	47,405	5,000	5,000	-
Other Income Subtotal	***385,888***	***9,630***	***47,405***	***5,000***	***5,000***	***-***
Total Unrestricted Revenue	***42,418,501***	***38,121,307***	***81,053,981***	***51,069,688***	***49,974,000***	***(1,095,688)***
UNRESTRICTED EXPENSES:						
Membership Direct Expenses						
Membership Services	1,586,202	1,634,378	1,709,299	1,797,094	1,778,788	(18,306)
Division of Membership	-	-	-	278,800	405,082	126,282
Membership Recruitment	144,313	115,017	125,997	174,030	170,530	(3,500)
Membership Affinity Programs	66	12,601	12,965	13,650	13,650	-
APA Job Bank (membership)	13,668	9,437	3,681	19,400	30,940	11,540
APA Store	22,357	6,206	18,356	12,600	-	(12,600)

American Psychiatric Association
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	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
Ethics/DB Relations	238,875	241,082	248,055	250,402	255,437	5,035
Library & Archives	122,078	105,661	95,734	140,021	99,350	(40,671)
International Affairs	30,148	32,517	28,326	127,792	166,959	39,167
Membership Direct Expenses Subtotal	***2,157,707***	***2,156,899***	***2,242,413***	***2,813,789***	***2,920,736***	***106,947***
Advocacy						
APA PAC Operating Expenses	141,270	172,687	158,725	147,585	169,389	21,804
Government Relations	1,844,221	2,000,971	2,009,618	1,873,678	2,866,220	992,542
Advocacy Leadership Conference	129,936	168,972	162,909	202,000	35,000	(167,000)
CALF	96,100	119,300	85,359	175,435	175,275	(160)
Advocacy Subtotal	**2,211,527**	**2,461,930**	**2,416,611**	**2,398,698**	**3,245,884**	***847,186***
Communications						
Communications & Public Affairs	660,860	670,532	991,846	1,442,313	1,593,117	150,804
Let's Talk Facts	-	-	-	7,000	-	(7,000)
Association Marketing	-	-	121,133	370,196	363,493	(6,703)
Communications Subtotal	**660,860**	**670,532**	**1,112,979**	**1,819,509**	**1,956,610**	***137,101***
Publishing*						
American Journal of Psychiatry	1,881,552	1,744,553	1,694,311	1,821,430	1,822,798	1,368
Journal of Psychiatric Services	720,531	567,229	633,350	614,799	645,847	31,048
Psych News	2,119,845	1,849,279	1,932,678	1,903,048	2,179,236	276,188
Unrelated Business Income Tax	83,494	68,468	88,495	200,000	100,000	(100,000)
Books	1,757,376	1,640,705	1,149,570	1,566,099	1,559,698	(6,401)
Specialty Journals	327,038	218,603	213,000	104,095	90,870	(13,225)
Psychiatry Online	388,388	233,700	210,887	459,700	379,500	(80,200)
Electronic Publishing	40,778	138,720	115,835	66,400	85,900	19,500
Publishing Subtotal	***7,319,002***	***6,461,257***	***6,038,126***	***6,735,571***	***6,863,849***	***128,278***

American Psychiatric Association
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	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
Publishing Overhead*						
Publishing Administration	790,721	659,665	657,078	631,764	694,022	62,258
Sales & Marketing	845,389	833,341	1,152,419	879,315	989,888	110,573
Customer Service	1,123,284	1,135,644	1,275,586	1,027,891	1,111,430	83,539
Advertising Sales	580,783	641,720	786,650	650,000	717,760	67,760
Periodical Services	755,507	279,006	26,617	-	-	-
Editorial Development	1,150,035	1,054,263	1,219,811	1,247,851	1,255,273	7,422
Editorial Production	272,170	921,417	843,372	964,562	786,628	(177,934)
Publishing Overhead Subtotal	***5,517,889***	***5,525,056***	***5,961,533***	***5,401,383***	***5,555,001***	153,618
Publishing (Non DSM) Total	***12,836,891***	***11,986,313***	***11,999,659***	***12,136,954***	***12,418,850***	***281,896***
DSM						
DSM IV*	370,317	375,033	227,522	20,000	-	(20,000)
DSM 5*	-	64,966	2,706,947	1,498,419	1,848,386	349,967
DSM5 Development	395,500	400,339	10,000,002	2,168,099	2,737,000	568,901
DSM Subtotal	***765,817***	***840,338***	***12,934,471***	***3,686,518***	***4,585,386***	***898,868***
Continuing Medical Education						
Annual Meeting*	2,354,029	2,590,317	3,176,149	3,481,295	3,179,233	(302,062)
CME Products & Accreditation	390,614	422,849	509,443	296,352	340,656	44,304
Department of Meetings & Conventions	858,218	796,743	730,478	740,236	747,855	7,619
Office of Scientific Programs	289,704	353,069	427,422	536,567	540,146	3,579
Institute on Psychiatric Services*	412,700	423,356	355,418	415,904	398,462	(17,442)
Focus Journal*	174,949	164,807	177,100	221,321	208,336	(12,985)
Continuing Medical Education Subtotal	***4,480,214***	***4,751,141***	***5,376,010***	***5,691,675***	***5,414,688***	***(276,987)***
Policy, Programs, & Partnerships						
Division of Policy, Programs, & Partnerships	-	-	-	315,200	314,143	(1,057)
Education	844,484	819,099	876,527	1,098,850	1,070,122	(28,728)
Healthcare Systems & Financing	1,017,630	1,218,120	1,200,914	1,611,173	1,744,961	133,788
Diversity & Health Equity	535,668	547,113	610,477	605,232	634,073	28,841
Research - Director's Office	353,649	311,292	637,795	735,679	1,154,133	418,454
Office of QIPS	348,549	482,687	461,285	551,372	760,112	208,740

American Psychiatric Association
C6 Only Statement of Activities

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
Practice Guidelines*	233,624	263,349	205,593	351,349	402,457	51,108
DSM Other	-	11,796	1,630,257	-	-	-
Policy, Programs, & Partnerships Subtotal	***3,333,604***	***3,653,456***	***5,622,848***	***5,268,855***	***6,080,001***	***811,146***
Foundation						
Foundation Operating	261,518	361,261	312,308	434,739	400,000	(34,739)
Foundation Subtotal	***261,518***	***361,261***	***312,308***	***434,739***	***400,000***	***(34,739)***
Operations						
Division of Operations	-	-	-	404,528	416,857	12,329
APA Answer Center *	1,367	-	56,468	146,261	151,418	5,157
Human Resources	490,654	419,982	445,428	616,289	608,913	(7,376)
Information Technology	2,580,404	3,088,390	3,234,634	3,443,793	3,643,606	199,813
Association Mgmt System	469,748	385,952	363,054	322,586	252,911	(69,675)
Association Governance Office	715,420	785,037	809,747	821,263	851,365	30,102
Operations Subtotal	***4,257,593***	***4,679,361***	***4,909,331***	***5,754,720***	***5,925,070***	***170,350***
Administration						
Office of the CEO	1,364,777	1,509,744	2,349,773	2,132,524	1,896,712	(235,812)
Finance & Administrative Services	2,328,825	2,458,038	2,488,305	2,469,597	2,455,445	(14,152)
Building Operations	2,613,942	2,688,198	2,773,866	3,082,561	3,161,584	79,023
Employee Benefits	5,612,403	6,150,257	1,579,480	5,359,507	5,868,432	508,925
Fringe Benefits Allocation	(4,896,789)	(5,288,423)	(5,197,429)	(5,899,884)	(6,063,925)	(164,041)
Legal Office	271,992	344,090	751,508	1,248,293	961,259	(287,034)
Administration Subtotal	***7,295,150***	***7,861,904***	***4,745,503***	***8,392,598***	***8,279,507***	***(113,091)***
Organization-Wide Expenses						
General**	621,733	800,785	2,552,604	1,386,496	826,083	(560,413)
Recovered OH Costs	(101,136)	(74,579)	(41,304)	(45,220)	(26,298)	18,922
APA Overhead	(1,713,196)	(1,611,759)	(1,925,601)	(1,763,036)	(1,790,826)	(27,790)
Strategic Planning	-	-	15,365	525,000	25,000	(500,000)
Organization-Wide Expenses Subtotal	***(1,192,599)***	***(885,553)***	***601,064***	***103,240***	***(966,041)***	***(1,069,281)***

American Psychiatric Association
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	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
Governance & Components Expenses						
Assembly	724,023	801,814	830,101	879,258	968,901	89,643
Board, Operating	624,434	661,038	612,579	836,486	952,580	116,094
Standing Committees	268,630	189,434	205,095	333,707	350,305	16,598
Direct DB Support						
DB Leadership	256,679	243,493	311,325	292,500	292,500	-
BD DB Infrastructure Grants	48,339	57,572	47,582	60,973	56,502	(4,471)
Components	266,536	261,979	204,324	421,710	466,137	44,427
Unspent Budgetary Allocation	-	-	-	-	(330,547)	(330,547)
Board Funds and Expenses	6,559	5,827	42,517	-	100,000	100,000
Governance & Components Expenses	***2,195,200***	***2,221,157***	***2,253,523***	***2,824,634***	***2,856,378***	***31,744***
Total Unrestricted Expenses	***39,263,482***	***40,758,739***	***54,526,719***	***51,325,929***	***53,117,069***	***1,791,140***
Unrestricted Operating Net Inc/(Loss)	***3,155,019***	***(2,637,432)***	***26,527,261***	***(256,241)***	***(3,143,069)***	***(2,886,828)***
Approved Reserve Funding					2,800,000	
New Unrestricted Operating Net Inc/(Loss)					***(343,069)***	

**** Expenses before Publishing allocations***

***Includes APA Board Bridge Fund for Awards, Corporate Insurance, Merit/COLA, Organization Dues, Bank Fees, Credit Card Fees and Budget Reallocation.*

American Psychiatric Association

APA Contribution Margin Report

2011 Actual - 2015 Budget

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
Membership					
Membership Dues Revenue	$9,575,516	$9,536,060	$9,712,559	$9,690,000	$9,765,000
Insurance Program Revenue	1,500,000	1,447,246	1,625,000	1,500,000	1,500,000
List Sales Revenue	112,946	83,185	50,441	80,000	60,000
Membership Revenue	11,188,462	11,066,491	11,388,000	11,270,000	11,325,000
Membership Services Expense	1,586,202	1,634,378	1,709,299	1,797,094	1,778,788
Division of Membership	-	-	-	278,800	405,082
Membership Recruitment	144,313	115,017	125,997	174,030	170,530
Ethics/DB Relations	238,875	241,082	248,055	250,402	255,437
Library & Archives	122,078	105,661	95,734	140,021	99,350
International Programs	30,148	32,517	28,326	127,792	166,959
Membership Expense	2,121,616	2,128,655	2,207,411	2,768,139	2,876,146
Contribution	***9,066,846***	***8,937,836***	***9,180,589***	***8,501,861***	***8,448,854***
Membership Affinity Programs Revenue	127,444	98,629	109,700	81,000	95,000
Direct Expense	66	12,601	12,965	13,650	13,650
Contribution	***127,378***	***86,028***	***96,735***	***67,350***	***81,350***
APA Job Bank Revenue	568,848	511,024	659,879	650,000	700,000
Direct Expense	13,668	9,437	3,681	19,400	30,940
Contribution	***555,180***	***501,587***	***656,198***	***630,600***	***669,060***

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
APA Store Revenue	5,895	5,625	11,294	11,000	-
Direct Expense	22,357	6,206	18,356	12,600	-
Contribution	***(16,462)***	***(581)***	***(7,062)***	***(1,600)***	***0***
Membership Subtotal	***9,732,942***	***9,524,870***	***9,926,460***	***9,198,211***	***9,199,264***
Advocacy					
PAC	7,299	7,553	6,282	7,000	7,500
APA PAC Operating Expenses	141,270	172,687	158,725	147,585	169,389
Contribution	***(133,971)***	***(165,134)***	***(152,443)***	***(140,585)***	***(161,889)***
Advocacy Leadership Conference	17,140	15,060	19,245	14,500	16,250
Expense	129,936	168,972	162,909	202,000	35,000
Contribution	***(112,796)***	***(153,912)***	***(143,664)***	***(187,500)***	***(18,750)***
Advocacy Subtotal	***(246,767)***	***(319,046)***	***(296,107)***	***(328,085)***	***(180,639)***
Communications					
OCPA & Let's Talk Facts	31,726	36,129	38,103	46,000	-
Expense	-	-	-	7,000	-
Communications Subtotal	***31,726***	***36,129***	***38,103***	***39,000***	***0***
Publishing					
American Journal of Psychiatry	5,003,632	4,794,412	5,118,143	5,272,150	5,098,900
Direct Expense*	1,881,552	1,744,553	1,694,311	1,821,430	1,822,798
Contribution	***3,122,080***	***3,049,859***	***3,423,832***	***3,450,720***	***3,276,102***

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
Journal of Psychiatric Services	755,340	707,689	805,610	900,225	905,900
Direct Expense*	720,531	567,229	633,350	614,799	645,847
Contribution	***34,809***	***140,460***	***172,260***	***285,426***	***260,053***
Psychiatric News	4,085,146	3,227,849	3,344,242	3,187,175	3,602,800
Direct Expense*	2,119,845	1,849,279	1,932,678	1,903,048	2,179,236
Unrelated Business Income Tax	83,494	68,468	88,495	200,000	100,000
Contribution	***1,881,807***	***1,310,102***	***1,323,069***	***1,084,127***	***1,323,564***
Books	4,913,219	4,092,535	4,803,414	5,684,000	5,637,200
Direct Expense*	1,757,376	1,640,705	1,149,570	1,566,099	1,559,698
Contribution	***3,155,843***	***2,451,830***	***3,653,844***	***4,117,901***	***4,077,502***
Specialty Journals	462,108	456,064	564,023	350,850	321,050
Direct Expense*	327,038	218,603	213,000	104,095	90,870
Contribution	***135,070***	***237,461***	***351,023***	***246,755***	***230,180***
Psychiatry Online*	2,253,299	2,600,093	3,137,569	3,400,000	3,600,000
Direct Expense*	388,388	233,700	210,847	459,700	379,500
Contribution	***1,864,911***	***2,366,393***	***2,926,722***	***2,940,300***	***3,220,500***
Electronic Publishing*	433,722	409,015	210,475	425,000	500,000
Direct Expense*	40,778	138,720	115,835	66,400	85,900
Contribution	***392,944***	***270,295***	***94,640***	***358,600***	***414,100***
Allocation of Epubs and POL	**(2,666,795)**	**(2,966,537)**	**(3,334,031)**	**(3,825,000)**	**(4,100,000)**
Legacy content Revenue	***112,083***	***48,636***	***22,515***	***50,000***	***25,000***

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
Publishing Administration	790,721	659,665	657,078	631,764	694,022
Sales & Marketing	845,389	833,341	1,152,419	879,315	989,888
Customer Service	1,123,284	1,135,644	1,275,586	1,027,891	1,111,430
Advertising Sales	580,783	641,720	786,650	650,000	717,760
Periodical Services	755,507	279,006	26,617	-	-
Editorial Development	1,150,035	1,054,263	1,219,811	1,247,851	1,255,273
Editorial Production	272,170	921,417	843,372	964,562	786,628
Publishing Overhead Subtotal	***5,517,889***	***5,525,056***	***5,961,533***	***5,401,383***	***5,555,001***
Publishing Contribution	***2,514,863***	***1,383,443***	***2,672,341***	***3,307,446***	***3,172,000***
DSM					
DSM IV	6,057,105	3,791,243	707,290	20,000	-
DSM 5	-	-	41,384,143	11,602,093	11,900,000
DSM IV Direct Expense*	370,317	375,033	227,522	20,000	-
DSM 5 Publishing Costs*	-	64,966	2,706,947	1,498,419	1,848,386
DSM 5 Development	395,500	400,339	10,000,002	2,168,099	2,737,000
DSM Contribution	***5,291,288***	***2,950,905***	***29,156,962***	***7,935,575***	***7,314,614***
Continuing Medical Education					
Annual Meeting	7,107,225	7,565,513	9,414,233	10,126,395	7,995,000
Direct Expense*	2,354,029	2,590,317	3,176,149	3,481,295	3,179,233
Department of Meetings & Conventions	858,218	796,743	730,478	740,236	747,855
Office of Scientific Programs	289,704	353,069	427,422	536,567	540,146
Contribution	***3,605,274***	***3,825,384***	***5,080,184***	***5,368,297***	***3,527,766***
CME Products and Accredition	138,518	219,705	794,859	230,000	415,000
Direct Expense	390,614	422,849	509,443	296,352	340,656
Contribution	***(252,096)***	***(203,144)***	***285,416***	***(66,352)***	***74,344***

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
Institute on Psychiatric Services	496,120	449,851	393,317	350,000	482,000
Direct Expense	412,700	423,356	355,418	415,904	398,462
Contribution	***83,420***	***26,495***	***37,899***	***(65,904)***	***83,538***
Focus Journal	803,381	907,116	1,272,044	1,132,300	1,335,900
Direct Expense*	174,949	164,807	177,100	221,321	208,336
Contribution	***628,432***	***742,309***	***1,094,944***	***910,979***	***1,127,564***
Continuing Medical Education Contribution	***4,065,030***	***4,391,044***	***6,498,443***	***6,147,020***	***4,813,212***
Practice Guidelines					
Practice Guidelines	131,696	67,982	83,606	80,000	106,500
Direct Expense*	233,624	263,349	205,593	351,349	402,457
Contribution	***(101,928)***	***(195,367)***	***(121,987)***	***(271,349)***	***(295,957)***
Other Income	***385,888***	***9,630***	***99,986***	***5,000***	***5,000***
Foundation Expense	***(261,518)***	***(381,261)***	***(312,308)***	***(434,739)***	***(400,000)***
Total Contribution	***21,411,524***	***17,400,347***	***47,661,893***	***25,598,079***	***23,627,494***
** Expenses exclude Publishing Allocations*					
Association Initiatives:					
Advocacy Subtotal	1,940,321	2,120,271	2,094,977	2,049,113	3,041,495
Communications Subtotal	660,860	670,532	1,112,979	1,812,509	1,956,610
Policy Plans Programs Subtotal	3,099,980	3,390,107	5,417,255	4,917,506	5,677,544
Governance & Components Expenses Subtotal	2,195,200	2,221,157	2,253,523	2,824,634	2,856,378
Association Initiatives	***7,896,361***	***8,402,067***	***10,878,734***	***11,603,762***	***13,532,027***

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Budget
Overhead Costs:					
Operations Subtotal	4,257,593	4,679,361	4,909,331	5,754,720	5,925,070
Administration Subtotal	7,295,150	7,861,904	4,745,503	8,392,598	8,279,507
Organization-Wide Expenses Subtotal	(1,192,599)	(885,553)	601,064	103,240	(966,041)
Overhead costs	***10,360,144***	***11,655,712***	***10,255,898***	***14,250,558***	***13,238,536***
Unrestricted Operating Income (Loss)	***3,155,019***	***(2,657,432)***	***26,527,261***	***(256,241)***	***(3,143,069)***
Approved Reserve Funding					**2,800,000**
New Unrestricted Operating Income (Loss)	***3,155,019***	***(2,657,432)***	***26,527,261***	***(256,241)***	***(343,069)***

American Psychiatric Foundation
C3 Statement of Activities

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
UNRESTRICTED REVENUE:						
Diversity & Health Equity Federal Awards	821,842	703,223	594,436	805,121	799,313	(5,808)
Research Federal Awards	422,829	574,058	363,214	473,038	420,046	(52,992)
General Unrestricted	445,502	456,482	331,350	401,800	519,800	118,000
Total Unrestricted Revenue	***1,690,173***	***1,733,763***	***1,289,000***	***1,679,959***	***1,739,159***	***59,200***
UNRESTRICTED EXPENSES:						
Research Federal Awards	422,802	556,135	442,226	473,039	420,046	(52,993)
Diversity & Health Equity Federal Awards	821,842	717,989	630,656	805,121	799,312	(5,809)
Office of Diversity & Health Equity	199,487	273,515	387,411	413,077	433,508	20,431
APF Office of Research	311,377	319,892	267,940	251,067	346,955	95,888
Practice Research Network	264,706	306,311	646,943	464,912	501,725	36,813
Office of HIV Psychiatry	158,965	119,755	116,218	173,056	149,133	(23,923)
Foundation Programs	16,910	2,642	104,868	14,340	-	(14,340)
National Partnership	140,944	167	202,781	185,756	192,993	7,237
Library & Archives	48,503	88,711	95,466	92,745	101,758	9,013
Subtotal, Program	***2,385,536***	***2,385,117***	***2,894,509***	***2,873,113***	***2,945,430***	***72,317***
Foundation Grants	76,926	53,070	170,107	150,142	290,413	140,271
Board Funds	2,675	2,132	2,928	398,243	213,748	(184,495)
New Initiatives Fund	-	-	-	100,000	50,000	(50,000)
Subtotal, Grants and Other	***79,601***	***55,202***	***173,035***	***648,385***	***554,161***	***(94,224)***
Foundation Operating	383,448	356,260	383,873	184,257	183,127	(1,130)
Fund Raising	122,846	96,811	309,904	334,643	311,424	(23,219)
Subsidiary Boards	60,982	99,498	79,022	62,914	48,687	(14,227)
Subtotal, Administration	***567,276***	***552,569***	***772,799***	***581,814***	***543,238***	***(38,576)***

American Psychiatric Foundation
C3 Statement of Activities

	2011 Actual	2012 Actual	2013 Actual	2014 Budget	2015 Proposed Budget	Change (2014 - 2015)
APA Overhead	1,713,196	1,611,759	1,925,601	1,763,036	1,790,827	27,791
Recovered OH Costs	(387,123)	(397,811)	(417,594)	(626,787)	(575,576)	51,211
Subtotal, Overhead	***1,326,073***	***1,213,948***	***1,508,007***	***1,136,249***	***1,215,251***	79,002
Total Unrestricted Expenses	***4,358,486***	***4,206,836***	***5,348,350***	***5,239,561***	***5,258,080***	***18,519***
Unrestricted Operating Net Income/(Loss)	***(2,668,313)***	***(2,473,073)***	***(4,059,350)***	***(3,559,602)***	***(3,518,921)***	***40,681***
Approved Reserve Funding	***2,668,313***	***2,473,073***	***4,059,350***	***3,559,602***	***3,518,921***	***(40,681)***
TEMPORARILY RESTRICTED						
Temporarily Restricted Revenue	1,003,300	2,106,424	2,193,391	1,944,788	1,324,166	(620,622)
Temporarily Restricted Expense	1,671,306	1,499,720	2,199,178	2,366,712	1,813,863	(552,849)
Net Temporarily Restricted Activity	***(668,006)***	***606,704***	***(5,787)***	***(421,924)***	***(489,697)***	***(67,773)***

Investment Oversight Committee
Report to the APA Board of Trustees
David Fassler, MD., Chair

The following is an update for the APA Board of Trustees about the investment performance and current committee activities. There are no actions being put forward for consideration at this time.

Long-Term Pooled Investment Performance Summary

As of September 30, 2014: The market value of the consolidated portfolio as of September 30th was approximately $126M. It includes approximately $32M fixed income, $48M US equity, $23M non-U.S. equity, $11M Hedge Fund of Funds, $11M real estate, and $617k cash and cash equivalents. The table below shows the asset distribution as of September 30:

		Policy Asset Allocation Guidelines		
Asset Class	% of Portfolio	Minimum	Target	Maximum
Fixed Income	25.4%	20.0%	25.0%	30.0%
U.S. Equity	38.1%	32.5%	37.5%	42.5%
Non-U.S. Equity	18.5%	12.5.0%	17.5%	22.5%
Hedge Fund of Funds	8.6%	3.0%	8.0%	13.0%
Real Estate	8.9%	7.0%	12.0%	17.0%
Cash Equivalents	0.5%	0.0%	0.0%	5.0%

Investment Activity: Overall investment activity resulted in net non-operating income of $6.1M as of September 30, 2014. The portfolio earned $1.7M of interest and dividends. There was +$4.7M of realized gains and -$1.5M of unrealized losses. There was $529k of realized gains for the Hedge Fund of Funds, and unrealized gains of $598k for the Hedge Funds and the real estate funds. On a year to date basis, the annualized (net of fee) return was +5.9%. The benchmark (net of fees) is +3.9%.[1]

[1] Each type of investment is assigned a comparable index, e.g. we use a blend of Russell MidCap Growth, Russell 2000, Dow Jones, MSCI ACWI ex USA Gross, Barclay's Aggregate, Barclay's High Yield, CSFB Leveraged Loan, HFRX Global Hedge Fund Index, HFRX Equity Hedge Fund Index, and NFI for Real Estate. These indices are then weighted to develop a composite index for the total portfolio.

The fund is doing well apart from Eaton Vance which is underperforming. The overall portfolio outperformed 95% of its peers. The Committee made the decision to reduce exposure to Eaton Vance and to place it on alert. The Committee voted and approved the following action:

Asset Allocation:

1. Add 2.5% allocation to emerging markets fixed income

    - Additional portfolio diversification
    - Low correlation with U.S. equity, core fixed income, and bank loans
    - Attractive yields and spreads relative to high yield and bank loans

2. Rebalance 2.5% out of the Eaton Vance Floating Rate Fund (bank loan fixed income)

    - Currently overweight and moving back in line with target allocation.

3. Hire Transamerica Emerging Markets Debt I Fund (EMTIX)

    - Strong and consistent track record relative to benchmark and peers
    - Fund is sub-advised by Logan Circle
    - Low expense ratio

Fees: Our total fees remain below industry average. The fee for the overall management of the Fund is $478k, or 38 basis points (0.38%), which is below industry standards of approximately 49 basis points (0.49%) for a fund with this target asset allocation.

After all fees were paid, APA's share of the portfolio is approximately $70M (55%); and APF's share is approximately $56M (45%).

Pension Fund

The market value of the Pension Fund as of September 2014 was approximately $10.1M including $3.5M fixed income, $4.6M U.S equity, $1.4M non-US equity, and $562k cash equivalents.

Fixed income was 34.9% versus a policy target of 40.0%, U.S. equity was 45.6% versus a target of 45.0%, non-U.S. equity was 14% versus a policy target of 15%, and cash equivalents totaled 5.5% versus a policy target of 0.0%.

The fee for management of the portfolio was $20k, or twenty basis points (0.20%) compared to an industry average of twenty seven basis points (0.27%). Fees for the management of the Pension Fund have declined since moving from State Street.

Asset Allocation: The Committee made the decision to rebalance 4% from cash back into the target asset allocation.

Retirement Savings Plan

The market value of the Retirement Savings Plan as of September 2014 was approximately $38M. The assets include $12M fixed Income, $17M U.S. equity, $3.3M non-U.S. equity, and $4.5M lifestyle funds. There are loans of $476k, and self-directed brokerage of $637k. The breakdown of current utilization is fixed income 31%, U.S. equity 45.6%, non-U.S. Equity 8.6%, lifestyle funds 11.8%, loans 1.2%, and the portion of the portfolio in self-directed brokerage is 1.7%.

Fees: The estimated annual fee for investment management is $262k, 68 basis points, (0.68%). The industry average is 64 basis points (0.64%). Revenue sharing for record keeping services is $92k, or 24 basis points, (0.24%). There are 188 participants in the Plan.

Investment Managers: Due to organizational concerns and portfolio manager departure, the Committee made the decision to monitor the PIMCO Total Return Fund over the next six months, and to add the Loomis Sayles Investment Grade Bond Y LSIIX, to give employees a comparable alternative in the Plan. The Committee will reevaluate PIMCO at its next meeting to determine if the fund should be removed as an investment option. In the interim, employees will be encouraged to seek their own investment advice should they have questions or concerns regarding the changes at PIMCO. Our investment advisor will work with Human Resources to develop an appropriate communication to employees.

Building Fund

The Committee encourages the APA Board of Trustees to make a timely decision regarding the purchase or lease of a new building because of the potential implications for our overall investment allocations and strategy. The Committee will work with the investment advisors to make such modifications as may be necessary based on the Board's decision.

Next Meeting

The next meeting of the Investment Oversight Committee will take place in the spring 2015, at a time and place to be determined.

REPORT OF THE NOMINATING COMMITTEE

Chairperson: Jeffrey A. Lieberman, MD; Members: Reena Kapoor, MD, Ann Marie Sullivan, MD, Kenneth Michael Certa, MD, Lisa A Rone, MD, Thomas Oscar Dickey, MD, Steve Hyun Koh, MD, Iqbal Ahmed, FRCPsych, Philip Aaron Bialer, MD; Consultant: Dilip V. Jeste, MD; Administration: Margaret C. Dewar, Chiharu Tobita

The call for nominations for the 2015 National Election began in June 2014 with announcements communicated to the membership through the APA Web Site, Headlines, Social Media (Facebook, Twitter & LinkedIn), Assembly-, Area Council, District Branch-listservs, and electronic member alerts. A call for nominations was published in Psychiatric News in both the print and e-newsletter versions of the publication.

The 2014-2015 Nominating Committee, chaired by Jeffrey A. Lieberman, M.D., met via (5) conference calls in July, August, September, and October to discuss the nominations process and review nominations and recommendations for APA's 2015 National Election. The initial slate of candidates was announced October 31, 2014 in accordance with the APA Bylaws to report the nominations to the Board "by November 1 for immediate dissemination to the members".

The Committee received and reviewed recommendations for the Area Trustee candidates from three Area Councils (Area I, Area IV and Area VII),, for the Early Career Psychiatrist (ECP) Trustee-at-Large candidates from the ECP Nominating Subcommittee, chaired by Molly K. McVoy, M.D., as well as recommendations for the Resident-Fellow Member Trustee-Elect (RFMTE) candidates from the RFMTE Nominating Subcommittee, chaired by Erik R. Vanderlip, M.D., M.P.H.

Minority/Underrepresented Representative (M/UR) Trustee position - On September 23, 2014, a formal complaint was sent to Saul Levin, M.D., M.P.A., Paul Summergrad, M.D., Jeffrey Lieberman, M.D., Maria Oquendo, M.D., Jenny Boyer, M.D., Ph.D., J.D., R. Scott Benson, M.D. and Annelle Primm, M.D., M.P.H. by an M/UR Committee member suggesting that voting for the final three (3) M/UR Trustee names (two nominees and one alternate) was not managed appropriately.

This issue was referred to the Nominating Committee by Drs. Levin and Summergrad for review and appropriate action.

The Nominating Committee brought forward a recommendation for a new, confidential vote to ensure that the voting procedures of the APA for selecting MUR Trustee candidates were properly followed. The recommendation was approved by the Board of Trustees Executive Committee on October 7, 2014.

The final result of the MUR Trustee candidates was presented to the Nominating Committee on October 20, 2014.

Resignation of Area IV & VII Reps from the Nominating Committee - In August 2014, an issue arose with respect to nominations for the Area IV & VII Trustee positions.

The Trustee Nominating Committees from Areas IV and VII nominated current members of the Nominating Committee, Shastri Swaminathan, M.D. (Area IV; 2013-2015) and Annette M. Matthews, M.D. (Area VII; 2014-2016) as one candidates for the Area IV & VII Trustee positions, respectively.

Initially, the Administration informed the members of the Nominating Committee that they could not resign from the Nominating Committee in order to run for a Trustee position. The *APA Operations Manual* says that acceptance of an appointment to the APA Nominating Committee will preclude consideration for any elected APA position during the committee member's appointment tenure.

Individuals within Area IV noted however, that two prior members of the APA Nominating Committee have not followed that rule, and resigned from the Committee to accept nominations as Area Trustees in the past elections. It is unlikely that people were aware of this rule when this occurred.

On August 14, 2014, the Executive Committee passed the motion to waive the restriction on accepting nomination as the Area Trustee for members of the current Nominating Committee if the nominee resigns from the Nominating Committee before accepting the nomination.

Going forward, the Administration will include language within future appointment letters for the Nominating Committee to note the restriction and ensure that all Area Councils and all Nominating Committee Members are fully aware that sitting Nominating Committee members may not accept nominations for APA national office during their two-year term.

New Committee Members from Area IV & VII were appointed by the current APA President, Paul Summergrad, M.D.: Lisa A. Rone, M.D. (Area IV; -2015) and Iqbal Ahmed, FRCPsych (Area VII; -2016).

Dr. Lieberman expresses his appreciation to all the members of the Nominating Committee for their contribution and participation during the nomination process, and to the membership for submitting nominations and letters of recommendation.

The Nominating Committee is pleased to announce the following final slate of candidates for the 2015 National Election, which will become official with the approval of the Board of Trustees.

PRESIDENT-ELECT
Barton J. Blinder, M.D., Ph.D.
Maria A. Oquendo, M.D.
Charles F. Reynolds III, M.D.

SECRETARY
Rahn K. Bailey, M.D., DFAPA
Altha J. Stewart, M.D.

EARLY CAREER PSYCHIATRIST (ECP) TRUSTEE-AT-LARGE
Lama Bazzi, M.D.
Paul O'Leary, M.D.

MINORITY/UNDERREPRESENTED REPRESENTATIVE (M/UR) TRUSTEE
Curley L. Bonds, M.D.
Gail E. Robinson, M.D.

AREA 1 TRUSTEE
Jeffrey L. Geller, M.D., M.P.H.
Anthony J. Rothschild, M.D.

AREA 4 TRUSTEE
Ronald M. Burd, M.D.
Shastri Swaminathan, M.D.

AREA 7 TRUSTEE
Jeffrey Akaka, M.D.
Stephen L. Brown, M.D.
Annette M. Matthews, M.D.

RESIDENT-FELLOW MEMBER TRUSTEE-ELECT (RFMTE)
Alicia Barnes, D.O., M.P.H.
Stella Cai, M.D.
Sarah Schmidhofer, M.D.

ACTION:
Will the Board of Trustees vote to accept the report of the Nominating Committee as presented?

November 2014

To: APA Board of Trustees

From: Carolyn B. Robinowitz, M.D., 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. This report is being written just days after the close of the 2014 Interim Meeting of the AMA House of Delegates (HOD) which was held in Dallas from November 7 through 11. The Interim Meeting is the second HOD meeting of the year, and it focuses on advocacy both for the profession and for patients. We have summarized the highlights below including the expansion of the Section Council on Psychiatry and the recognition of two psychiatrists who have been leaders in our work at the AMA. Included is an attachment listing important policy decisions made by the HOD that are relevant to psychiatry. Apart from the HOD meetings, we are continuing our preparation for the re-election in June 2015 of Patrice Harris, M.D. to the AMA Board of Trustees for a second four-year term.

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 leadership positions within the AMA (e.g., councils and committees) at which policies and programs are developed and implemented; as well as 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 state and specialty organizations on topics of mutual interest and concern.

AMA House of Delegates Meeting, November 8 -11, 2014

The AMA Section Council on Psychiatry increased its membership and reach at this meeting, with the addition of the Gay and Lesbian Medical Association (GLMA) to the list of participating organizations in the Section. Additionally, the American Association for Geriatric Psychiatry (AAGP) met the qualifications established by the HOD for a seat in the House and will have official delegate status in June 2015. These actions increase the total number of delegate seats held in the Section Council to 12 seven from APA, one each from the American Academy of Child and Adolescent Psychiatry, the Academy of Psychiatry and the Law, GLMA and AAGP as well as our Resident and Fellow Sectional Delegate, Simon Faynboym).

Unfortunately, there was schedule overlap between the APA Assembly and the beginning of the AMA meeting, such that the APA President-Elect and Speaker Elect (who serve as alternate delegates) were not able to attend, while other delegates and alternates including the Medical Director/CEO joined us after the conclusion of the Assembly. The following delegates and alternate delegates attended on behalf of the APA: Carolyn Robinowitz, M.D. (senior delegate and chair of the Section Council on Psychiatry), Jeffrey Akaka, M.D., Kenneth Certa, M.D., Jerry Halverson, M.D., Jack McIntyre, M.D., Joseph English, M.D., Paul Wick, M.D., delegates; and alternate delegates, Donald Brada, M.D., Saul Levin, M.D., MPA

(CEO, Medical Director), Barbara Schneidman, M.D., MPH, Harsh Trivedi, M.D., John Wernert, M.D., Ray Hsiao, M.D., Paul O'Leary, M.D., Simon Faynboym, M.D., and Sean Moran, M.D. The American Academy of Child and Adolescent Psychiatry (AACAP) was represented by Louis Kraus, M.D., David Fassler, M.D., and Sharon Hirsch, M.D. The American Academy of Psychiatry and the Law (AAPL) was represented by Barry Wall, M.D., Ryan Hall, M.D., and Jennifer Piel, M.D. The Gay and Lesbian Medical Association was represented by Brian Hurley, M.D. The Section Council on Psychiatry was assisted in its efforts by staff including Erin Connors, Kristin Kroeger Ptakowski, Deana McRae, Mark Moran, and Becky Yowell (APA staff): Heidi Fordi, and Ronald Szabat (AACAP staff).

We have attached a chart summarizing the key issues covered during this meeting (Attachment 1)

Recognition
Two psychiatrist leaders were honored for their service to the AMA and the APA.

AMA Honors Dr. James Scully
The American Medical Association presented former APA Medical Director and CEO James H. Scully, Jr., M.D., with the Medical Executive Lifetime Achievement Award during the opening session of the HOD. The award honors medical executives who have made significant contributions to their county medical society, state medical association, or national medical specialty society over the course of their tenure. Nominated by the Council of Medical Specialty Societies and the American Board of Psychiatry and Neurology as well as APA, Dr. Scully was selected for this award for his leadership and dedication to medical education and clinical care throughout his career. AMA Board Chair Barbara L. McAneny, M.D., presented Dr. Scully with the award citing, "… his impact on the APA and organized medicine as a whole."

Over the years, Dr. Scully has worn many hats including those of teacher and clinician in addition to his role as an executive and administrator. During his 10-year tenure as Medical Director and CEO of APA, he strengthened the organization's role in psychiatric education, focusing on professional development and quality improvement. As a residency director and department chair, he emphasized education of future generations of psychiatrists.

Dr. Scully has held multiple leadership roles in the medical community including President of the South Carolina Psychiatric Association, Director of the American Board of Psychiatry and Neurology, Senior Delegate to the AMA HOD, and President of the Council of Medical Specialty Societies. Currently, he is President of the American College of Psychiatrists.

APA and AMA Honor Dr. Joseph English
The AMA Section Council on Psychiatry honored Joseph English, M.D., who is retiring after 19 years of service as a Delegate from the APA to the AMA HOD. The Section Council, led by APA delegates and elected leadership and joined by AMA Board of Trustees members, recognized Dr. Joseph English at a reception on November 8.

Dr. English served with great distinction as Chairman of the AMA Section Council on Psychiatry from 1996 through 2001. He initiated a strategic planning process for the Section Council, and through his superb leadership ensured that the strategic priorities developed during that process informed and guided the work of the Section Council for more than a decade. As a result of that effort, the Section Council on Psychiatry became a significant, influential, and respected voice in the HOD. Issues of importance to psychiatrists and their patients were addressed through resolutions and reports, some two dozen psychiatrists were elected and appointed to membership on AMA Councils and committees and assumed leadership positions within the HOD. He continued his outstanding contributions to the work of the Section Council through the second decade of his membership, ensuring that the gains made during his first decade of leadership would continue and flourish

The contributions of Dr. English were recognized by AMA leaders, who appointed him as a Commissioner of The Joint Commission, where his impact was strong and effective as well.

Dr. English has had a long and distinguished professional career as a scholar and leader both in academic medicine and in national government. He has served the APA for more than four decades as a member leader, including President, on numerous efforts related to medical education and clinical services especially in reimbursement for psychiatric care, prospective payment, the resource based relative value system, general hospital psychiatry, liability insurance, organizational development and function. His strong hand and steady vision set a successful course for the APA, its members and the patients they treat.

Speeches

Veterans Affairs Secretary Robert McDonald

The U.S. Department of Veterans Affairs Secretary Robert McDonald addressed the AMA HOD during its opening session.

Citing recent access-to-care issues for veterans, McDonald spoke about the VA's "Blueprint for Excellence," which seeks to: improve performance of the VA health care system; reset the VA's culture to place value on job performance; transition from "sick care" to "health care"; and develop efficient, transparent processes to support the VA's span of care, services and programs.

During his presentation, Secretary McDonald acknowledged one of the biggest challenges the VA faces is the shortage of clinicians. "The demand for VA care will not decrease any time soon. The nation's been at war for over a decade, and we'll continue to be caring for many of our severely wounded and ill veterans for decades to come," McDonald said. To mitigate this shortage, he's intends to visit a number of U.S. medical schools to recruit students to work for the VA. He highlighted federal legislation, including the Veterans Access, Choice and Accountability Act—a law that APA advocated for the inclusion of provisions surrounding access to mental health —which will give authority for funding and other tools to better serve veterans in the short term.

McDonald asked AMA members to provide their input and advice on the VA's Choice Act and its future plans. "We need to configure the Choice program in a way that enables all doctors caring for veterans to work as teams, no matter who is paying the bill," McDonald said. "We need you to participate in the program, and we know you won't if it's too much trouble."

Secretary McDonald also singled out mental health care during the question and answer portion of the session. When asked what he could do about the low reimbursement rates paid to physicians to treat veterans, he initially responded by saying that the rates established by the government must be appropriate and perhaps the problem was the cost structure of the practice. He then paused and went on to single out the impact low reimbursement has had on access to mental health care. He commented, "If the feeling is that the rates that the government reimburses are too low, I'm happy to use my bully pulpit, my convening authority to help attack those, because I think that is certainly the case in mental health…."

AMA Executive Vice President and CEO James L. Madara, M.D.

Dr. Madara began by mentioning the AMA's partnership with TEDMED, the health and medicine edition of the TED conference, dedicated to "ideas worth spreading." He noted the success of the September annual event which was "full of innovative and thought provoking ideas." The forum encourages innovation and pushes the field forward in a variety of ways.

Dr. Madara then described the progress that has occurred in AMA's three areas of focus:

Professional Satisfaction and Practice Sustainability initiative: Dr. Madara announced that beta testing has begun for the first four modules in the AMA's new online platform to help physicians address common clinical challenges. He also discussed how the AMA is working to understand and improve new payment models, teaming up with the AHA to ensure physician leadership in new practice models and working to improve the usability of electronic health records (EHR).

Accelerating Change in Medical Education initiative: The 11 schools that received grants from the AMA to innovate changes to the medical school curriculum are "making great strides". Schools are doing a variety of things from embedding patient navigators into health systems to using authentic clinical data in curriculum.

Improving Health Outcomes initiative: The AMA has led pilot programs in both diabetes prevention and hypertension initiatives over the past year, and is turning its attention to spreading effective strategies to help more physicians manage these conditions in their practices. AMA is working collaboratively with the CDC, several universities, and other medical specialty groups in this effort.

He concluded by reminding the HOD that "together, we are breathing new life into our mission statement for each other, for the next generation of physicians, for our patients and for a healthier nation."

AMA President Robert Wah, M.D.
Dr. Wah spoke about the view of healthcare from his vantage point as AMA president, focusing on AMA's successes over the previous months. He noted the recent bipartisan and bicameral support of efforts to repeal and replace Medicare's sustainable growth rate formula. He promised that AMA will continue the fight to achieve repeal saying "it is not a matter of "if," it is now a matter of "when". He spoke about the delay in the implementation of ICD 10 and AMA's work to ensure that information made public through the Sunshine Act was accurate. He went on to describe the "tsunami" of regulatory penalties physicians will face over the next decade and urged the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health IT to make the meaningful use, Physician Quality Reporting System and Value-Based Modifier programs more simple and streamlined. "Recognizing potential problems is the first step toward overcoming them," Dr. Wah said. "We've taken that step … with positive action on behalf of our physicians and our 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).

Facebook: Pictures and videos were posted to APA's Facebook page including interviews with Drs. Harris, Levin, Hurley and English. To date, these postings have been viewed 9,889 times.

Twitter: Pictures were posted to the APA Twitter site during the meeting. To date, the tweets have a total of 74 likes and 81 retweets. This included a few likes and retweets by the AMA communications office.

Video Interviews: Long-form interviews were completed with Dr. Patrice Harris and Dr. Saul Levin.
http://www.psychiatry.org/advocacy--newsroom/newsroom/video-news

Psych News Blogs and Stories: Three blogs were posted during the HOD meeting and an additional four stories will appear in a future issue of Psych News.

On-Going Tasks
As part of our commitment to continuous quality improvement to promote our effectiveness, our work does not end with the end of the meeting but is year-long. We will participate in a number of AMA activities prior to the next HOD meeting in June 2015. 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 to ensure not only her re-election in June 2015, but to maintain and improve 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's, Medical Schools, Organized Medical Staff) as well as State Delegations. We have formed a new internal committee on Resolutions charged to work with the Section Council parent organizations and to recommend resolutions affecting their organizations' priorities for presentation to the HOD. Finally, we continue to plan transitions in the APA appointed Delegation, 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 as some 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. Consequently, 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 We recognize the differences in style and function between APA and AMA are hope to recruit new members of the Section who are both comfortable with and effective in working with their colleagues in all medical specialties and settings.

Working effectively at the AMA is vital for our future, and we appreciate the support of the Officers and BOT in our efforts to strengthen and enhance the role and function of psychiatry in the House of Medicine.

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Actions

The following are just a few of the actions taken by the HOD at the 2014 Interim meeting. For all of the AMA HOD Interim 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	CEJA 03	Modernized Code of Medical Ethics *The Council on Ethical and Judicial Affairs recommends that the individual opinions contained in the 2014-2015 edition of the AMA Code of Medical Ethics be amended by substitution with proposed new opinions. With CEJA's agreement, the document will remain posted through December 31, 2014. CEJA will review all feedback and revise the document accordingly. CEJA will post revisions prior to the A-15 meeting*	**REFERRED**
.Con	Res. 003	Solitary Confinement RESOLVED, That our American Medical Association oppose the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances such as the protection of the juvenile, staff, or other detainees (New HOD Policy); and be it further RESOLVED, That our AMA oppose the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities (New HOD Policy); and be it further RESOLVED, That our AMA support that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician. (New HOD Policy) **AACAP, with endorsement from the Section Council and SSS, offered modified language to RESOLVE 1; which was adopted** *That our American Medical Association oppose the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances, regarding acute risk of harm to self or others (New HOD Policy); and be it further*	**ADOPTED as amended**
.Con	Res. 008	Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth RESOLVED, That our American Medical Association work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (New HOD Policy)	**ADOPTED as amended**
B	BOT 05	FDA Regulation of Off-Label Drug Promotion 1. That Policy H-120.988 be amended by addition and deletion to read as follows: H-120.988 Patient Access to Treatments Prescribed by Their Physicians (1) The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. (2) Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. (3) Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be	**ADOPTED as amended**

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Cmte	Item	Title / Recommendations or Resolves	
		provided in its entirety, not edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. (4) Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). (5) Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. (6) Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act (Modify Current HOD Policy) 2. That Policy H-60.933, Reauthorization of BPCA and PREA be rescinded. (Rescind HOD Policy)	
B	Res 205	Juvenile Justice System Reform RESOLVED, That our American Medical Association advocate for the Department of Justice to work towards the elimination of the school to jail pipeline which disproportionately affects African American youth (Directive to Take Action); and be it further RESOLVED, That our AMA lobby the US Department of Health and Human Services and the Department of Justice to ensure that youth incarcerated in short-term and long-term correctional facilities receive medical and mental health care consistent with community standards in order to improve their health outcomes (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for the Department of Housing and Urban Development to reconsider banning non-violent juvenile offenders from public housing thereby preventing a minor child from returning to their family. (Directive to Take Action) **Introduced by the Minority Affairs Section, the author is Dr. Dionne Hart (APA member.** *After much discussion of the floor of the House, the majority agreed to refer the resolution*	**REFERRED**
B	Res 213	Cannabis - Expanded AMA Advocacy RESOLVED, That our American Medical Association educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH report I-13 and A-09, and as additional scientific evidence becomes available (Directive to Take Action); and be it further RESOLVED, That our AMA urge legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research; (Directive to Take Action) and be it further RESOLVED, That our AMA also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal", approach to cannabis. (Directive to Take Action) RESOLVED, That our AMA should encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. FDA: “Marijuana has high potential for drug abuse. It has no scientifically proven currently accepted medical use for preventing or treating any disease process in the U.S.”	**ADOPTED as amended**
B	Res 215	Preauthorization RESOLVED, That our American Medical Association reaffirm existing policy H-320.950, which seeks to mitigate the burden of preauthorization and other utilization review efforts; and be it further RESOLVED, That our AMA conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative	**ADOPTED as amended** *Substitute Res.*

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Cmte	Item	Title / Recommendations or Resolves	
		tasks, to include (1) authorizations and preauthorizations, and (2) denial of authorization appeals, and report back to the House of Delegates at A-15; and be it further RESOLVED, That there be a report back to the House of Delegates at A-15. RESOLVED, that our AMA utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advanced notification or prior authorization of outpatient laboratory services.	*215 was recommended to be adopted in lieu of Res. 215, 219, 221, and 222*
F	Res 606	RESOLVED, That our American Medical Association create and provide significant initial and ongoing funding for a new subsidiary, the AMA Super PAC, to participate in independent expenditures for or against candidates for federal office (Directive to Take Action); and be it further RESOLVED, That the AMA Super PAC only support candidates that have already been endorsed by AMPAC at the recommendation of state medical society PACs (Directive to Take Action); and be it further RESOLVED, That the AMA Board of Trustees determine the structure, organizing principles, name, membership and terms of office of the Organizing Board of Directors of the AMA Super PAC (Directive to Take Action); and be it further RESOLVED, That the AMA Board of Trustees determine the amount of money to be dedicated to the AMA Super PAC annually (Directive to Take Action); and be it further RESOLVED, That the AMA Super PAC Board of Directors be responsible for determining the allocation of monies for independent expenditures, actively participate in all operational decisions regarding the independent expenditures and develop a plan to encourage contributions from other entities eligible to contribute to our Super PAC for the purposes of advancing the AMA's agenda for our patients and our profession (Directive to Take Action); and be it further RESOLVED, That the AMA Board of Trustees report back at the 2015 Annual Meeting with recommendations for the new AMA Super PAC. (Directive to Take Action)	**REFERRED** Report back at the 2015 Annual Meeting
J	CMS 04	Network Adequacy 1. That our American Medical Association (AMA) reaffirm Policy H-285.924, which states that health plans should provide patients with an accurate, complete directory of participating physicians through multiple media outlets, including the Internet. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-285.991, which outlines requirements that must be met prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason, as well as requirements for ~~a~~ an meaningful appeals process for physicians whose health insurance contract is terminated or not renewed. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy D-285.972, which states that our AMA will seek legislation or regulation that prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Reaffirm HOD Policy) 4. That our AMA support state regulators as the primary enforcer of network adequacy requirements. (New HOD Policy) 5. That our AMA support requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. (New HOD Policy) 6. That our AMA support requiring health insurers to submit and make publicly available, at least quarterly reports, to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. (New HOD Policy)	**ADOPTED as amended**

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Cmte	Item	Title / Recommendations or Resolves	
		7. That our AMA support requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. (New HOD Policy) 8. That our AMA advocate for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. (New HOD Policy) 9. That our AMA provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. (Directive To Take Action) 10. That our AMA support fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. (New HOD Policy) 11. That our AMA support the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. (New HOD Policy) 12. That our AMA advocate for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. (Directive to Take Action)	
J	CMS 07	Medicaid Primary Care Payment Increases 1. That our American Medical Association (AMA) reaffirm Policy H-290.976, which advocates that Medicaid payments to physicians must be at a minimum 100 percent of Medicare payment rates. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-385.959, which recognizes obstetricians and gynecologists as capable of providing both primary care and consultative care. (Reaffirm HOD Policy) 3. That our AMA advocate that the Affordable Care Act's Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as qualifying specialists, and support flexibility to achieve the best possible outcome. (Directive to Take Action) 4. That our AMA advocate for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact payment for any other physician. (Directive to Take Action)	**ADOPTED as amended** *Adopted as amended in lieu of Resolution 813 – Medicaid Enhanced Rates*
J	Res 808	Access to Psychiatric Services RESOLVED, That our American Medical Association advocate for improving access to psychiatric services by improving reimbursement (Directive to Take Action); and be it further RESOLVED, That our AMA develop a policy that the reimbursement for psychiatric services for Medicaid patients be increased to Medicare levels (New HOD Policy); and it be further RESOLVED, That our AMA advocate for the addition of psychiatry to family practice, internal medicine, pediatrics and obstetrics and gynecology as those specialties require additional reimbursement for Medicaid patients to Medicare levels (Directive to Take Action); and be it further	**REAFFIRM IN LIEU**

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Cmte	Item	Title / Recommendations or Resolves	
		RESOLVED, That our AMA develop a policy that this increased reimbursement for Medicaid patients to Medicare levels be continued beyond the two years as stipulated in the Affordable Care Act. (New HOD Policy) **Reaffirmation of AMA policies:** H-345.981 Access to Mental Health Services H-345.978 Access to Psychiatric Beds and Impact on Emergency Medicine H-385.921 Health Care Access for Medicaid Patients D-345.997 Access to Mental Health Services	
K	BOT 03	Facilitating State Licensure for Telemedicine Services 1. That our American Medical Association support the Federation of State Medical Boards Interstate Compact for Medical Licensure. (Directive to Take Action) 2. That our AMA work with interested medical associations, the Federation of State Medical Boards and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Directive to Take Action) 3. That our AMA reaffirm Policies H-255.982, H-275.955, H-275.962, H-275.973, H 275.977, H-275.978, H-480.946, H-480.969, D-275.991, D-275.994, D-275.995 and D 480.999. (Reaffirm HOD Policy) 4. That our AMA rescind Policy D-480.971, which requested this report. (Rescind HOD Policy)	**ADOPTED**
K	CSAPH 02	Electronic Cigarettes, Vaping, and Health: 2014 Update 1. That Policy H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products be amended by addition and deletion to read as follows: Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act. (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (Modify HOD Policy) (3) That our AMA encourage further clinical and epidemiological research on e-cigarettes. (New HOD Policy) 2. That our AMA urges physicians to: (a) educate themselves about e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes;	**ADOPTED as amended** Adopted as amended in lieu of Resolutions 919, 927 and 930

Selected Report Recommendations and Resolution Resolve Statements from 2014 AMA Interim Meeting

Cmte	Item	Title / Recommendations or Resolves	
		(c) promote the use FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. (New HOD Policy) 3. That Policy H-490.909 Use of Electronic Cigarettes (e-cigarettes) in Smoking Cessation Programs be rescinded. (Rescind HOD Policy)	
K	Res 901	Addressing Emerging Trends in Illicit Drug Use RESOLVED, That our American Medical Association (AMA) support ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets and other educational materials (New HOD Policy); and be it further RESOLVED, That our AMA encourage the development of continuing medical education on emerging trends in illicit drug use; (Directive to Take Action); and be it further RESOLVED, That our AMA support efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (New HOD Policy)	**ADOPTED as amended**
K	Res 920	Principles on Maintenance of Certification RESOLVED, That our American Medical Association amend the Policy H-275.924, Principles on Maintenance of Certification (MOC), to include the following: • MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. • The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. • MOC should be used as a tool for continuous improvement. • The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, or network participation or employment. • Actively practicing physicians should be well-represented on specialty boards developing MOC. • MOC activities and measurement should be relevant to clinical practice. • MOC process should not be cost prohibitive or present barriers to patient care. RESOLVED, That our AMA encourage specialty boards to investigate and/or establish alternative approaches for MOC (Directive to Take Action); and be it further RESOLVED, That our AMA prepare a yearly report regarding the maintenance of certification process. (Directive to Take Action) RESOLVED, That our AMA work with the ABMS to eliminate practice performance assessment models, as currently written, from the requirement of the MOC. (New HOD Policy) **The Council on Medical Education will report back at A-15, and the report will include a review, update and consolidation of AMA policies on this topic, which includes the Principles on MOC that were originally adopted in 2009.** RESOLVE, That our AMA work with specialty boards, which develop MOC standards, may approve curriculum, but should be independent from actively designing and delivering curriculum, and should have no financial interest in the process - - - **REFERRED**	**ADOPTED as amended** Adopted as amended in lieu of Resolutions 920, 926, 928 and 929

Report of the Conflict of Interest Committee to the Board of Trustees
December 2014

The Conflict of Interest Committee was charged to review the completed disclosure forms for the nominees to the DSM Steering Committee. The DSM Steering Committee, established by the Board of Trustees, is charged to

> monitor developments in biomedical research and clinical psychiatry that might warrant revision of the disorders and/or the criteria which define them, and determine if and how to do so; to review proposals for DSM changes submitted to APA; to determine how best to coordinate the DSM with ICD-10-CM code planning and harmonization with ICD-11, and alignment with RDoCs development; and to participate in developing a process by which the DSM can be iteratively updated as developments in the field of psychiatric medicine warrant.

Similar to the DSM 5 development process, a DSM specific disclosure form was developed by APA legal counsel for the DSM Steering Committee. Prospective members of the DSM Steering Committee completed disclosure forms, which were vetted by the Conflict of Interest Committee. Individuals serving as ex-officio representatives from the NIMH, NIDA, NIAAA and the WHO, were not required to complete disclosure forms and were not vetted by the Conflict of Interest Committee.

Meeting through email and by conference call, the Committee reviewed each prospective member's disclosure form, comparing what was disclosed against their curriculum vitae and the BOT Principles for DSM Appointments and Disclosures (approved by the Board of Trustees in July 2014). When information was unclear, contradictory or the Committee needed more detailed information to understand a disclosure, questions were asked of the prospective member. All individuals were forthcoming and timely in their responses.

The table attached depicts the Committee's responses for the prospective participants on the DSM Steering Committee.

ACTION:

Will the Board of Trustees approve the participation on the DSM Steering Committee of the following individuals, as recommended by the Conflict of Interest Committee?

Paul Appelbaum, MD – Chairperson
Kenneth Kendler, MD – Vice Chairperson
Renato Alarcon, MD – Member
Deanna Barch, PhD – Member
Pamela Collins, MD, MPH – Member
Michelle Craske, PhD – Member
Michael First, MD – Member
Dilip Jeste, MD – Member
Ellen Leibenluft, MD – Member

Susan Schultz, MD – Member
Kimberly Yonkers, MD – Member
Glenn Martin, MD – Assembly Liaison*
Rebecca Rinehart – APPI Liaison

Wilson Compton, MD – Ex-officio/NIDA
Bruce Cuthbert, PhD – Ex-officio/NIMH
George Koob, PhD – Ex-officio/NIAAA
Geoffrey Reed, PhD – Ex-officio/WHO

*The COI Committee notes that Dr. Martin has investments over the $10,000 limit that may give the appearance of conflict. However, in his role as Assembly Liaison, the committee recommends his appointment to the DSM-5 Steering Committee.

Final Grid of Input/Review update as of 11/18/2014

DSM Steering Cmte	Role on Steering Cmte	Dr. Oquendo	Dr. Brendel	Dr. Fayad	Dr. Harding	Dr. Lawson	Dr. Sullivan	Dr. Teague	Income >10K	Income<10K	NO COI (Apparent)
Dr. Appelbaum	Chairperson	Yes	Yes	Yes	Yes		Yes	Yes		X	
Dr. Kendler	Vice Chairperson	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Alarcón	Member	Yes	Yes	Yes	Yes	Yes	Yes	Yes		X	
Dr. Barch	Member	Yes	Yes	Yes	Yes	Yes	Yes	Yes		X	
Dr. Collins	Member	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Craske	Member	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. First	Member	Yes	Yes	Yes	Yes		Yes	Yes		X	
Dr. Hyman	Member	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Dr. Jeste	Member	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Leibenluft	Member	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Schultz	Member	Yes	Yes	Yes	Yes	Yes	Yes	Yes		X (funds through University)	
Dr. Yonkers	Member	Yes	Yes	Yes	Yes	Yes	Yes	Yes			x
Dr. Martin	Assembly Liaison	?	?	Yes	?	Yes	Yes	Yes	?		
Ms. Rinehart	APPI Liaison	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Koob	Ex-officio/NIAAA*	Yes	Yes	Yes	Yes		Yes	Yes			X
Dr. Cuthbert	Ex-officio/NIMH*										
Dr. Compton	Ex-officio/NIDA*	?	?	Yes	Yes		?	Yes			
Dr. Reed	Ex-officio/WHO*										

*These individuals need not submit DSM V SC Component Disclosure forms because each serves in an ex-officio capacity and as such, is not required to complete a disclosure form for participation on the DSM V Steering Committee. [per Colleen Coyle, Esq.]

EXECUTIVE SUMMARY

Assembly

The Assembly met in Washington, DC, November 7-9, 2014, and refers the following actions to the Board of Trustees (BOT), below. The draft summary of actions from the Assembly meeting is provided as attachment 31.

9.A The Assembly brings the following action items:

1. Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist* (ASM Item #2014A2 4.B.1)

   The Assembly voted to approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*. (Attachment 1)

   Action: Will the Board of Trustees approve the Position Statement on *Residency Training Needs in Addiction Psychiatry for the General Psychiatrist*?

2. Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services* (ASM Item #2014A2 4.B.2)

   The Assembly voted to approve the Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*. (Attachment 2)

   Action: Will the Board of Trustees approve the Proposed Position Statement on *Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services*?

3. Retain Position Statement: *Relationship between Treatment and Self Help* (ASM Item #2014A2 4.B.3)

   The Assembly voted to retain the Position Statement: *Relationship between Treatment and Self Help*. (Attachment 3)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *Relationship between Treatment and Self Help*?

4. Retire Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions* (ASM Item #2014A2 4.B.4)

   The Assembly voted to retire the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions* (Attachment 4)

   Action: Will the Board of Trustees approve the retirement of the Position Statement: *Mental Health & Substance Abuse and Aging: Three Resolutions*?

5. Retain Position Statement: *Elder Abuse, Neglect and Exploitation* (ASM Item #2014A2 4.B.5)

   The Assembly voted to retain the Position Statement: *Elder Abuse, Neglect and Exploitation* (Attachment 5)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *Elder Abuse, Neglect and Exploitation*?

6. Retain Position Statement: *Discriminatory Disability Insurance Coverage* (ASM Item #2014A2 4.B.6)

   The Assembly voted to retain the Position Statement: *Discriminatory Disability Insurance Coverage* (Attachment 6)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *Discriminatory Disability Insurance Coverage*?

7. Retain Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations* (ASM Item #2014A2 4.B.7)

   The Assembly voted to retain the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations* (Attachment 7)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *Psychiatrists Practicing in Managed Care: Rights and Regulations*?

8. Retain Position Statement: *State Mental Health Services* (ASM Item #2014A2 4.B.8)

   The Assembly voted to retain the Position Statement: *State Mental Health Services* (Attachment 8)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *State Mental Health Services*?

9. Retain Position Statement: *Universal Access to Healthcare* (ASM Item #2014A2 4.B.9)

   The Assembly voted to retain the Position Statement: *Universal Access to Healthcare* (Attachment 9)

   Action: Will the Board of Trustees approve the retention of the Position Statement: *Universal Access to Healthcare*?

10. Retain Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion* (ASM Item #2014A2 4.B.10)

    The Assembly voted to retain the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion* (Attachment 10)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Federal Exemption from the Institutions for Mental Diseases (IMD) Exclusion*?

11. Retire Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Treatment* (ASM Item #2014A2 4.B.11)

    The Assembly voted to retire the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Care* (Attachment 11)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *2002 Access to Comprehensive Psychiatric Assessment and Integrated Care*?

12. Retire Position Statement: *Psychotherapy and Managed Care* (ASM Item #2014A2 4.B.12)

    The Assembly voted to retire the Position Statement: *Psychotherapy and Managed Care* (Attachment 12)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *Psychotherapy and Managed Care*?

13. Retire Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks* (ASM Item #2014A2 4.B.13)

    The Assembly voted to retire the Position Statement: *Proposed Guidelines for Handing the Transfer of Provider Networks* (Attachment 13)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *Proposed Guidelines for Handling the Transfer of Provider Networks*?

14. Retire Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter* (ASM Item #2014A2 4.B.15)

    The Assembly voted to retire the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter* (Attachment 14)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *Endorsement of Medical Professionalism in the New Millennium: A Physician Charter*?

15. Retire Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded* (ASM Item #2014A2 4.B.16)

    The Assembly voted to retire the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded* (Attachment 15)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *Desegregation of Hospitals for the Mentally Ill and Retarded*?

16. Retain Position Statement: *Abortion and Women's Reproductive Health Rights* (ASM Item #2014A2 4.B.17)

    The Assembly voted to retain the Position Statement: *Abortion and Women's Reproductive Health Rights* (Attachment 16)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Abortion and Women's Reproductive Health Rights*?

17. Retain Position Statement: *Xenophobia, Immigration and Mental Health* (ASM Item #2014A2 4.B.18)

    The Assembly voted to retain the Position Statement: *Xenophobia, Immigration and Mental Health* (Attachment 17)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Xenophobia, Immigration and Mental Health*?

18. Retire Position Statement: *Juvenile Death Sentences* (ASM Item #2014A2 4.B.19)

    The Assembly voted to retire the Position Statement: *Juvenile Death Sentences* (Attachment 18)

    Action: Will the Board of Trustees approve the retirement of the Position Statement: *Juvenile Death Sentences*?

19. Retain Position Statement: *Peer Review of Expert Testimony* (ASM Item #2014A2 4.B.20)

    The Assembly voted to retain the Position Statement: *Peer Review of Expert Testimony* (Attachment 19)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Peer Review of Expert Testimony*?

20. Retain Position Statement: *Joint Resolution against Torture* (ASM Item #2014A2 4.B.21)

    The Assembly voted to retain the Position Statement: *Joint Resolution against Torture* (Attachment 20)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Joint Resolution against Torture*?

21. Retain Position Statement: *Moratorium on Capital Punishment in the United States* (ASM Item #2014A2 4.B.22)

    The Assembly voted to retain the Position Statement: *Moratorium on Capital Punishment in the United States* (Attachment 21)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Moratorium on Capital Punishment in the United States*?

22. Retain Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment* (ASM Item #2014A2 4.B.23)

    The Assembly voted to retain the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment* (Attachment 22)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Discrimination against Persons with Previous Psychiatric Treatment*?

23. Retain Position Statement: *Insanity Defense* (ASM Item #2014A2 4.B.24)

    The Assembly voted to retain the Position Statement: *Insanity Defense* (Attachment 23)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Insanity Defense*?

24. Retain Position Statement: *Psychiatric Participation in the Interrogation of Detainees* (ASM Item #2014A2 4.B.25)

    The Assembly voted to retain the Position Statement: *Psychiatric Participation in the Interrogation of Detainees* (Attachment 24)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Psychiatric Participation in the Interrogation of Detainees*?

25. Retain Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury* (ASM Item #2014A2 4.B.26)

    The Assembly voted to retain the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury* (Attachment 25)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Death Sentences for Persons with Dementia or Traumatic Brain Injury*?

26. Retain Position Statement: *Mentally Ill Prisoners on Death Row* (ASM Item #2014A2 4.B.27)

    The Assembly voted to retain the Position Statement: *Mentally Ill Prisoners on Death Row* (Attachment 26)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Mentally Ill Prisoners on Death Row*?

27. Retain Position Statement: *Diminished Responsibility in Capital Sentencing* (ASM Item #2014A2 4.B.28)

    The Assembly voted to retain the Position Statement: *Diminished Responsibility in Capital Sentencing* (Attachment 27)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Diminished Responsibility in Capital Sentencing*?

28. Retain Position Statement: *Endorsement of the Patient-Physician Covenant* (ASM Item #2014A2 4.B.29)

    The Assembly voted to retain the Position Statement: *Endorsement of the Patient-Physician Covenant* (Attachment 28)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Endorsement of the Patient-Physician Covenant*?

29. Retain Position Statement: *Provision of Psychotherapy for Psychiatric Residents* (ASM Item #2014A2 4.B.30)

    The Assembly voted to retain the Position Statement: *Provision of Psychotherapy for Psychiatric Residents* (Attachment 29)

    Action: Will the Board of Trustees approve the retention of the Position Statement: *Provision of Psychotherapy for Psychiatric Residents*?

30. 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 (ASM Item #2014A2 8.L.1)

    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 (Attachment 30)

    Action: Will the Board of Trustees 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?

31. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment (ASM Item #2014A2 8.L.2)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 2- Substance Use Assessment?

32. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk (ASM Item #2014A2 8.L.3)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 3- Assessment of Suicide Risk?

33. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors (ASM Item #2014A2 8.L.4)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 4- Assessment of Risk for Aggressive Behaviors?

34. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors (ASM Item #2014A2 8.L.5)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 5- Assessment of Cultural Factors?

35. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health (ASM Item #2014A2 8.L.6)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 6- Assessment of Medical Health?

36. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment (ASM Item #2014A2 8.L.7)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 7- Quantitative Assessment?

37. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making (ASM Item #2014A2 8.L.8)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 8- Involvement of the Patient in Treatment Decision-Making?

38. Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation (ASM Item #2014A2 8.L.9)

    The Assembly voted to approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation (Attachment 30)

    Action: Will the Board of Trustees approve the Practice Guidelines for Psychiatric Evaluation of Adults: Guideline 9- Documentation of the Psychiatric Evaluation?

The Assembly brings the following informational items:

1. Assembly Nominating Committee Report

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

Speaker-Elect:	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

Attachment #1
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."

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

Adoption Date: Assembly Approved November 2014

Attachment #2
Item 2014A2 4.B.2
Assembly
November 7-9, 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

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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.

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

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.

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

"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 Dachler, 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.

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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.

Attachment #30

DRAFT
October 6, 2014
Not for citation

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults

APA Work Group on Psychiatric Evaluation

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Contents

EXECUTIVE SUMMARY

Background and development process

These Practice Guidelines for the Psychiatric Evaluation of Adults mark a transition in the American Psychiatric Association's Practice Guidelines. Since the publication of the Institute of Medicine report, *Clinical Practice Guidelines We Can Trust*, (2011), there has been an increasing focus on using clearly defined, transparent processes for rating the quality of evidence and the strength of the overall body of evidence in systematic reviews of the scientific literature. These guidelines were developed using a process intended to be consistent with the recommendations of the Institute of Medicine (2011), the Principles for the Development of Specialty Society Clinical Guidelines of the Council of Medical Specialty Societies (2012) and the requirements of the Agency for Healthcare Research and Quality (AHRQ) for inclusion of a guideline in the National Guidelines Clearinghouse. Parameters used for the guidelines' systematic review are included with the full text of the guidelines; the development process is fully described in the following document available on the APA website: http://www.psychiatry.org/File%20Library/Practice/APA-Guideline-Development-Process--updated-2011-.pdf. To supplement the expertise of members of the guideline work group, we used a "snowball" survey methodology to identify experts on psychiatric evaluation and solicit their input on aspects of the psychiatric evaluation that they saw as likely to improve specific patient outcomes (Yager 2014). Results of this expert survey are included with the full text of the practice guideline.

Rating the strength of research evidence and recommendations

The new guideline recommendations are rated using GRADE (Grading of Recommendations Assessment, Development and Evaluation), which is used by multiple professional organizations around the world to develop practice guideline recommendations (Guyatt et al., 2013). With the GRADE approach, the strength of a guideline statement reflects the level of confidence that potential benefits of an intervention outweigh the potential harms (Andrews et al., 2013). This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. Evidence for the benefit of a particular intervention within a specific clinical context is identified through systematic review and is then balanced against the evidence for harms. In this regard, harms are broadly defined and might include direct and indirect costs of the intervention (including opportunity costs) as well as potential for adverse effects from the intervention. Whenever possible, we have followed the admonition to current guideline development groups to avoid using words such as "might" or "consider" in drafting these recommendations as they can be difficult for clinicians to interpret (Shiffman et al., 2005).

As described under Guideline Development Process, each final rating is a consensus judgment of the authors of the guidelines and is endorsed by the APA Board of Trustees. A "recommendation" (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A "suggestion" (denoted by the numeral 2 after the guideline

statement) indicates uncertainty, i.e., the balance of benefits and harms is difficult to judge, or either the benefits or the harms are unclear. Each guideline statement also has an associated rating for the "strength of supporting research evidence". Three ratings are used: high, moderate, or low (denoted by the letters A, B and C, respectively) and reflect the level of confidence that the evidence reflects a true effect based on consistency of findings across studies, directness of the effect on a specific health outcome, precision of the estimate of effect and risk of bias in available studies (AHRQ 2014, Guyatt et al., 2006 Balshem et al., 2013).

It is well recognized that there are guideline topics and clinical circumstances for which high quality evidence from clinical trials is not possible or unethical to obtain (CMSS, 2012). For example, it would not be ethical to randomly assign only half of patients with depression to be asked about suicidal ideas. Many questions need to be asked as part of the assessment and inquiring about a particular symptom or element of the history cannot be separated out for study as a discrete intervention. It would also be impossible to separate changes in outcome due to assessment from changes in outcomes due to ensuing treatment. Research on psychiatric assessment is also complicated by multiple confounding factors such as the interaction between the clinician and the patient or the patient's unique circumstances and experiences. For these and other reasons, the vast majority of topics covered in these guidelines on psychiatric evaluation have relied on forms of evidence such as consensus opinions of experienced clinicians or indirect findings from observational studies rather than being based upon research from randomized trials. The GRADE working group and guidelines developed by other professional organizations have noted that a strong recommendation may be appropriate even in the absence of research evidence when sensible alternatives do not exist (Andrews et al., 2013; Brito et al, 2013; Djulbegovic et al., 2009; Hazlehurst et al., 2013).

Goals and scope of guidelines for the psychiatric evaluation of adults

Despite the difficulties in obtaining quantitative evidence from randomized trials for practice guidelines such as psychiatric evaluation, guidance to clinicians can still be beneficial in enhancing care to patients. Thus, in the context of an initial psychiatric evaluation, a major goal of these guidelines is to improve the identification of psychiatric signs and symptoms, psychiatric disorders (including substance use disorders), other medical conditions (that could affect the accuracy of a psychiatric diagnosis) and patients who are at increased risk for suicidal or aggressive behaviors. Additional goals relate to identifying factors that could influence the therapeutic alliance, enhance clinical decision-making, enable safe and appropriate treatment planning, and promote better treatment outcomes. Finally, the psychiatric evaluation is the start of a dialog with patients about many factors including diagnosis and treatment options. Further goals of these guidelines are to improve collaborative decision-making between patients and clinicians about treatment-related decisions as well as increase coordination of psychiatric treatment with other clinicians who may be involved in the patient's care.

Time required to complete a psychiatric evaluation

It is essential to note that these guidelines are not intended to be comprehensive in scope. Many critical aspects of the psychiatric evaluation are not addressed by these guidelines. For example, it is assumed that initial psychiatric or other medical assessments will need to identify the reason that the patient is presenting for evaluation. It is similarly important to understand the patient's background, relationships, life circumstances, strengths and vulnerabilities.

Furthermore, depending upon the context, recommended areas of inquiry may need to be postponed until later visits and recommended questions will not always be indicated for a specific patient. The findings of the expert survey reiterate that experts vary in the extent to which particular elements of the initial 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 an initial assessment.

Proper use of guidelines

The American Psychiatric Association Practice Guidelines are not intended to serve or be construed as a "standard of medical care." Judgments concerning clinical care depend upon the clinical circumstances and data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These guideline statements were determined based upon the relative balance of potential benefits and harms of a specific assessment, intervention or other approach to care. As such, it is not possible to draw conclusions about the effects of omitting a particular recommendation, either in general or for a specific patient. Furthermore, adherence to these guidelines will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of evaluation and care or excluding other acceptable methods of evaluation and care aimed at the same results. The ultimate recommendation regarding a particular assessment, clinical procedure or treatment plan must be made by the psychiatrist in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available. Such recommendations should be made in collaboration with the patient and family, whenever possible, and incorporate the patient's personal and sociocultural preferences and values in order to enhance the therapeutic alliance, adherence to treatment, and treatment outcomes.

Organization of the practice guidelines for the psychiatric evaluation of adults

As part of aligning the practice guidelines' development process with national standards, we have transitioned to a new guideline format. Each set of Practice Guidelines will consist of multiple discrete topics of relevance to an overall subject area. In the Practice Guidelines for the Psychiatric Evaluation of Adults, these topics consist of Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History; Substance Use Assessment; Assessment of Suicide Risk; Assessment of Risk for Aggressive Behaviors; Assessment of Cultural Factors; Assessment of Medical Health; Quantitative Assessment; Involvement of the Patient in Treatment Decision-Making; and Documentation of the Initial Psychiatric Evaluation. For each topic, guideline statements will be followed by a discussion of the

rationale, potential benefits and harms and approaches to implementing the guideline statements. This portion of the practice guidelines is expected have the greatest utility for clinicians. A second section of the Practice Guidelines provides a detailed review of the evidence for guideline statements in accord with national guideline development standards. This review of research evidence and data from the expert survey is followed by a discussion of quality measurement considerations, including their appropriateness for each topic.

Guideline statements

The following represents a summary of the recommendations and suggestions compiled from all Practice Guidelines for the Psychiatric Evaluation of Adults, with some statements being a part of more than one of these Guidelines. In the context of these guideline statements, it is important to note that assessment is not limited to direct examination of the patient. Rather, it is defined as "The process of obtaining information about a patient through any of a variety of methods, including face-to-face interview, 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 evaluation may also require several meetings, with the patient, family or others, before it can be completed. The amount of time spent depends on the complexity of the problem, the clinical setting, and the patient's ability and willingness to cooperate with the assessment.

This summary is organized according to common headings of an evaluation note. As noted above, the guidelines are not intended to be comprehensive, and many aspects of the psychiatric evaluation are not addressed by these recommendations and suggestions. Recommendations for the initial psychiatric evaluation of a patient appear in bold font whereas suggestions appear in italic font. The strength of supporting research evidence for these recommendations and suggestions is given rating C (low) because of the difficulties in studying psychiatric assessment approaches in controlled studies as described above. References to the specific guideline in which the recommendation or suggestion is found are denoted by footnotes.

<<N.B.: the following statements are hyper-linked to the actual recommendations or suggestions.>>

History of present illness (in addition to reasons that the patient is presenting for evaluation)

- **Psychiatric review of systems,[1] including anxiety symptoms and panic attacks[3]**
- **Past or current sleep abnormalities, including sleep apnea[6]**
- **Impulsivity[3, 4]**

Psychiatric history

- **Past and current psychiatric diagnoses[1, 3]**
- **Prior psychotic or aggressive ideas, including thoughts of physical or sexual aggression or homicide[4]**

- **Prior aggressive behaviors, e.g., homicide, domestic or workplace violence, and other physically or sexually aggressive threats or acts**[4]
- **Prior suicide ideas, plans, and attempts, including attempts that were aborted or interrupted as well as the details of each attempt (e.g., context, method, damage, potential lethality, intent)**[3]
- **Prior intentional self-injury in which there was no suicidal intent**[3]
- **History of psychiatric hospitalization and emergency department visits for psychiatric issues**[1, 3, 4]
- **Past psychiatric treatments (type, duration and, where applicable, doses)**[1]
- **Response to past psychiatric treatments**[1]
- **Adherence to past and current pharmacological and non-pharmacological psychiatric treatments**[1]

Substance use history

- **Use of tobacco, alcohol, and other substances (e.g., marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications or supplements**[2]
- **Current or recent substance use disorder or change in use of alcohol or other substances** [3,4]

Medical history[6]

- **Allergies or drug sensitivities**
- **All medications the patient is currently or recently taking and the side effects of these medications, i.e., both prescribed and non-prescribed medications, herbal and nutritional supplements, and vitamins**
- **Whether or not the patient has an ongoing relationship with a primary care health professional**
- **Past or current medical illnesses and related hospitalizations**
- **Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments**
- **Past or current neurological or neurocognitive disorders or symptoms**[4]
- **Physical trauma, including head injuries**
- **Sexual and reproductive history**
- *Cardiopulmonary status*
- *Past or current endocrinological disease*
- *Past or current infectious disease, including sexually transmitted diseases, HIV, tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease*
- *Past or current symptoms or conditions associated with significant pain and discomfort*

Review of systems[6]

- **Psychiatric (if not already included with history of present illness)**
- *Constitutional symptoms (fever, weight loss, etc.)*

- *Eyes*
- *Ears, Nose, Mouth, Throat*
- *Cardiovascular*
- *Respiratory*
- *Gastrointestinal*
- *Genitourinary*
- *Musculoskeletal*
- *Integumentary (skin and/or breast)*
- *Neurological*
- *Endocrine*
- *Hematologic/Lymphatic*
- *Allergic/Immunologic*

Family history

- **History of suicidal behaviors in biological relatives (for patients with current suicidal ideas)[3]**
- **History of violent behaviors in biological relatives (for patients with current aggressive ideas)[4]**

Personal and social history

- **Presence of psychosocial stressors, (e.g., financial, housing, legal, school/occupational or interpersonal/relationship problems; lack of social support; painful, disfiguring or terminal medical illness)[3,4]**
- **Review of the patient's trauma history[1, 3]**
- **Exposure to violence or aggressive behavior, including combat exposure or childhood abuse[4]**
- **Legal or disciplinary consequences of past aggressive behaviors[4]**
- **Cultural factors related to the patient's social environment[5]**
- *Personal/cultural beliefs and cultural explanations of psychiatric illness*[5]
- **Patient's need for an interpreter[5]**

Examination, including mental status examination

- **General appearance and nutritional status[6]**
- *Height, weight, and body mass index (BMI)*[6]
- *Vital signs*[6]
- *Skin, including any stigmata of trauma, self-injury, or drug use*[6]
- **Coordination and gait[6]**
- **Involuntary movements or abnormalities of motor tone[6]**
- **Sight and hearing[6]**
- **Speech, including fluency and articulation[6]**
- **Mood, level of anxiety, thought content and process, and perception and cognition[1, 3]**
- **Hopelessness[3]**

- **Current suicidal ideas, plans, and intent, including active or passive thoughts of suicide or death[3]**

  If current suicidal ideas are present, assess:
  - **Patient's intended course of action if current symptoms worsen**
  - **Access to suicide methods including firearms**
  - **Patient's possible motivations for suicide (e.g., attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations)**
  - **Reasons for living (e.g., sense of responsibility to children or others, religious beliefs)**
  - **Quality and strength of the therapeutic alliance**
- **Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide[3, 4]**

  If current aggressive ideas are present, assess:
  - **Specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present**
  - **Impulsivity, including anger management issues**
  - **Access to firearms**

Impression and plan

- **Documentation of an estimate of the patient's suicide risk, including factors influencing risk[3]**
- **Documentation of the rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice[9]**
- **Asking the patient about treatment-related preferences[8]**
- **An explanation to the patient of the following: the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment[8]**
- **Collaboration between the clinician and the patient about decisions pertinent to treatment[8]**
- *Quantitative measures of symptoms, level of functioning, and quality of life[7]*
- *Documentation of an estimated risk of aggressive behavior (including homicide), including factors influencing risk[4]*
- *Documentation of the rationale for clinical tests[9]*

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[1] Guideline 1. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History
[2] Guideline 2. Substance Use Assessment
[3] Guideline 3. Assessment of Suicide Risk
[4] Guideline 4. Assessment of Risk for Aggressive Behaviors
[5] Guideline 5. Assessment of Cultural Factors
[6] Guideline 6. Assessment of Medical Health
[7] Guideline 7. Quantitative Assessment
[8] Guideline 8. Involvement of the Patient in Treatment Decision-Making
[9] Guideline 9. Documentation of the Psychiatric Evaluation

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PRACTICE GUIDELINES FOR THE PSYCHIATRIC EVALUATION OF ADULTS

I. Guidelines and Implementation

Guideline 1. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Psychiatric Evaluation

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient's mood, level of anxiety, thought content and process, and perception and cognition.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient's trauma history.

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the following aspects of the patient's psychiatric treatment history:

- Past and current psychiatric diagnoses
- Past psychiatric treatments (type, duration and, where applicable, doses)
- Adherence to past and current pharmacological and nonpharmacological psychiatric treatments
- Response to past psychiatric treatments
- History of psychiatric hospitalization and emergency department visits for psychiatric issues[1]

Rationale

The goal of these guidelines is to improve the quality of the doctor-patient relationship, the accuracy of psychiatric diagnoses, and the appropriateness of treatment selection.

The strength of research evidence supporting this recommendation is low. No prospective studies have addressed whether outcomes such as diagnostic accuracy and appropriate treatment planning are improved when the initial psychiatric evaluation includes review of psychiatric symptoms, trauma history, and psychiatric treatment history. Despite this, there is consensus by experts that the potential benefits described above clearly outweigh the potential harms.

The process of determining a patient's psychiatric diagnosis is complex (American Psychiatric Association 2013). It requires knowledge of whether a patient is experiencing specific symptoms or exhibiting specific signs. Diagnostic accuracy also requires gathering information about the temporal development and duration of those signs and symptoms. For trauma-related diagnoses as well as for neurocognitive disorders that are due to traumatic brain injury, the presence of a traumatic event is a precondition of diagnosis. Past trauma can also be a risk factor for the development of other diagnoses such as

[1] As recommended in Assessment of Suicide Risk and Assessment of Risk of Aggressive Behaviors

depressive or anxiety disorders (Hovens et al. 2012). A significant proportion of individuals with psychiatric illnesses appear to have experienced traumatic events (Frueh et al. 2005; Cusack et al. 2004; Coverdale & Turbott 2000; Oram et al. 2013; Posner et al. 2008; Lu et al. 2013), but trauma-related diagnoses such as post-traumatic stress disorder are often overlooked (Mueser et al. 1998). Thus, it is intuitively obvious that reviewing a patient's trauma history is essential to diagnostic accuracy. Knowledge of prior psychiatric diagnoses can also inform current diagnosis, since a patient may be presenting with a continuation of the prior disorder or may now have a different disorder that commonly co-occurs with the first (Kessler & Wang 2008; Kessler et al. 2005; Gadermann et al. 2012; Lenzenweger et al. 2007). The relevance of past treatments to diagnostic accuracy is more indirect but still relevant. If a patient has not responded to the primary treatments for a given diagnosis, it may suggest a need to reconsider the accuracy of that diagnosis. Treatment-emergent symptoms and signs (e.g., hypomania or mania in a depressed patient) may also require reassessment of the diagnosis.

Selecting an appropriate treatment will be an outgrowth of the patient's diagnosis as determined during the psychiatric evaluation; however, it also requires knowledge of the patient's current symptoms, trauma history, and previous diagnoses and psychiatric treatment experiences. The elements of the treatment plan will vary depending upon the individual needs and preferences of the patient but will generally include treatment that addresses the patient's primary and co-occurring diagnoses. Often co-occurring psychiatric symptoms are present that are subthreshold or subsyndromal or may not respond to the treatment for the primary disorder (e.g., psychotic symptoms in mood disorders, cognitive impairment in schizophrenia). Such symptoms may contribute to functional impairments or risk of relapse and may also require specific intervention. Prior diagnoses of a co-occurring personality disorder may signal a need for a differing approach to psychotherapy than in an individual without such comorbidity. For individuals who have experienced a past trauma, this may influence their ability to establish a trusting relationship, which may need to be considered in terms of the therapeutic alliance.

Recommended treatments also need to be feasible and tolerable as well as showing a preponderance of benefit over harm for the patient. Information about the patient's past treatment provides information on the prior benefits and tolerability of specific interventions but may also be relevant to the likely benefits and adverse effects of similar treatments. However, judgments about therapeutic benefits will need to be shaped by information on the adequacy of the treatment trial. For example, a different treatment or combination of treatments may be needed if a patient’s symptoms do not respond to an adequate dose and duration of a medication or to an evidence-based psychotherapy delivered with high fidelity and for adequate duration. If a pattern of treatment resistance is identified, possible contributors need to be assessed and more aggressive treatment instituted to optimize the patient’s functional outcomes.

Information on treatment-related side effects can be important in predicting the tolerability and safety of future treatment (e.g., agranulocytosis with clozapine, neuroleptic malignant syndrome or severe dystonic reactions with antipsychotic medication). Similarly, if adherence has been difficult for the patient in the past, it may suggest difficulties with the tolerability or feasibility of a particular treatment

that would need to be addressed as part of the current treatment plan. Some treatments may be less likely to benefit the patient or more likely to be harmful to the patient depending upon his or her prior psychiatric diagnoses or comorbidities (e.g., antidepressants in depressive episodes that occur in the context of bipolar disorder, use of bupropion in patients with an eating disorder).

Potential Benefits and Harms

In an initial psychiatric evaluation, there are a number of reasons that it is potentially beneficial to determine whether or not the patient has been experiencing abnormalities of mood, anxiety, thought content, thought process, perception and cognition. Such signs and symptoms are important in developing a differential diagnosis and then determining whether or not criteria for a specific DSM diagnosis have been met. Even when symptoms are subsyndromal, they may suggest the presence of additional co-occurring conditions or signal a need for additional treatment to address residual manifestations of illness. The pattern and presence of particular signs and symptoms is often important in considering the potential benefits and risks of treatment options. Baseline data may also be useful in interpreting signs and symptoms that develop during the course of treatment, either related to emergence or progression of underlying psychiatric disorders or as side effects of treatments. There are no plausible harms to determining if the patient is experiencing specific psychiatric signs or symptoms.

Determining whether or not the patient has a history of trauma is also important. Although most traumatized individuals will not develop psychopathology in the aftermath of a trauma, acute stress disorder or posttraumatic stress disorder may be part of the differential diagnosis when trauma-exposed individuals present for a psychiatric assessment. Regardless of whether or not a trauma-related disorder is present, past trauma may need to be specifically addressed as a part of the treatment. Given the emotional impact of traumatic events on individuals, many patients feel relieved to be able to discuss traumatic experiences when these are raised in a sensitive manner. However, it is also possible that raising questions about trauma could cause distress to some patients.

Obtaining information about current and previous psychiatric diagnoses can often be critical in formulating a differential diagnosis. Choosing among treatment options can be aided by determining whether a patient has already had a trial of a particular treatment. If a treatment has been tried in the past, knowledge of the patient's response, including therapeutic benefits and side effects, is relevant to determining whether an additional trial is warranted. In interpreting information about the patient's response, knowledge of the patient's adherence is also important as are specific aspects of treatment (e.g., type, duration, dose).

Assessment of psychiatric symptoms and psychiatric treatment history is by definition a core activity of an initial psychiatric evaluation. Other core activities include identifying the reason that the patient is presenting for evaluation and understanding the patient's background, relationships, life circumstances, strengths and vulnerabilities. Each of these elements can be affected if a patient has been exposed to trauma. As a result, the cost of assessment of these domains is not possible to separate from the overall cost of the evaluation itself, which will vary depending on the patient, the setting, and the model of

payment.

Implementation

As described in the definition of “assessment” (see Glossary) there are a variety of ways that clinicians may perform these recommended assessments. Typically, a psychiatric evaluation involves a direct interview between the patient and the clinician. The specific approach to the interview will depend upon many factors including the patient's ability to communicate, degree of cooperation, illness severity, and ability to recall historical details. In some circumstances, questions on a particular topic (e.g., traumatic experiences) may cause the patient significant distress and may have to be pursued at a later session. Sensitivity can also be needed if a patient has experienced a traumatic event such as physical or sexual assault, as this can influence the ability to establish trust within the therapeutic relationship. Factors such as the patient's vocabulary and cultural background (Thombs et al. 2007; APA 2013a) can also influence the patient's understanding and interpretation of questions and may require additional sensitivity on the part of the interviewer. Patients with intellectual disability or neurocognitive disorders may have difficulty in understanding questions as initially posed. In older individuals, difficulty understanding questions may signal unrecognized impairments in cognition or in hearing that require more detailed assessment. Flexibility may also be needed to frame questions in a clearer manner. At times (such as an evaluation of a patient with severe psychosis or dementia), obtaining information on psychiatric symptoms and history may not be possible through direct questioning.

When available, prior medical records, electronic prescription databases, and input from other treating clinicians can raise previously unknown information. Such sources can also be used to add details or corroborate information obtained in the interview. Family members, friends and other individuals involved in the patient's support network can be important sources of collateral information about the reason for evaluation, the patient's current symptoms and behavior, and past history, including trauma exposure and psychiatric treatment. Additional information such as knowledge of the patient's pre-morbid personality and level of function can help in identifying co-occurring disorders, including neurodevelopmental disorders, and in interpreting the onset and temporal course of the patient's illness. Communicating with family members or other caretaking persons can be particularly important when the patient requires assistance or supervision because of impaired function, unstable behavior or neurocognitive impairment. Communication as part of the initial evaluation can also lay the groundwork for collaborating with the patient and involved family members in planning for and educating them about treatment. The extent of collateral interviews and review of prior records will be commensurate with the purpose of the evaluation, the complexity of the clinical presentation, and the diagnostic and therapeutic goals. For example, in an acute setting, collateral information may be crucial to developing an understanding of the patient’s clinical condition, whereas in long-term outpatient psychotherapy it would be important to consider potential effects on the therapeutic relationship before obtaining collateral information from family or others. Except when immediate safety concerns are paramount, the confidentiality of the patient should be respected. In general, the default position is to maintain confidentiality unless the patient gives consent to a specific intervention or communication. At the same

time, it is permissible for the clinician to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant.

In some clinical contexts, such as a planned outpatient assessment, patients may be asked to complete an electronic- or paper-based form that inquires about psychiatric symptoms and key elements of the psychiatric history. Such forms may be completed prior to the visit or upon arrival at the office and can serve as a starting point to explore reported symptoms or historical information. As an example of such a form, the DSM-5 Level 1 Cross-Cutting Symptom Measure (APA 2013b) can be a useful tool to aid assessment of symptoms that may occur across different psychiatric diagnoses. The tool may be used both during an initial psychiatric evaluation and for subsequent monitoring. A self-report measure exists for adults and for children ages 11–17. A parent/guardian measure exists for children ages 6-17. Online versions of the measure are available at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1. Findings of the Level 1 Measure can be amplified by follow-up questioning or the use of additional measures, such as the DSM-5 Level 2 Cross-Cutting Symptom Measures. To aid the assessment of a patient's exposure to trauma, a brief self-report screening measure, the Trauma History Screen (Carlson et al. 2011), is available on request from the VA National Center for PTSD, at http://www.ptsd.va.gov/professional/pages/assessments/ths.asp.

In addition to inquiring about the reason that the patient is seeking evaluation and learning about his or her current life circumstances, asking open-ended empathic questions about psychiatric symptoms and is a common initial approach to the interview. This can be followed by more structured inquiry about specific symptoms (e.g., worries; preoccupations; changes in mood; suspicions; delusions or hallucinatory experiences; recent changes in sleep, appetite, libido, concentration, memory, or behavior)? What is the severity of the patient's symptoms? Over what time course have these symptoms developed or fluctuated? Are associated features of specific psychiatric syndromes (i.e., pertinent positive or negative factors) present or absent during the present illness? What factors does the patient believe are precipitating, aggravating, or otherwise modifying the illness or are temporally related to its course? If suicidal or aggressive symptoms or behaviors are reported, these will also require further questioning to assess the patient's level of risk, as described in Assessment of Suicide Risk and Assessment of Risk for Aggressive Behaviors. Inquiry about specific symptoms may also be suggested by observations of the patient's behavior during the interview. For example, the presence of tremulousness might prompt questions about anxiety or about typical symptoms of alcohol or substance withdrawal.

Inquiring about a patient's trauma history also begins with open-ended and empathic questions. Individuals may differ in their perception of what constitutes a trauma. Asking about trauma in a non-specific fashion will help identify the experiences that had the greatest impact for the patient as well as giving an opportunity to learn about the patient's coping strengths and resilience in addressing past traumas. Information about traumas, including early adversity, may also be raised by the patient in the context of providing background information about his or his childhood upbringing, developmental

history, school or occupational history, military history, relationship history, or family constellation. A history of childhood physical or sexual abuse is relatively common but may not be raised spontaneously by the patient unless specifically asked. Other follow-up questions about possible trauma will be suggested by other elements of the history (e.g., combat-related trauma in service members, migration stress in immigrants, post-traumatic symptoms relating to medical care in individuals who received major injury or required intensive care).

In obtaining information about the past psychiatric history, questioning may vary in its level of detail at the initial meeting depending on the available time, the patient's recall of information, the patient's level of cooperation, and the complexity and urgency of clinical decision-making. In many situations, the history of past diagnoses and treatments will need to be expanded at subsequent visits or augmented by history from other sources (e.g., prior clinicians, review of medical records). In terms of current and prior psychiatric diagnoses, information about principal and working diagnoses is relevant, when available, with specific attention to co-occurring psychiatric disorders, including neurodevelopmental disorders, neurocognitive disorders, substance use disorders and personality disorders.

In reviewing prior trials of psychiatric treatment, the clinician may begin with open-ended questions about recent treatments, those that have been particularly helpful, and those that have been problematic. Follow-up questions could pursue more details on those treatments and then inquire about other treatments that had not yet been mentioned. Alternatively, a detailed longitudinal history of treatment can be obtained beginning with the patient's initial episode of illness and inquiring about each treatment in sequence. It is useful to inquire specifically about the full range of treatment settings (e.g., outpatient, partial hospital, inpatient) and treatment approaches, including psychotherapies, prescribed medications, electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), self-help groups, 12-step programs, over-the-counter medications, herbal products, nutritional supplements, spiritual healers, and complementary or alternative treatment approaches. In addition to identifying the category of treatment used, additional details are helpful to obtain depending on the type of treatment. Thus, for psychotherapies, it is useful to learn more about the format of therapy (e.g., individual, family, group), its type (e.g., supportive, cognitive behavioral, interpersonal, psychodynamic, exposure with response prevention), the length and frequency of sessions, the duration of the course of therapy, and the quality of the relationship with the treating clinician. With pharmacological treatments (e.g., prescribed medications, over-the-counter medications, herbal products, nutritional supplements), information about the formulation, route, and dose and duration of treatment are important to obtain. With neurostimulatory treatments (e.g, ECT, TMS), the device type, treatment parameters, frequency of treatments, total number of treatments, and duration of the treatment course are important to know, including whether treatment included only an acute course or was followed by less frequent maintenance treatments. Similar information can be obtained for other forms of treatment. Regardless of the details of the treatment itself, it is important to determine how the patient responded to the treatment, both in terms of therapeutic benefits and side effects. When inquiring about therapeutic benefits, it is useful to ask about symptom response and remission as well as changes in quality of life or

levels of functioning and disability. For patients who did not respond to a specific treatment, the adequacy of treatment may depend on the clinical context (e.g., obsessive-compulsive disorder typically requiring higher dose, longer duration treatment with a selective serotonin reuptake inhibitor than major depressive disorder). Such details may be important in judging whether a patient's symptoms appear to be treatment resistant, with associated implications for treatment planning.

Typical side effects of treatment will vary with the treatment being used. Starting with open-ended questions about side effects with a particular treatment can help identify less common side effects that may have occurred and can also illuminate the kinds of side effects that may be of particular importance to the patient. With follow-up questions, the clinician can probe for more details and ask about more common adverse effects of a particular treatment, as indicated.

The clinician may also inquire in an open-ended fashion about the patient's adherence with previous treatments, e.g., by asking about the patient's overall satisfaction with previous treatments and about any difficulties in taking medications (Velligan et al. 2010) or adhering to other forms of treatment. Problems with adherence in older individuals may signal early neurocognitive impairment that would warrant detailed cognitive assessment. Further questions can determine whether adherence problems related to specific side effects of treatment, perceived lack of treatment benefits, personal beliefs about treatment (e.g., culturally related beliefs, personal preferences, family members' response to treatment, delusional ideas), or logistical barriers to treatment (e.g., cost, transportation to appointments, lack of child care). Depending on the clinical context, questions about adherence may extend to asking about court-ordered treatment programs.

These recommendations should not be viewed as an endorsement of a checklist approach to evaluation or as representing a comprehensive set of questions relating to psychiatric assessment. Depending upon the clinical setting, the patient's cooperation and ability to respond, the time available for the evaluation, and the type of treatment planned, some information may be more or less relevant to obtain as part of the initial assessment. The timing of the clinical event may also influence the need to obtain information at the initial interview as well as affecting the level of detail that is required. With some information (e.g., severe medication side effects such as neuroleptic malignant syndrome), details are essential to obtain regardless of when the treatment may have occurred. Often, more recent symptoms, diagnoses, and details of treatment may be of greater relevance than those in the distant past.

The context and accuracy of the information obtained in the interview are also important to keep in mind before applying it to treatment planning. Simply asking about a patient's symptoms or history will not ensure that accurate or complete information is received. In some circumstances, the patient may minimize the severity or even the existence of his or her difficulties, particularly if help-seeking is not voluntary. If observations of the patient's behavior during the interview or other aspects of the clinical presentation seem inconsistent with the patient's reported symptoms or history, additional questioning of the patient or others may be indicated. Factors such as time pressures, interviewing style and clinician

attitudes can also influence the ability to obtain accurate information during the assessment. Thus, the interviewer will want to be aware of his or her own emotions and reactions that may interfere with the evaluation process. Individuals also vary in their ability to recall details of diagnosis and treatment in an accurate manner. Gaps and inaccuracies in patient reports can arise from ordinary errors in comprehension, recall, and expression (Redelmeier et al. 2001; Simon et al. 2012; Patten et al. 2012). More errors occur when recalling more distant events (Patten et al. 2012; Simon et al. 2012). Factors other than time may also play a role in these variations in recall (Leikauf et al. 2013). For example, in older individuals, inconsistencies in the reported history may raise the possibility of a neurocognitive disorder that would warrant more detailed assessment of cognition.

Even when rigorous approaches are used to establish diagnoses, there may be shifts in the patient's diagnosis over time (Bromet et al. 2011; Mueller et al. 1999). Thus, the reported presence of a specific diagnosis in the past does not mean that the same diagnosis is accurate or persists. Issues with the accuracy of recall can also exist with respect to prior treatment (Simon et al. 2012). In addition, the patient's apparent therapeutic response, lack of response, or reported side may not be a direct result of the treatment itself. Rather, they may reflect the natural course of illness (e.g., transitioning to an episode of hypomania or mania), positive or negative life events, concomitant treatments (e.g., drug-drug interactions influencing serum levels, potential for augmenting effects of psychotherapies and medication), or other biologically mediated processes (e.g., cigarette use altering metabolism of prescribed medications).

Barriers to the use of these recommendations also exist, with a major barrier being constraints on clinician time and the need to assess many aspects of the patient's signs, symptoms, and history within a circumscribed period.

Guideline 2. Substance Use Assessment

Guideline statements

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the patient's use of tobacco, alcohol, and other substances (e.g., marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications or supplements.

Rationale

The goal of these guidelines is to improve, during an initial psychiatric evaluation, the identification of patients with a substance use disorder, and to facilitate treatment planning.

The strength of research evidence supporting these guidelines is low. A systematic search identified four studies that address the specific clinical question described under Review of Supporting Research Evidence. The studies found that use of standardized questionnaires and collateral information can improve the identification of risky drinking, alcohol use disorders, and substance use compared to clinical interviews or routine care. All four studies were observational in design, and confounding factors were present in each. Furthermore, the applicability of the studies is limited. The studies mainly investigated the assessment of alcohol use, assessment did not necessarily occur in the context of a psychiatric evaluation, and the settings studied were not representative of the full range of settings in which psychiatric evaluations are performed.

Despite the low strength of this supporting research evidence, there is consensus by experts that assessing the patient's use of tobacco, alcohol, and other substances and misuse of prescribed or over-the-counter medications or supplements as part of an initial psychiatric evaluation has benefits that clearly outweighs the harms.

Additional indirect support for this recommendation comes from studies that have examined screening for tobacco and alcohol use in primary care and other medical settings. Based upon a rigorous systematic review (Fiore et al. 2008), the U.S. Preventive Services Task Force (USPSTF) has concluded that "the net benefits of tobacco cessation interventions in adults and pregnant women remain well established." Accordingly, the USPSTF recommends with high certainty of substantial benefit that clinicians should "ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products" and "ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke" (USPSTF 2009). The USPSTF has also concluded "with moderate certainty that there is a moderate net benefit to screening for alcohol misuse and brief behavioral counseling interventions in the primary care setting for adults aged 18 years or older" (Moyer 2013; Jonas et al. 2012a, 2012b). In addition, the American College of Obstetricians and Gynecologists (ACOG) recommends screening of pregnant women for smoking (ACOG 2010) and for at-risk drinking and alcohol dependence, with behavioral counseling provided if screening is positive (ACOG 2011). They also recommend screening pregnant women for opioid use (ACOG 2012). By extension, screening and behavioral counseling is very likely to be beneficial in psychiatric settings, although further research confirmation is needed. Finally, the substantial rates at which substance use disorders and other

psychiatric disorders co-occur (Grant et al. 2004; Hasin et al. 2007; Compton et al. 2007; Smith et al. 2006; Huang et al. 2006) also implies that screening for alcohol and substance use disorders would be relevant to differential diagnosis. Treatment planning is also influenced by identification of co-occurring substance use disorders and other psychiatric illnesses as well as detection of medical conditions that commonly co-occur with substance use.

Potential Benefits and Harms

Assessment of tobacco, alcohol, and other substance use during the initial psychiatric evaluation may improve identification of patients with substance use disorders, including substance intoxication or withdrawal. Ensuring that initial psychiatric evaluations include assessment of substance use may improve the clinician's differential diagnosis because substance use disorders, other psychiatric disorders, and other medical conditions may share similar presenting symptoms, including anxiety, depression, mania, and psychosis.

If assessment identifies the presence of a substance use disorder, interventions can be offered, and there may be reductions in associated morbidity and mortality, such as from cardiovascular, respiratory, or hepatic diseases; blood-borne and sexually transmitted infectious diseases; injuries from motor vehicle accidents and other trauma; or deaths from suicide. Patients' psychological and social functioning may also be improved. Depending upon the substance being used, provision of appropriate interventions may be associated with reductions in problems such as unemployment, divorce, homelessness, and criminal behaviors.

Potential harms of assessment have not been a focus of study but are likely to be minimal. Identifying a patient as having a substance use disorder when one is not present could result in unneeded treatment. If a patient becomes anxious or annoyed by being asked about substance use, this could interfere with the therapeutic relationship between the patient and the clinician. The cost of assessing substance use is difficult to separate from the overall cost of an initial psychiatric evaluation, which varies depending on the patient, the setting, and the model of payment. Another potential consequence is that time used to focus on assessment of substance use could reduce time available to address other issues of importance to the patient or of relevance to diagnosis and treatment planning.

Implementation

The clinical approach to inquiring about a patient's use of tobacco, alcohol, and other substances will vary with the context of the evaluation and with the patient's presenting symptoms. Typically, questions will focus on current use, but past use may also be relevant in patients with current use or when past use influences planning of treatment, e.g., decision-making about the prescription of medication with potential for misuse or addition of treatment to maintain remission from substance use disorder. The specific substances that are asked about may be licit and illicit, including but not limited to tobacco, alcohol, caffeine, marijuana, cocaine, methamphetamine, club drugs, inhalants, hallucinogens, or heroin.

Questions about misuse of prescribed or over-the-counter medications or supplements can often be

introduced while taking a history of the patient's prescribed medications. Prescribed medications that may be prone to misuse include but are not limited to androgens, benzodiazepines, barbiturates, other sedative-hypnotics, muscle relaxants and opiate medications. Over-the-counter medications or supplements that may be misused include but are not limited to dextromethorphan, diphenhydramine, chlorpheniramine, caffeine, nicotine replacements, laxatives, and creatine. Newer substances of abuse are continuing to emerge and are frequently available over the counter, with names such as "bath salts" or "spice" that can disguise their true nature as substances of abuse.

A straightforward, non-confrontational and open-ended approach to questions will usually elicit the most accurate responses, although individuals may underestimate their level of use or be reluctant to discuss their use of substances. Factors such as time pressures and clinician attitudes can also influence the ability to conduct an accurate assessment. When speaking with patients about their current life circumstances and the reasons they are presenting for evaluation, it can be useful to consider whether unrecognized alcohol or substance use may be contributing to their symptoms or associated with stressors such as recent medical problems, relationship conflicts, traumatic exposures, or school/occupational, financial or legal difficulties. This can also serve as an opening to raise questions about the presence of tobacco, alcohol or substance use. Observations made during the interview can provide additional clues to possible use (e.g., an odor of cigarettes or alcohol on the patient's breath; physical stigmata of injection drug use; slurred speech or other evidence of substance intoxication; tremulousness, abnormal vital signs or other indications of alcohol or substance withdrawal).

Flexibility may be needed in tailoring questions to the individual patient. Slang terms for abused substances may be better understood by patients than medical terminology but the specific words that are chosen may need to vary depending upon factors such as patient age, culture or locality. Family members and others who are involved in the patient's life may be able to give information that helps to identify and corroborate the type and extent of alcohol or substance use. In addition to information from spouses or intimate partners, parents of adult children who are living at home may have observed changes in behavior associated with substance use. Conversely, adult children may have noted signs of alcohol or other substance use in their parents. For individuals who reside in sober houses or community residence programs, affiliated staff members may be able to provide additional information on the patient's alcohol and substance use.

Asking questions during the initial psychiatric interview can also be supplemented by the use of self-report rating scales such as the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure, with administration of the DSM-5 Level 2–Substance Use Measure if the patient gives a positive response on the Level 1 alcohol or substance use items (APA 2013). These measures are available online at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures. Other measurement-based approaches to asking questions about alcohol or substance use include but are not limited to screening tests such as the Alcohol, Smoking and Substance Involvement Screening Test, or ASSIST (World Health Organization 2002); the Fagerström Test for Cigarette Dependence (Fagerström 2012; Heatherton et al. 1991); the Alcohol Use Disorders Identification Test, or AUDIT (Saunders et al. 1993),

or its shortened form the AUDIT-C (Bush et al. 1998); and the Drug Abuse Screening Test, or DAST (Skinner 1982). In some circumstances, information from laboratory testing may be available that provides clues to substance use. Examples include urine toxicology, blood alcohol levels, measures of substance metabolites or biological effects of alcohol use (e.g., abnormal liver function, mean corpuscular volume of erythrocytes). If the patient exhibits signs of intoxication or withdrawal, scales such as the Revised Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar; Sullivan et al. 1989) or the Clinical Opiate Withdrawal Scale (COWS; Wesson & Ling 2003) can be used to document signs and symptoms and guide treatment. When a patient has evidence of tobacco, alcohol, or other substance use in response to screening measures, interview questions, or laboratory testing, additional follow-up questions will generally be needed. Depending upon the substance(s) being used, it may be important to delineate the route, quantity, frequency, pattern, typical setting, and circumstances of use as well as self-perceived benefits and psychiatric and other consequences of use.

Barriers to carrying out an assessment for tobacco, alcohol, and other substance use include the time required for a thorough assessment and lack of certainty that information obtained will be of value in establishing a diagnosis, e.g., because patients may not provide full details about their substance use. In addition, clinicians may be reluctant to ask questions about tobacco, alcohol, or substance use if they fear that it will upset patients, if they lack the time or confidence in their ability to follow through with appropriate interventions, or if resources for treatment are unavailable in the community.

Guideline 3. Assessment of Suicide Risk

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Current suicidal ideas, plans, and intent, including active or passive thoughts of suicide or death
- Prior suicide ideas, plans, and attempts, including attempts that were aborted or interrupted
- Prior intentional self-injury in which there was no suicidal intent
- Anxiety symptoms, including panic attacks
- Hopelessness
- Impulsivity
- History of psychiatric hospitalization and emergency department visits for psychiatric issues
- Current or recent substance use disorder or change in use of alcohol or other substances
- Presence of psychosocial stressors, (e.g., financial, housing, legal, school/occupational or interpersonal/relationship problems; lack of social support; painful, disfiguring or terminal medical illness)
- Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide [2]
- Mood, level of anxiety, thought content and process, and perception and cognition[3]
- Past and current psychiatric diagnoses[3]
- Trauma history[3]

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports current suicidal ideas* include assessment of the following:

- Patient's intended course of action if current symptoms worsen
- Access to suicide methods including firearms
- Patient's possible motivations for suicide (e.g., attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations)
- Reasons for living (e.g., sense of responsibility to children or others, religious beliefs)
- Quality and strength of the therapeutic alliance
- History of suicidal behaviors in biological relatives

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports prior suicidal attempts* include assessment of the details of each attempt (e.g., context, method, damage, potential lethality, intent).

Statement 4. APA recommends (1C) that the clinician who conducts the initial psychiatric evaluation

[2] As recommended in the Assessment of Risk for Aggressive Behaviors
[3] As recommended in the Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History

document an estimation of the patient's suicide risk, including factors influencing risk.

Rationale

The goal of these guidelines is to improve, during an initial psychiatric evaluation, the identification of patients who are at increased risk for suicide.

The strength of research evidence supporting these guidelines is low. However, a substantial body of epidemiologic, cohort, case-control, and psychological autopsy studies have shown associations between the risk factors described in these guidelines and long-term relative risk of suicide or suicide attempts in populations (Arsenault-Lapierre et al. 2004; Assessment and Management of Risk for Suicide Working Group 2013; Baxter & Appleby 1999; Bertolote et al. 2004; Brown et al. 2000; Borges et al. 2010; Carroll et al. 2014; Cavanagh et al. 2003; Conner et al. 2001; Geulayov et al. 2012; Haney et al. 2012; Harris & Barraclough 1997; Hawton et al. 2013; Ilgen et al. 2013; Large et al. 2011; Li et al. 2011; Liu et al. 2014; Milner et al. 2013; Nock et al. 2008). Nevertheless, there is no evidence that assessment of any of these factors can predict suicide in an individual (Assessment and Management of Risk for Suicide Working Group 2013; Brown et al. 2000; Coryell & Young 2005; Goldstein et al. 1991; Haney et al. 2012; King et al. 2001; Large et al. 2011; Pokorny 1993). Similarly, no study has shown the ability of a specific rating scale or assessment instrument to predict suicide in an individual (Assessment and Management of Risk for Suicide Working Group 2013; Haney et al. 2012; O'Connor et al. 2013). Furthermore, the utility of any assessment depends on availability of an effective treatment for the identified disorder or risk factor. Despite these limitations of the available research evidence, there is consensus by experts that the benefits of assessing the factors described in statements 1, 2, and 3 in an initial psychiatric evaluation clearly outweigh the potential harms including unclear costs.

Suicide and suicide attempts occur at an increased rate in individuals with psychiatric disorders (Hawton & van Heeringen 2009, Harris & Barraclough 1997; Assessment and Management of Risk for Suicide Working Group 2013; Baxter & Appleby 1999; Borges et al. 2010; Haney et al. 2012; Li et al. 2013; Nock et al. 2008), and more than 90% of persons who die by suicide satisfy the diagnostic criteria for one or more mental disorders (Conner et al. 2001, Bertolote et al. 2004, Arsenault-Lapierre et al. 2004; Cavanagh et al. 2003). Suicide is rare, even within populations with a specific, high-risk mental disorder, such as major depressive disorder. Nevertheless, when it occurs, it is a devastating outcome for patients, their families, their communities and clinicians. Substantial morbidity also occurs due to suicide attempts and other suicide-related behaviors. Assessment is an essential first step to help clinicians estimate the patient's risk for suicide and other suicidal behaviors. When a patient is judged to be at risk, the clinician may use information obtained during the evaluation to determine an appropriate treatment setting and formulate an individualized treatment plan that addresses specific modifiable risk factors and may include heightened observation.

Potential Benefits and Harms

Inquiring about suicidal thoughts and related risk factors during the initial psychiatric evaluation may improve identification of patients who are at increased risk of suicide. If suicidal thoughts or other

modifiable risk factors are found, specific interventions may be able to reduce the patient's subjective distress, symptom level and overall risk of death or self-injury.

There is no evidence that risk of suicide is increased by asking a patient about prior experiences, symptoms such as hopelessness, or current suicidal ideas or plans. A detailed systematic review on screening for suicide risk in primary care settings also has not identified any serious harms (O'Connor et al., 2013); however, assessment could misidentify individuals as being at significant acute risk when they are not. This could result in unneeded treatment, hospitalization or other consequences for patients. Just as it is not possible to predict which individuals will die by suicide, there is no way to predict which individuals would be incorrectly identified as being at significant acute risk and no way to estimate the potential magnitude of this harm.

The cost of a suicide assessment is difficult to separate from the overall cost of an initial psychiatric evaluation, but both are low relative to the cost of suicide and suicide-related morbidity. . Depending on the clinical characteristics of the patient and constraints such as time and setting, clinicians may prioritize suicide risk assessment over other parts of the evaluation and be unable to address other issues in as much detail.

Documenting an estimation of a patient's suicide risk may improve a clinician's decision-making about the patient's diagnosis and treatment plan and may improve coordination of the patient's treatment with other clinicians. Potential consequences could include reducing time available to inquire about and document other, potentially more important findings of an evaluation.

Implementation

As described in the definition of "assessment" (see Glossary), there are a variety of ways clinicians may obtain recommended information about a patient's suicide risk during an initial psychiatric evaluation. Typically, an evaluation involves a direct interview between the patient and the clinician. In some circumstances (such as an evaluation of a patient with severe psychosis or dementia), obtaining information on history, symptoms, and current mental status may not be possible through direct questioning. With all patients, other sources of information such as prior medical records and other treating clinicians can be important in corroborating information obtained in the interview or in raising previously unknown information. Family members, friends, and others in the patient's support network may be able to provide information about the patient's past history, family history, current mental state, activities, and psychosocial crises or stressors. They may also have observed behavior or been privy to communications from the patient that suggest suicidal ideation, plans, or intentions. Such information can be obtained without the psychiatrist's revealing private or confidential information about the patient. In clinical circumstances in which sharing information is important to maintain the safety of the patient or others, it is permissible to share such information without the patient's consent.

In implementing these recommendations, some terms and concepts do not have precise definitions. Time-based terms such as "current", "recent," or "past" are often used in clinical contexts without a clear meaning. The concepts of active and passive suicidal ideas are commonly used by clinicians to

contrast a specific "active" suicidal thought with “passive” ideas such as indifference to an accidental demise, a wish for death, or a desire to fall asleep and not wake up. The concepts of aborted and interrupted suicide attempts have also been defined in several ways, e.g., that the attempt is stopped prior to fatal injury (Crosby et al. 2011) or stopped before any injury occurs (Barber et al. 1998). In questioning patients about suicidal behaviors, the primary goal is to identify any suicidal behaviors in which an attempt is begun, recognizing that it may not be conceptualized by the patient as a suicide attempt if was stopped or interrupted.

Many suicide risk factors, such as hopelessness, are difficult to assess in a standardized way. In practice, clinicians must apply knowledge of the individual patient's circumstances to formulate useful questions about such risk factors. It would be impossible to list all of the possible elements that may contribute to a reason for living, a psychosocial stressor, a way to access suicide means, or a motivation or plan for suicide. Consequently, the clinician will need to frame specific questions related to these topics based upon other information that has already been gathered in the interview.

Flexibility is also needed in the way that specific information is elicited. For example, to determine the patient's intended course of action if current symptoms or psychosocial stressors worsen, it is important to know which symptoms (e.g., depression, hallucinations, chronic pain, insomnia) or stressors are most upsetting and how these may interact with other factors motivating suicide. However, it is also important to frame the question in a way that gives the patient hope or suggests ways of coping if symptoms were to worsen (e.g., development of a safety plan, strengthen support networks, educate about ways to contact the clinician) and to determine the patient's level of comfort in accessing such strategies. It may be useful to include family or friends in building support and strengthening approaches to coping. In some individuals, suicidal ideas may be motivated by feelings such as loneliness, self-hatred, or a sense of being a burden, not belonging, feeling trapped or having no purpose (van Order et al. 2010; Jobes 2012). Such psychologically painful thoughts may be difficult to share, particularly at an initial interview. Cultural factors are also important to consider when framing questions, since issues such as shame, guilt, or humiliation can be culturally mediated and influence a patient's risk or willingness to discuss suicidal thoughts or plans. If the patient has family members, friends or other social acquaintances who have died by suicide or made suicide attempts, this can affect the patient’s level of comfort in discussing his or her own thoughts and feelings.

Throughout the assessment, clinical judgment is needed in synthesizing information and observations. For example, determining whether the patient shows an "increased use of alcohol or other substances" will require a comparison of patterns of use at two or more points and then determining if a clinically significant change has occurred. Affirmative answers to some questions will often suggest other important lines of inquiry. For example, if a patient reports impulsivity, this may lead a clinician to inquire about traumatic brain injury or thoughts about harming others; if a patient reports a suicide attempt, this may lead a clinician to ask about precipitants, preparatory behaviors, method, physical damage, degree of lethality and subsequent treatment. Information obtained may be relevant across multiple domains of a psychiatric evaluation, e.g., the specific content of a patient’s suicidal thoughts

may be relevant to the clinician's estimation of the patient's risk of aggressive behaviors in addition to his or her risk of suicide.

Determining the quality and strength of the therapeutic alliance is also a multifaceted clinical judgment. At an initial evaluation, information may be limited to behavioral observations such as whether the patient appears to be cooperative with the assessment and forthcoming in answers to questions in contrast to being sullen, guarded, irritable or agitated. Information about the patient's prior treatment relationships and current attitudes toward treatment may also provide insights into whether an alliance is beginning.

When communicating with the patient, it is important to remember that simply asking about suicidal ideas or other elements of the assessment will not ensure that accurate or complete information is received. Patients with intellectual disability or neurocognitive disorders may have difficulty in understanding questions as initially posed. In older individuals, difficulty understanding questions may signal unrecognized impairments in cognition or in hearing. Flexibility may be needed to frame questions in a clearer manner. In other circumstances, the patient may minimize the severity or even the existence of his or her difficulties, particularly if help-seeking is not voluntary. If other aspects of the clinical presentation seem inconsistent with an initial denial of suicidal thoughts, additional questioning of the patient or others may be indicated. Factors such as time pressures, interviewing style and clinician attitudes can also influence the ability to conduct an accurate assessment. Thus, the psychiatrist will want to be aware of his or her own emotions and reactions that may interfere with the interview process. Use of open-ended questions is also more conducive to capturing the nuances and narrative of the patient's concerns, with follow-up questioning as needed to hone in additional details. These recommendations should not be viewed as representing a comprehensive set of questions or endorsing a checklist approach to suicide risk assessment. They also should not be viewed as suggesting the use of a standardized scale to identify individuals at high suicide risk. Many such scales have been designed and studied. Scales may be useful clinically, e.g., to assist the clinician in developing a thorough line of questioning or to open communication with patients about particular feelings or experiences. However, no scale has been shown to provide a numerical score with clinically useful predictive value (Assessment and Management of Risk for Suicide Working Group 2013; Haney et al. 2012; O'Connor et al. 2013). Furthermore, no study has shown an ability to use population-based risk factors or combinations of those risk factors to accurately predict patients who die by suicide (Assessment and Management of Risk for Suicide Working Group 2013; Brown et al. 2000; Coryell & Young 2005; Goldstein et al. 1991; Haney et al. 2012; King et al. 2001; Large et al. 2011; Pokorny 1993). Accordingly, estimation of an individual patient's risk for suicide is ultimately a matter of clinician judgment that requires synthesizing the available information and deciding how to weigh the contributions of multiple factors in estimating the patient's overall risk.

In synthesizing and documenting information gained from the initial evaluation, the clinician will focus primarily on estimating the patient's immediate suicide risk, while also considering longer term contributors to risk that may need to be considered in treatment planning. Depending on the setting, if

risk is judged to be elevated, the focus of the interview may shift to address the patient's safety such as strengthening the patient's support network, developing a safety plan, or arranging for hospitalization.

In the context of suicidal behaviors, risk factors and protective factors interact in complex ways (Kraemer et al. 1997). In estimating suicide risk and developing a plan to address it, it is helpful to distinguish between non-modifiable risk factors and modifiable risk factors. The epidemiological concepts of distal and proximal risk factors can also help in thinking about suicide risk (Mościcki 2001). Distal risk factors reflect underlying vulnerabilities and predispositions while proximal risk factors reflect more immediate precipitants or "triggers" for suicidal behaviors. Although proximal and distal risk factors may each be modifiable, they may require different types of interventions to address risk. Examples of non-modifiable risk factors include demographic variables such as age and sex and factors related to clinical history such as past hospitalizations, past suicidal behaviors, childhood abuse, history of trauma, loss of a child or family history of suicide or psychiatric illness. Although these factors are immutable, their relative impact on suicide risk may vary. For example, the relative risk of suicide can change as a person ages with particularly high risk seen in white males over the age of 65. The risk associated with a prior hospitalization or prior suicide attempt is highest in the weeks to months after the event but still confers some increased risk months or years later. Individuals with multiple suicide attempts or hospitalizations have additional increases in static risk. When there is a history of suicidal ideas, risk may vary depending upon the worst-ever suicidal ideas. Learning about the ways in which the patient kept from acting on suicidal ideas can provide clues about available coping strategies as a protective factor. Where there is a history of suicide attempts, aborted or interrupted attempts, or other self-harming behavior, the patient's estimated risk can be modulated by other features of the suicidal behavior (e.g., psychosocial context, precipitating thoughts, presence of intoxication, timing, method, intent, consequences). Factors such as an early age of onset of depression or impulsive-aggressive traits, in combination with family history, can also be a marker of underlying vulnerability and risk (Mann et al. 2009). Psychiatric diagnoses and serious medical conditions, particularly those that are chronic, debilitating, disfiguring or painful, can also contribute to an increase in the long-term relative risk of suicide (Harris & Barraclough 1997, Hawton & van Heeringen 2009 , Assessment and Management of Risk for Suicide Working Group 2013; Baxter & Appleby 1999; Haney et al. 2012; Ilgen et al. 2013; Li et al. 2013; Nock et al. 2008). Again, the extent of risk can vary depending on factors such as illness severity, recency of diagnosis and the number of comorbid conditions that are present. Among psychiatric disorders, mood disorders, psychotic disorders, anxiety disorders, posttraumatic stress disorder, substance use disorders and disorders associated with impulsivity are most often associated with increased risk.

Superimposed on these non-modifiable risk factors, most patients will also have one or more modifiable factors that influence their suicide risk. Some of these factors are indications of an underlying or newly identified psychiatric disorder and can be reduced by treating the disorder itself or through targeted treatment of the specific sign or symptom. Examples of such signs and symptoms that can influence risk include psychosis, mood changes, hopelessness, insomnia, irritability, agitation, aggressive behaviors

and increases in substance use. In terms of suicidal ideas, the clinician will generally assign a higher level of risk to patients who have high degrees of suicidal intent or describe more detailed and specific suicide plans, particularly those involving accessible means and violent irreversible methods. Psychosocial stressors may serve as precipitants to suicidal behaviors. Examples include lack of social support, stress relating to immigration, bereavement, problematic relationships (e.g., family members, intimate partners, friends, co-workers), and financial, housing, legal or school/occupational problems. Other stressors may be relevant to certain groups of patients, e.g., military service members (Assessment and Management of Risk for Suicide Working Group 2013). These stressors may be modifiable to some degree but they also may be ongoing contributors to risk.

Individuals also have a unique balance between their personal motivations for suicide on one hand and their reasons for living on the other hand. Motivations for suicide can include factors such as revenge, shame, humiliation, delusional guilt, command hallucinations, gaining attention or reaction from others, escaping physical or psychological pain, loneliness, self-hatred, or a sense of being a burden, not belonging, feeling trapped or having no purpose. In contrast, reasons for living can include factors such as religious beliefs, sense of responsibility to children or others, plans for the future or a sense of purpose in life. A strong social support network can also serve as a protective factor.

Given the large number of factors that can modify the risk of suicide, documentation should not intend to review all possible influences. Rather, it provides an estimated level of suicide risk, including factors that influence risk. It may also be helpful to conceptualize the overall risk in terms of underlying non-modifiable risk factors as well as more immediate precipitants that may contribute to acute risk but are more likely to be modifiable. In addition to supporting clinical decision making and communication, such documentation can also serve as a foundation for planning of treatment. When implementing recommendations, a common barrier consists of constraints on clinician time and the need to assess many aspects of the patient's symptoms and history within the time available for the evaluation. Depending on the setting and clinical characteristics of the patient, clinicians may judge some parts of the evaluation as being of greater value in addressing safety concerns and planning initial treatment.

Guideline 4. Assessment of Risk for Aggressive Behaviors

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide
- Prior aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide
- Past aggressive behaviors, e.g., homicide, domestic or workplace violence, and other physically or sexually aggressive threats or acts
- Legal or disciplinary consequences of past aggressive behaviors
- History of psychiatric hospitalization and emergency department visits for psychiatric issues
- Current or recent substance use disorder or change in use of alcohol or other substances
- Presence of psychosocial stressors
- Exposure to violence or aggressive behavior, including combat exposure or childhood abuse
- Past or current neurological or neurocognitive disorders or symptoms

Statement 2. When it is determined during an initial psychiatric evaluation that the patient has aggressive ideas, APA recommends (1C) assessment of the following:

- Impulsivity, including anger management issues
- Access to firearms
- Specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present
- History of violent behaviors in biological relatives

Statement 3. APA suggests (2C) that the clinician who conducts the initial psychiatric evaluation should document an estimation of risk of aggressive behavior (including homicide), including factors influencing risk.

Rationale

The goal of these guidelines is to improve, during an initial psychiatric evaluation, the identification of patients at risk for aggressive behaviors.

The strength of research evidence supporting these guidelines is low. A substantial body of epidemiologic, cohort, and case-control studies have shown associations between the risk factors described in these guidelines and medium- to long-term relative risk of aggression in populations (Coid et al. 2006; Elbogen and Johnson 2009; Eriksson et al. 2011; Falk et al. 2013; Swanson et al. 1990; Ten Have et al. 2013; Van Dorn et al. 2012; Doyle et al. 2012; Doyle et al. 2006; Elbogen et al. 2006; Harford et al., 2013; Whittington et al., 2013; Witt et al., 2013). However, there is no evidence that assessment

of any of these factors can predict aggression in an individual (Buchanan et al. 2012; Singh et al., 2014; Thomas et al., 2005; Singh et al. 2011; Fazel et al. 2012; Rossegger et al., 2013; Large et al., 2011). Similarly, no study has supported the ability of a specific rating scale to predict aggression in an individual. Furthermore, the utility of any assessment depends on availability of an effective treatment for the identified disorder or risk factor. Despite these limitations of the available research evidence, there is consensus by experts that the benefits of assessing the factors described in statements 1 and 2 in an initial psychiatric evaluation clearly outweigh the potential harms including unclear costs.

Potential Benefits and Harms

Inquiring about aggressive and homicidal thoughts and related risk factors during the initial psychiatric evaluation may improve identification of patients who are at increased risk of aggressive behaviors. If aggressive and homicidal thoughts or other modifiable risk factors are found, specific interventions may be able to reduce the patient's subjective distress and diminish the overall risk of harm. For example, assessment may help the clinician to determine an appropriate treatment setting and formulate an individualized treatment plan that may include heightened observation or may target specific modifiable risk factors.

There is no evidence that risk of aggression is increased by asking a patient about prior experiences, symptoms such as impulsivity, or current aggressive and homicidal ideas or plans; however, assessment could identify individuals as being at risk when they are not. This could result in unneeded treatment or hospitalization or other consequences for patients. Just as it is not possible to predict which individuals will exhibit aggressive behaviors, there is no way to predict which individuals would be incorrectly identified as being at risk and no way to estimate the potential magnitude of this harm.

The cost of assessing aggression is difficult to separate from the overall cost of an initial psychiatric evaluation, but both are low relative to the costs and harms of aggressive or homicidal behaviors. Depending on the clinical characteristics of the patient and constraints such as time and setting, clinicians may prioritize assessment of aggression risk over other parts of the evaluation and be unable to address other issues in as much detail.

Documenting an estimation of a patient's aggression risk may improve a clinician's decision-making about the patient's diagnosis and treatment plan and may improve coordination of the patient's treatment with other clinicians. As above, potential harms could include reducing time available to document other, potentially more important findings of an evaluation.

Implementation

As described in the definition of "assessment" (see Glossary) ,there are a variety of ways clinicians may obtain recommended information about a patient's aggression risk during an initial psychiatric evaluation. Typically, an evaluation involves a direct interview between the patient and the clinician. In some circumstances (such as an evaluation of a patient with severe psychosis or dementia), obtaining information on history, symptoms, and current mental status may not be possible through direct questioning. With all patients, other sources of information can be important in corroborating

information obtained in the interview or in raising previously unknown information. When available, prior medical records, input from other treating clinicians and information from family members or friends can provide added details on issues such as recent symptoms, stressors, past history, and family history. Because aggression may have genetic patterns, “family history” should be understood to include any history of abuse or violence in the patient’s biological relatives. Exposure to violence by non-biological family members can also be important to consider.

When communicating with the patient, it is important to remember that simply asking about aggressive ideas or other elements of the assessment will not ensure that accurate or complete information is received. Patients with intellectual disability or neurocognitive disorders may have difficulty in understanding questions as initially posed. In older individuals, difficulty understanding questions may signal unrecognized impairments in cognition or in hearing. Such individuals may also become more agitated when feeling overwhelmed or overloaded with cognitive demands. Flexibility may be needed to frame questions in a clearer and simpler manner. In other circumstances, the patient may minimize the severity or even the existence of his or her difficulties, particularly if help-seeking is not voluntary. If other aspects of the clinical presentation seem inconsistent with an initial denial of aggressive thoughts or prior aggressive behaviors, additional questioning of the patient or others may be indicated. Factors such as time pressures, interviewing style and clinician attitudes including concern for personal safety can also influence the ability to conduct an accurate assessment. Thus, the psychiatrist will want be aware of his or her own emotions and reactions that may interfere with the interview process and also attend to his or her own safety as well as that of the patient.

Some terms and concepts used in these guidelines are impossible to define precisely. Time-based terms such as "current", "recent," or "prior" are often used in clinical contexts without a clear meaning. Many aggression risk factors, such as “impulsivity,” would be difficult or even impossible to assess in a standardized way. A progressive sequence of open-ended questions is more conducive to capturing the nuances and narrative of the patient's concerns and can often provide a starting point for further discussion (e.g., What types of situations can trigger you to become angry? When you do become angry, do you lose your temper easily? How often do angry urges happen and how long do they last? Do you ever get so angry that you feel like you want to hurt someone? Do you ever daydream about hurting others? Are there specific individuals who you have thought of hurting? What helps you calm down when you are feeling angry? What ways do you use to keep yourself from acting on your angry impulses?). Understanding the reasons that the patient is presenting for evaluation is also important in determining the interpersonal and psychosocial context in which aggressive thoughts might arise.

In practice, clinicians must also apply knowledge of the individual patient's circumstances to formulate useful questions about risk factors for aggression. For example, firearms may be readily available in some geographic regions or with some occupations. Relevant psychosocial stressors may commonly include housing problems or homelessness, financial stresses, job loss, relationship loss or lack of social support but may also include other stressors that are particularly salient for a given individual (e.g., public humiliation, victim of violence or bullying, custody disputes or spousal estrangement, grievance

against a specific person including past or current clinicians). In addition, the clinician will need to frame specific questions based upon other information that has already been gathered in the interview. Inquiring about legal or disciplinary consequences of aggressive behaviors such as school expulsions, warrants, arrests, jail or prison sentences, probation, parole or orders of protection, would depend upon the answers to prior questions. When aggressive behaviors have occurred, it is often helpful to learn about the context of those events (e.g., setting, precipitants, object of violence including other people or animals, cultural mediators of behavior including gang membership, associated use of substances or potentially disinhibiting medications, subsequent callousness or remorse). In terms of neurological disorders, common concerns would include traumatic brain injury (Fazel et al. 2009b), but other information from the history or interview may suggest other possible conditions such as intellectual disability or neurocognitive disorders.

Clinical judgment may also be needed in synthesizing information and observations from the interview. For example, determining whether the patient shows an "increased use of alcohol or other substances" will require a comparison of patterns of use at two or more points and then determining if a clinically significant change has occurred. Diagnostic considerations can also be relevant since research studies have identified diagnostic subgroups such as individuals with substance use disorders or antisocial personality disorder, who show an increased relative risk of aggression on a long-term basis in community settings (for more information, see Coid et al. 2006; Elbogen and Johnson 2009; Eriksson et al. 2011; Falk et al. 2013; Swanson et al. 1990; Ten Have et al. 2013; Van Dorn et al. 2012; Doyle et al. 2012; Doyle et al. 2006; Harford et al., 2013; Elbogen et al. 2006, all cited in “Rationale”). Individuals in other settings, including psychiatric inpatient or forensic units, or with specific diagnoses may show somewhat different patterns of risk factors (Cornaggia et al., 2011; Dack et al. 2013; Doyle et al. 2012; Douglas et al. 2009; Fazel et al. 2009a; Fazel et al. 2010), with substantial variability across studies. In nursing home patients, a substantial proportion of individuals with neurocognitive disorders exhibit agitated or aggressive behaviors (Selbæk et al. 2013). Such behaviors are also a common precipitant for hospital admission when a neurocognitive disorder is present (Toot et al. 2013), requiring additional questions about concurrent medical conditions such as infections or recent medication changes.

For an individual patient, other factors may be relevant to clinical decision making about aggression risk. For example, for those whose psychiatric disorder is currently symptomatic the severity of symptoms may be relevant as well as whether they are unusually angry or irritable during the evaluation, feel persecuted by an identified individual, or are experiencing command hallucinations to harm others. Whenever an individual has aggressive or homicidal ideas or behaviors, it is important to identify any intended targets of aggression. If a specific target is identified, the clinician will need to use his or her clinical judgment in deciding whether the patient requires a more supervised setting of care (to provide protection for the identified target and more intensive treatment for the patient) or whether the identified target should be warned of the potential for harm or both. There is also considerable variability by state on the case law and statutes that address Tarasoff duty to protect (Soulier et al. 2010), and the clinician will wish to become familiar with any of the requirements of his or her local

jurisdiction. Assessment of aggressive ideas will commonly be integrated with assessment for suicidal ideation and, if suicidal thoughts are identified, it is important to look for factors that might suggest a possible risk of murder-suicide.

Additional details on conducting a risk assessment for aggressive behaviors can be found in the APA Resource Document "Psychiatric Violence Risk Assessment" (Buchanan et al. 2012) and the supplemental materials posted on the American Journal of Psychiatry website (http://ajp.psychiatryonline.org/data/Journals/AJP/20334/340_ds001.pdf).

These recommendations should not be viewed as representing a comprehensive set of questions relating to aggression risk assessment, nor should they be viewed as an endorsement of a checklist approach to evaluation. Although structured assessments of aggression risk have been developed and studied, none has sufficient predictive validity to identify individuals at high aggression risk in clinical settings (Singh et al. 2011; Buchanan et al. 2012; Fazel et al. 2012; Singh et al. 2014; Thomas et al. 2005; Rossegger et al. 2013; Large et al. 2011). Accordingly, estimation of an individual patient's risk for aggression is ultimately a matter of clinician judgment that requires synthesizing the available information and deciding how to weigh the contributions of multiple factors, including those that may prevent the patient from acting on aggressive ideas. This clinical decision-making process and a discussion of the factors that are judged to influence the risk of aggressive behavior for the individual patient can be included as part of the clinical documentation, typically in a brief paragraph. Distinctions between modifiable risk factors (e.g., alcohol or substance use, psychosis) that could be reduced by treatment (Swanson et al. 2008; Elbogen et al. 2006) or other interventions and static nonmodifiable risk factors (e.g., age, sex, clinical history) are also important to note in assessing and documenting risk and arriving at a plan for addressing it.

When implementing recommendations, a common barrier consists of constraints on clinician time and the need to assess many aspects of the patient's symptoms and history within the time available for the evaluation. Depending on the setting and clinical characteristics of the patient, clinicians may prioritize some parts of the evaluation and documentation process that are judged to have greater value in addressing safety concerns and planning initial treatment.

Guideline 5. Assessment of Cultural Factors

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the patient's need for an interpreter.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of cultural factors related to the patient's social environment.

Statement 3. APA suggests (2C) that the initial psychiatric evaluation of a patient include assessment of the patient's personal/cultural beliefs and cultural explanations of psychiatric illness.

Rationale

The goal of these guidelines is to improve, during an initial psychiatric evaluation, identification of cultural factors that could influence the therapeutic alliance, promote diagnostic accuracy, and enable appropriate treatment planning.

The strength of research evidence supporting these guidelines is low. Despite this, there is consensus by experts that the benefits of including the assessments described in statements 1 and 2 in an initial psychiatric evaluation clearly outweigh the potential harms.

Individuals present for psychiatric assessment with a wide range of backgrounds, cultures, and beliefs. Data from the American Community Survey (2010) show that the U.S. population is extremely diverse in its ancestry and racial and ethnic characteristics. About 13% of persons living in the United States were born in a different country, with about one-half of these individuals born in Latin America and about a one-quarter in Asia. Approximately one-fifth of the U.S. population, about 60 million individuals, speak a language other than English in their home. Of these individuals, slightly more than one-half also speak English very well. Nevertheless, increasing numbers of individuals in the United States have limited proficiency in English, which can affect their receipt of appropriate health care.

No study has specifically examined if health outcomes are improved when an initial psychiatric evaluation includes assessment of the patient's language needs and culture. Available studies do suggest, however, that discordance between the patient's and the clinician's language or limitations in English proficiency challenge health-related communication, reduce diagnostic reliability, decrease the effectiveness of care, and heighten the risks of treatment in psychiatric (Bauer & Alegría 2010; Bauer et al. 2010; Leng et al. 2010; Kim et al. 2011) and nonpsychiatric (Wilson et al. 2005; Fernandez et al. 2011) settings. Furthermore, in nonpsychiatric settings, the use of professionally trained interpreters when evaluating patients with limited English proficiency has been found to reduce communication errors and enhance comprehension of medical information, health care utilization, clinical outcomes, and satisfaction with care (Karliner et al. 2007).

On the basis of this indirect research evidence and common sense, assessing a patient's need for an interpreter during an initial psychiatric evaluation is a necessary first step to promote effective

communication between the patient and the clinician. This is true even when the patient speaks the same language as the clinician. Some patients will speak more than one language and have differing levels of fluency in each. Verbal and written language fluency may be discordant, and comprehension may differ from spoken language fluency. Even when an interpreter is not used, knowledge of the patient's language ability may help the clinician tailor his or her communications appropriately, e.g., use vocabulary the patient understands or provide written educational materials in the patient's preferred language and at his or her reading level.

Factors such as age, ethnicity, gender, race, religion, and sexuality can shape a patient's personal and cultural identity as well as influence his or her communications with mental health professionals. Some of these factors, including sex, race, ethnicity, and sexual orientation, have been found to be associated with disparities in medical care and health outcomes (Institute of Medicine of the National Academies 2003; Lagomasino et al. 2005; Gone & Trimble 2012; Thomas et al. 2011; Hall-Lipsy & Chisholm-Burns 2010; Vega et al. 2009; Primm 2006).

Individuals from different backgrounds may also differ in their explanations of illness, views of mental illness and preferences for psychiatric treatment, particularly given the cross-cultural differences in the stigma of psychiatric disorders (Angermeyer & Dietrich 2006; Abdullah & Brown 2011, Jimenez et al. 2012). For example, an individual's self-concept, response to stressors, or current symptomatology may be shaped by racism, sexism, or discrimination; by traumatic experiences during or after migration from other countries; or by challenges of acculturation, such as intergenerational family conflict. Cultural factors can also influence the patient's style of relating with authority figures such as health care professionals. The relevance of cultural factors to both diagnosis and treatment suggest potential benefits of identifying personal and cultural factors and integrating that understanding into the provision of care including psychoeducation and other interventions to address culturally related stigma and shame. Such an approach has been recommended by experts (Mezzich et al. 2009; Yamada & Brekke 2008) and organizations including APA (DSM-5 Cultural Formulation Interview), the Joint Commission (The Joint Commission (a), Accessed on September 16, 2012; The Joint Commission (b), Accessed on September 16, 2012), and the U.S. Department of Health and Human Services, Office of Minority Health (National Standards for Culturally and Linguistically Appropriate Services in Health Care, Accessed on October 5, 2014).

Clinicians can improve their ability to assess cultural factors that are relevant to diagnosis and treatment by using an assessment instrument such as the DSM-5 Cultural Formulation Interview and by learning about cultures that are represented among their patients.

Potential Benefits and Harms

In an initial psychiatric evaluation, the clinician typically gathers information about a patient through a face-to-face interview. There are obvious potential benefits to ensuring that the patient's need for an interpreter is assessed early in the evaluation. Use of an interpreter could improve the accuracy of diagnosis by allowing the patient to communicate nuances of his or her mental state and symptoms. It

could also ensure the formulation and implementation of an appropriate treatment plan and assist the clinician in providing education about symptoms, potential treatments, and their possible side effects. There are no plausible harms of assessing the need for an interpreter, and the cost of the assessment seems negligible.

Similarly, the potential benefits of inquiring about a patient's cultural beliefs, cultural explanations of illness, and cultural factors related to his or her social environment during an initial psychiatric evaluation include promoting a therapeutic alliance, improving the accuracy of a diagnosis, and ensuring the formulation of an appropriate treatment plan. For example, for cultural reasons, a patient may consider some treatments to be particularly valuable and others unacceptable. Furthermore, interventions may be available that are designed for patients with a specific cultural background or that are designed to address disparities in the care of specific populations such as ethnic minorities. Knowledge of the patient's sociocultural environment may help the clinician to choose interventions that take advantage of the patient's existing networks of support.

Potential harms of a cultural assessment, e.g., if done poorly, could include offending the patient and damaging the alliance. The cost of doing a cultural assessment is difficult to separate from the overall cost of an initial psychiatric evaluation, which varies depending on the patient, the setting, and the model of payment. When time is used to focus on cultural issues, this could reduce time available to address other issues of importance to the patient.

Implementation

For many patients, language needs can be easily determined. For others, assessment may need to establish both the need for an interpreter and the appropriateness of different interpreter options. This may be apparent at the time an appointment is being scheduled, but it may also be identified as a need at the time of the initial visit. Although language-concordant physicians or trained in-person interpreters have typically been used (Locatis et al. 2010), telephonic and video-based options for accessing professional interpreters are increasingly available and offer greater patient privacy (Gany et al. 2007). However, remote interpreting services can be more challenging to use if patients speak softly or are unable to cooperate fully with the interview. Some individuals who are deaf or hard-of-hearing may prefer to communicate through an in-person or video-based sign language interpreter, whereas others prefer to communicate through other approaches (e.g., lip reading, face-to-face keyboards, writing) (Fellinger et al. 2012).

Psychiatrists and other mental health professionals may speak more than one language and may be able to communicate in the patient's preferred language. Even if the clinician is reasonably fluent in the patient's preferred language, there may be situations in which a trained interpreter may have a greater understanding of the nuances of the patient's communication. In addition to considering concordance of language per se, clinicians and interpreters will want to consider the effects that different dialects and uses of idiom can have in the communication process.

With respect to the assessment of a patient's culture, beginning with open-ended questions is likely to

be more conducive to learning about the individual and his or her beliefs. These questions may flow naturally from the reasons that the patient presents for evaluation or may require more specific attention during the interview. An individualized approach is important because there is substantial heterogeneity of individual beliefs including those related to cultural factors. Even the definition of cultural factors and personal/cultural beliefs is vague and broad in scope, with significant overlap with other biopsychosocial influences. Individuals within a specific cultural group will have a wide range of beliefs relating to that culture. Some patients will use culturally specific treatments including medications, supplements, health practices, and consultation with culturally specific healers. Other treatments may be prohibited or misunderstood due to cultural beliefs. There is also substantial heterogeneity in the degree to which an individual patient may gain support or feel estranged from cultural networks, making it important to explore the patient's views and feelings. When they are present, cultural networks (e.g., religious affiliations, tribal supports, military command structure) can help to enhance a patient's social ties and supports. In many cultures, families play an important source of support during times of illness and in some cultures treatment decisions are made by family members rather than by the individual. Family members or members of a patient's cultural group may also be helpful in explaining the patient's belief system and whether the patient's current beliefs and behaviors are at odds with it. Examples may include spiritual beliefs that are not part of an organized religion or cultural or religious rituals, including food preferences.

A number of barriers exist to conducting such an assessment including underlying cultural biases of clinicians and the time needed to conduct a thorough exploration of culturally related beliefs, influences, and networks. Some clinicians are unsure of the value of assessing cultural factors or feel unskilled in conducting a complex assessment of this type. In some settings, elements of the assessment may be elicited by other mental health professionals and can serve as the starting point for the psychiatrist's evaluation. In other situations, the psychiatrist will wish to begin assessment of culture factors at the initial evaluation, particularly as they relate to the patient's presenting problem. More detailed inquiry can then occur as the therapeutic relationship develops, the patient's sociocultural context changes, or other findings suggest the need for in-depth knowledge of the patient's culturally related beliefs.

For clinicians who lack experience in assessing cultural factors, the DSM-5 Cultural Formulation Interview (APA 2013) offers a semi-structured framework for initiating questioning relating to key elements of the cultural identity of the individual, cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and resilience and cultural features of the relationship between the individual and the clinician. Depending upon the patient's answers to initial questions in the interview, supplementary modules are available to guide detailed questioning.

Guideline 6. Assessment of Medical Health

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of whether or not the patient has an ongoing relationship with a primary care health professional.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- General appearance and nutritional status
- Involuntary movements or abnormalities of motor tone
- Coordination and gait
- Speech, including fluency and articulation
- Sight and hearing
- Physical trauma, including head injuries
- Past or current medical illnesses and related hospitalizations
- Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments
- Allergies or drug sensitivities
- Sexual and reproductive history
- Past or current sleep abnormalities, including sleep apnea

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of all medications the patient is currently or recently taking and the side effects of these medications, i.e., both prescribed and non-prescribed medications, herbal and nutritional supplements, and vitamins.

Statement 4. APA suggests (2C) that the initial psychiatric evaluation of a patient also include assessment of the following:

- Height, weight, and body mass index (BMI)
- Vital signs
- Skin, including any stigmata of trauma, self-injury, or drug use
- Cardiopulmonary status
- Past or current endocrinological disease
- Past or current infectious disease, including sexually transmitted diseases, HIV, tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease
- Past or current neurological or neurocognitive disorders or symptoms
- Past or current symptoms or conditions associated with significant pain and discomfort

Statement 5. In addition to a psychiatric review of systems, [4] APA suggests (2C) that the initial psychiatric evaluation of a patient include a review of the following systems:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Rationale

The goal of these guidelines is to improve, during an initial psychiatric evaluation, identification of nonpsychiatric medical conditions that could affect the accuracy of a psychiatric diagnosis and the safety of a psychiatric treatment plan.

The strength of research evidence supporting statements 1, 2, and 3 is low. As described under "Review of Available Supporting Research Evidence," studies were identified that do address whether diagnostic accuracy is improved by physical assessment or a medical history, but these elements of the evaluative process were not examined as discrete interventions. The studies also do not address whether treatment safety is affected by physical assessment, medical history, review of medications, or review of systems, or whether diagnostic accuracy is affected by review of medications or review of systems. The lack of generalizability of these studies is an additional factor that weakens their strength. Despite this, there is consensus by experts that including the assessments described in statements 1, 2, and 3 in an initial psychiatric evaluation has benefits for diagnostic accuracy and treatment safety that clearly outweigh the potential harms.

Individuals with psychiatric disorders can have medical conditions that influence their functioning, quality of life, and lifespan. Relative to the general population, mortality rates are increased for individuals with mental illness, particularly those with psychotic disorders, depressive disorders, alcohol/substance use disorders, personality disorders and delirium (Chwastiak et al. 2010; Markkula et al. 2012; Chang et al. 2010; Haklai et al. 2011; Honkonen et al. 2008; Lemogne et al. 2013; Witlox et al. 2010; Fok et al. 2012; Høye et al. 2013). Estimates suggest that the lifespan of an individual with a

[4] Recommended in Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History

mental illness is approximately 8 years shorter than the lifespan of individuals in the general population (Druss et al. 2011). For individuals with serious mental illness, the reduction is even more dramatic: up to 25 years (Saha et al. 2007; Parks & National Association of State Mental Health Program Directors Medical Directors Council 2006). Individuals with mental illness have increased cardiovascular mortality (Parks & National Association of State Mental Health Program Directors Medical Directors Council 2006; Miller et al. 2006; Morden et al. 2012; Osborn et al. 2007; Piatt et al. 2010; Newcomer & Hennekens 2007; Roshanaei-Moghaddam & Katon 2009), a greater incidence of medical conditions (Osborn et al. 2007; Kisely et al. 2008; McGinty et al. 2012; Dickerson et al. 2006a; Leucht et al. 2007), greater risk of injury (Piatt et al. 2010; McGinty et al. 2013), and greater rates of health risk factors such as obesity and tobacco use (Dickerson et al. 2006b; Lawrence et al. 2009; Osborn et al. 2006). Dental health is also poorer in those with severe mental illness (Leucht et al. 2007; Kisely et al. 2011) and can contribute to health risks such as community acquired pneumonia and endocarditis. Physical functioning is often reduced as well (Chafetz et al. 2006) and may be independently associated with mortality risk (Hayes et al. 2012). When individuals with a serious mental illness are diagnosed with medical conditions, they may be less aware of their concomitant disorders than individuals without a mental illness (Kilbourne et al. 2006). In addition, the quality and type of treatment they receive is frequently disparate from care received by the general population (Goldberg et al. 2007; Mitchell et al. 2009; Mitchell et al. 2012; Salsberry et al. 2005; Druss et al. 2011; Kilbourne et al. 2008; Kisely et al. 2011). Furthermore, some individuals with mental illness may be unable to understand and adhere to treatment for their illness. These disparities in care for those with psychiatric illness worsen the morbidity and mortality due to medical conditions as compared to individuals in the general population.

Psychiatric and medical issues are interdigitated in a number of other ways. Medical conditions can contribute to the genesis of psychiatric symptoms and syndromes (APA 2013; David et al., eds., 2009) or can complicate the diagnosis of psychiatric disorders. For example, an individual with hyperthyroidism may develop symptoms of anxiety. A frontal lobe tumor may result in a mood syndrome or neurocognitive impairment. An individual with uremia or obstructive sleep apnea may feel apathetic, fatigued, and inattentive, wrongly implying the presence of depression even in the absence of mood changes.

Knowledge of the medications that a patient is taking is also important. Medications used to treat medical conditions can interact with psychotropic medications (Sinclair et al. 2010; Ferrando et al., eds., 2010; Zorina et al. 2013). Many individuals receiving psychiatric treatment are taking multiple medications, which magnifies the likelihood of drug-drug interactions (Sandson et al. 2005; Haueis et al. 2011; Mojtabai & Olfson 2010; Thomas et al. 2010). Patients may also be taking nonprescribed medications such as nutritional supplements or herbal products (Freeman et al. 2010; Ravindran & da Silva 2013; Meeks et al. 2007), which can interact with psychotropic medications, influencing therapeutic benefits or side effects. Side effects of somatic treatments for psychiatric conditions can also produce or increase the risks of pre-existing medical conditions (Goldberg & Ernst 2012). Other medication effects can mask physical findings that are important to clinical decision-making. For

example, a beta adrenergic receptor antagonist can blunt changes in vital signs (e.g., tachycardia, elevations in blood pressure) that signal alcohol or benzodiazepine withdrawal. In addition, medications can be associated with false positive results on toxicology testing (Rengarajan & Mullins 2013; Brahm et al. 2010) or modify other laboratory findings leading to an incorrect diagnosis. Lack of information or confusion about prescribed medications and dosages can also contribute to medical errors (Procyshyn et al. 2010; Tully et al. 2009; Fitzgerald 2009).

Given the above, an understanding of the patient's medical status is important to (1) properly assess the patient's psychiatric symptoms and their potential cause, (2) determine the patient's need for medical care, and (3) consider potential effects on the patient's medical conditions or related treatments when choosing among psychiatric treatments.

Potential Benefits and Harms

In an initial psychiatric evaluation, determining whether or not the patient has an ongoing relationship with a primary care health professional is potentially beneficial from several vantage points. In patients who are already receiving medical care, communication with the primary care professional could be useful in coordinating assessments and treatment. If the patient has had a recent medical assessment, the psychiatrist may be able to review the results of the history, physical examination, and laboratory or imaging findings in lieu of a direct assessment of the patient. Such information is often important in formulating a differential diagnosis and considering the benefits and risks of potential treatment options. There are no plausible harms to determining if the patient has a relationship with a primary care professional.

Similarly, there are many potential benefits to ensuring that the initial psychiatric evaluation includes assessment of the aspects of the patient's medical health listed in statement 2. Signs and symptoms of illness may be consistent with either a psychiatric disorder or another medical condition. Differential diagnosis can be aided by knowledge of past or current non-psychiatric medical disorders. Previously unrecognized medical illnesses may also be identified and addressed directly or by referral to another clinician. Baseline data about medical conditions may be useful later in interpreting physical signs and symptoms that emerge in the course of treatment, either related to progression of underlying medical conditions or as side effects of psychiatric treatments.

The potential benefits of knowing the medications that a patient is taking are also multi-faceted. Use of prescribed medications, over-the-counter medications, vitamins, nutritional supplements, and herbal products can be associated with psychiatric signs and symptoms that would be relevant to differential diagnosis. These medications can also interact with medications for psychiatric conditions and thereby influence treatment planning.

The cost of assessing these aspects of the patient's medical health is difficult to separate from the overall cost of an initial psychiatric evaluation, which varies depending on the patient, the setting, and the model of payment. When time within the initial psychiatric evaluation used to focus on assessment of aspects of the patient's medical health, this could reduce time available to address other issues that

are of importance to the patient or of relevance to diagnosis and treatment planning.

Implementation

As described in the definition of “assessment” (see Glossary), there are a variety of ways clinicians may obtain recommended information about a patient’s medical health during an initial psychiatric evaluation. Typically, an evaluation involves a direct interview between the patient and the clinician. In some circumstances (such as an evaluation of a patient with severe psychosis or dementia), obtaining information on history and review of symptoms may not be possible through direct questioning. When available, prior medical records, electronic prescription databases, input from other treating clinicians and information from family members or friends can raise previously unknown information. Added details or corroboration of information obtained in the interview is often helpful since gaps in patient report can arise from ordinary errors in comprehension, recall, and expression (Redelmeier et al. 2001; Ryan et al. 2013; Simon et al. 2012). Flexibility may be needed in framing questions in terms that patients or family members are able to understand. For example, patients with intellectual disability or neurocognitive disorders may have difficulty in understanding questions as initially posed. In older individuals, difficulty understanding questions may signal unrecognized impairments in hearing or in cognition that would benefit from more detailed evaluation.

In some clinical contexts, such as a planned outpatient assessment, patients may be asked to complete an electronic- or paper-based form that inquires about key elements of the medical history and review of systems. Such forms may be completed prior to the visit or upon arrival at the office and can serve as a starting point to explore reported symptoms or historical information. Discussion may also be initiated with a brief open-ended question, which is conducive to capturing the nuances and narrative of the patient's concerns. Thus, with the sexual history, a patient may be asked "Do you have any sexual concerns or problems that you would like to discuss?" or "Are you sexually active?" (Althof et al. 2013), with follow-up questions asked (e.g., about contraceptive use), as indicated. Laboratory data or findings of electrocardiography, imaging studies, other radiological investigations or neuropsychological testing may also provide clues to past or current medical conditions

These recommendations should not be viewed as an endorsement of a checklist approach to evaluation nor are they intended to be comprehensive. For example, there are frequent overlaps between medical health and substance use disorders, but recommendations for substance use assessment are provided in Substance Use Assessment. Depending upon the clinical setting and type of treatment, some information may be more or less relevant to obtain as part of the evaluation. Thus, it may be important to assess diseases and symptoms of disease that have a high prevalence among individuals with the patient’s demographic characteristics and background, such as infectious disease in a patient who uses intravenous drugs or pulmonary and cardiovascular disease in a patient who smokes. Identifying a family history of hyperlipidemia or early cardiac death would be more relevant to obtain in an individual with multiple cardiac risk factors or risk for metabolic syndrome. A detailed review of systems may be less crucial in a generally healthy individual who receives regular primary preventive care although the Current Procedural Terminology and the United States Center for Medicare and Medicaid Services

describe the review of systems as a part of a comprehensive evaluation (Schmidt et al., 2010; Centers for Medicare and Medicaid Services. Evaluation and Management Services Guide. Accessed on October 5, 2014). In patients who will be treated with psychotherapy by the psychiatrist who is performing the evaluation, some aspects of the history (e.g., sexual and reproductive history) may be more appropriate to defer until later in treatment.

Information may also be more or less relevant to obtain based on the timing of a clinical event. Time-based terms such as "current," "recent," or "past" are often used in clinical contexts but are impossible to define precisely and introduce vagueness into recommendations. With some information (e.g., allergies), details are essential to obtain regardless of when the clinical event may have occurred. With other information (e.g., minor surgical procedures, minor trauma), more recent events may be of relevance whereas events in the distant past would be of minimal importance to elicit in a thorough fashion.

To determine whether the patient has an ongoing relationship with a primary care health professional requires gathering additional information besides a simple recording of the clinician's name. Some patients may be assigned to a primary care health professional, yet rarely meet with the individual or receive preventive care. Under such circumstances, inquiring about the patient's relationship with his or her primary care practitioner can be a starting point for improved access to quality health care and preventive services. For individuals who are receiving care from multiple specialty physicians, initial questions about having a primary care health professional can be followed up with additional questions about other clinicians who are providing them with care. Obtaining a complete and accurate list of the patient's medications can be challenging but has many implications for diagnosis and avoiding medication errors. When asked about the medications that they are taking, most patients think in terms of prescriptions they receive at a pharmacy, but they may not report receiving long-acting injectable antipsychotic medications, oral or long-acting injectable contraceptives or non-prescribed medications (e.g., over-the-counter medications, vitamins, herbal products, nutritional supplements) unless specifically asked. Approaches that have been employed to develop an accurate medication list include a structured format for the medication history (Drenth-van Maanen et al. 2013) or involving hospital-based clinical pharmacists or pharmacy technicians in taking a medication history (Kwan et al. 2013; Brownlie et al. 2013). With the use of electronic prescribing and electronic health records, information on patients' previous medications will be increasingly available to clinicians. Again, this data can be used as a starting point for discussion but still requires verification by the clinician to assure that the electronic information is correct and consistent with the patient's current use of the medication and pattern of adherence. Particularly with older individuals, it can be useful to remind patients to bring a current list of their medications and bring all of their medication bottles from home at the time of the visit. If a patient's recall of medications is inconsistent or erroneous, it may signal a need for detailed cognitive examination to identify possible neurocognitive impairments that would pose medication safety risks or interfere with adherence.

The physical examination may be performed by the psychiatrist, another physician, or a medically

trained clinician. Elements of the examination such as vital signs, height and weight may also be obtained by nursing staff or a medical assistant. The results of the patient's most recent physical examination may also be relied upon in obtaining information about the patient's physical status. Considerations influencing the decision of whether the psychiatrist will personally perform the physical examination include potential effects on the psychiatrist-patient relationship, the purposes of the evaluation, and the complexity of the medical condition of the patient. The timing and scope of the examination will vary according to clinical circumstances. In some individuals, portions of the examination (e.g., vital signs) may be important to perform as soon as possible to identify an urgent need for referral (e.g., in a patient with symptoms of alcohol withdrawal). In other individuals, it may be appropriate to defer the examination. For example, the physical examination of an otherwise healthy patient with paranoia may be deferred to a different clinician or a more appropriate time or setting. Depending upon the setting and type of treatment, transference issues could arise and interfere with effective treatment if the psychiatrist conducts the physical examination him or herself. If physical assessments are done as part of the evaluation rather than relying on examinations by other health professionals, provisions for chaperones should be considered.

Barriers to the use of these recommendations also exist, with a major barrier being constraints on clinician time and the need to assess many aspects of the patient's symptoms and history within a circumscribed period. Depending on the setting, general health status and other clinical characteristics of the patient, clinicians may judge other parts of the evaluation as having a greater priority in planning initial treatment. In terms of conducting a physical examination, assessment of some organ systems may be viewed as being outside the scope of typical psychiatric practice. In addition, many psychiatrists, particularly in an outpatient setting, will not have access to a fully equipped room for conducting physical examinations. For medically ill patients, elements of the physical examination such as gait may not be possible to assess due to the severity of the patient's condition. In other individuals, the severity of their psychiatric illness may limit their ability to collaborate with a general medical history, medication history, review of systems and physical examination.

Guideline 7. Quantitative Assessment

Guideline statements

APA suggests (2C) that the initial psychiatric evaluation of a patient include quantitative measures of symptoms, level of functioning, and quality of life.

Rationale

The goal of these guidelines is to improve, during and after an initial psychiatric evaluation, clinical decision-making and treatment outcomes.

The strength of supporting research evidence for this guideline statement is low. Two studies were identified that compared the use of a quantitative measure to clinical interview in patients who presented with a psychiatric symptom, sign, or syndrome and that looked for an impact on clinical decision-making. Both studies were observational in design, and both examined the use of a scale that assessed only for delirium. Use of the scale was associated with greater diagnostic accuracy as compared to assessment without the scale, but the effect was weak and the study population was limited to patients in an intensive care setting.

Many studies have addressed the development, use, and statistical characteristics of psychiatric rating scales, but there have not been specific comparisons of these measures and non-quantitative assessment. In addition, there has not been specific examination of effects on clinical decision-making. Nevertheless, other studies have examined potential benefits and utility of quantitative measures in psychiatric practice and contribute to the rationale for using ratings scales in clinical practice. For example, in addition to use of the self-rated 9-item Patient Health Questionnaire (PHQ-9) in depression screening, benefits have been found when the PHQ-9 is used for ongoing monitoring of depressed patients, either by psychiatrists (Chung et al. 2013; Katzelnick et al. 2011; Duffy et al. 2008; Arbuckle et al. 2013) or in primary care settings (Yeung et al. 2012). The STAR-D study (Trivedi et al. 2007; Trivedi 2009) and other studies (Zubkoff et al. 2012; Allen et al. 2009; Zimmerman & McGlinchey 2008; Bickman et al. 2011; Zimmerman et al. 2011) have shown success in the clinical implementation of quantitative measures and in the use of measurement-based approaches to clinical decision-making, i.e., “measurement-based care.” An additional study that randomized patients to monthly use of standardized measures compared to treatment as usual showed a reduction in inpatient days, although subjective outcomes were unaffected (Slade et al. 2006). In studies of psychotherapy, systematic rating scales have been used to provide “outcome-informed treatment” in which patients provide feedback on levels of distress as well as on facets of the therapeutic alliance and perceived benefits of treatment (Boswell et al., in press).

The field trials for the DSM-5 also demonstrated the feasibility and reliability of using the DSM-5 Level 1 Cross-Cutting Measures in clinical practice (Narrow et al. 2013). Furthermore, research studies have demonstrated the validity and reliability of many quantitative measures including both self- and clinician-administered scales, which can also be useful in routine clinical practice (Rush et al. 2008).

Despite insufficient research evidence, many experts agree that clinical decision-making is improved by the use of quantitative measures in an initial psychiatric evaluation. Intuitively, and by analogy with other medical specialties in which standardized measurement (e.g., of physiological signs or laboratory tests) guides treatment, the use of a systematic and quantifiable approach to assessment would seemingly produce better patient outcomes and greater standardization of care across patients (Harding et al. 2011). Other experts contend that the benefits are uncertain or depend on clinical factors such as the setting of the evaluation and individual patient characteristics. Furthermore, expert opinion suggests that quantitative measures may not have clear advantages to a comprehensive interview by an experienced clinician and may even have disadvantages such as inflexibility and cost, which are not clearly outweighed by the burden of using measures. These differences of opinion are reflected in the results of a survey of experts conducted by APA, as described under "Review of Supporting Research Evidence."

Potential Benefits and Harms

Clinical decision-making, including but not limited to diagnosis and treatment planning, requires a careful and systematic assessment of the type, frequency, and magnitude of psychiatric symptoms as well as an assessment of the impact of those symptoms on the patient's day-to-day functioning and quality of life. There are a number of potential benefits to obtaining this information as part of the initial psychiatric evaluation through the use of quantitative measures. Compared with a clinical interview, quantitative measures may help the clinician to conduct a more consistent and comprehensive review of the multiplicity of symptoms that the patient may be experiencing. This may prevent the patient and the clinician from overlooking symptoms that are of potential relevance to diagnosis, treatment planning, and other clinical decision-making. For example, subthreshold symptoms or comorbid subsyndromal conditions may be identified that are relevant to treatment planning and functioning. Similarly, the use of quantitative measures to assess the patient's level of functioning and quality of life may provide information about how illness affects the patient's daily life that is more consistent and comprehensive than information gained by clinical interview. Measures of the patient's level of functioning and quality of life may also signal the need for psychiatric or psychosocial interventions that target specific aspects of disability. If co-occurring medical illnesses are affecting level of functioning and quality of life, this may signal a need for consulting and collaborating with other treating clinicians or strengthening the patient's ability to cope with a chronic medical condition. Using systematic measures may also increase the efficiency of asking routine questions and allow more time for clinicians to focus on symptoms of greatest severity or issues of most concern to the patient.

Another key potential benefit of obtaining quantitative measures during an initial evaluation is to establish baseline measurements against which progress can be measured as treatment unfolds. For example, baseline data may help the clinician later to assess the adequacy of treatment or the need for treatment modifications as well as to interpret symptoms that emerge during the course of treatment, either related to progression of underlying psychiatric disorders or as side effects of treatments. Without the use of a consistent quantitative measure, recall biases may confound the ability of patients and clinicians to compare past and current levels or patterns of symptoms and functioning. When

patients have had substantial improvements in symptoms and functioning, it can be easy to focus on the improvements and overlook residual symptoms or side effects of treatment that are contributing to ongoing impairment or quality of life. Ongoing use of quantitative assessments may also foster identification of residual symptoms or impairments and early detection of illness recurrence. Systematic use of quantitative measures can also facilitate communication among treating clinicians and can serve as a basis for enhanced management of populations of patients as well as individual patients.

Most patients will be able to appreciate the ways in which the use of quantitative measures will be of benefit to them. The fact that the clinician is using a systematic approach to address their symptoms and functioning sends a positive message that could improve the therapeutic relationship. Especially in developed countries, patients are used to and expect digital, computerized information exchange, including for health-related monitoring and communication. For these patients, the use of quantitative measures within the context of an electronic health record, mobile app, or other computerized technology may have positive effects on the relationship of the patient with the psychiatrist and the health system.

Use of quantitative measures can have a number of potential harms. Overreliance on quantitative measures may lead other key elements of the patient's symptoms and life circumstances to be overlooked. Some patients may view quantitative measures as impersonal or may feel annoyed by having to complete detailed scales, particularly if done on a frequent basis. If a patient feels negatively about quantitative measures, this could alter the developing therapeutic alliance.

The amount of time available for an initial psychiatric evaluation is typically constrained by clinician availability, cost, and other factors. Under such circumstances, time that is used to obtain quantitative measures could introduce harms by reducing time available to address other issues of importance to the patient or of relevance to clinical decision-making. Logistical barriers to using quantitative measures appear to be common. Depending on the patient characteristics, the setting, and the model of payment, using systematic ratings can be associated with financial costs. Systematic use of measures may require changes in workflow to distribute scales and additional time to review the results with the patient. Unreimbursed costs of practice may also increase if additional staff are needed to support modified workflows, if changes are needed to an electronic health record system to permit integration of measures, or if payment is needed to use copyrighted versions of scales.

Implementation

The specific tasks required for implementation of quantitative measurement will vary with the setting and the patient population served by the clinician's practice. In all situations, a necessary first step will be selecting appropriate scales for use. Selected measures should be appropriate for the clinical setting and should consider factors such as patient language, literacy, and health literacy. Other factors that can affect the statistical reliability and validity of rating scale measures can include comorbid illnesses, race, ethnicity, and cultural background. It is important to consider whether the chosen scales have appropriate norms based on patient characteristics and setting. Depending upon predictive values,

sensitivity, and specificity, some rating scales may be better suited to screening whereas other rating scales may be better suited for detailed assessments of symptoms and for outcome monitoring. If more than one quantitative measure is being used, it is important to minimize duplication of questions and avoid overwhelming the patient with an excessive number of scales to complete. Rating scales should always be used as a supplement and not a replacement for clinical assessment and should be implemented in a way that supports development of the therapeutic relationship with the patient.

For assessment of psychiatric symptoms and behaviors across a range of domains, the DSM-5 Level 1 Cross-Cutting Symptom Measure (APA 2013) may be useful (Narrow et al. 2013). A self-report measure exists for adults and for children ages 11–17. A parent/guardian measure exists for children ages 6–17. Online versions of the measure are available at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1. Findings of the Level 1 Measure can be amplified by follow-up questioning or by the use of additional measures, such as the DSM-5 Level 2 Cross-Cutting Symptom Measures. The M-3 checklist (http://www.annfammed.org/content/suppl/2010/03/04/8.2.160.DC1/Gaynes_Supp_App.pdf; http://www.whatsmym3.com) is another self-report measure that screens for multiple disorders including questions on depressive, bipolar, anxiety, obsessive-compulsive and trauma-related disorders. Other specific rating scales may also be of use. For example, a number of clinician-rated and/or self-rated scales have been widely used in research and are increasingly used in ongoing clinical monitoring of depression (Duffy et al. 2008; Katzelnick et al. 2011; Chung et al. 2013). These include the PHQ-9 (http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/; Kroenke et al. 2001), the clinician-rated Hamilton Rating Scale for Depression (HAM-D; http://healthnet.umassmed.edu/mhealth/HAMD.pdf; Hamilton 1960; McIntyre et al. 2005), and the Inventory of Depressive Symptoms (IDS), which is available in clinician-rated and self-rated versions (http://www.ids-qids.org/; Rush et al. 1996). Other symptom scales are described in *Handbook of Psychiatric Measures*, edited by Rush et al. (2008) and available from American Psychiatric Publishing. For the assessment of functional impairments, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item version, self-administered scale that also has a proxy-administered version (http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/WHODAS2SelfAdministered.pdf; World Health Organization 2010). Quality of life can also be measured using a scale developed by the World Health Organization, the WHOQOL-BREF quality of life assessment (http://depts.washington.edu/seaqol/WHOQOL-BREF; The WHOQOL Group 1998; Skevington et al. 2004). The CDC Healthy Days Measures (HR-QOL-4 and HR-QOL-14) have also been used in general population samples to assess physical and emotional symptoms as related to an individual's perceived sense of well-being (Moriarty et al. 2003). The Satisfaction With Life Scale (Diener et al. 1985) has been developed and used to assess life satisfaction and quality of life in individuals with chronic mental illness. For a nonspecific measure of quality of life, patients can be asked to rate their overall (physical and mental) quality of life in the past month on a scale from 0 ("about as bad as dying") to 10 ("life is perfect") (Unützer et al. 2002).

In some clinical contexts, such as a planned outpatient assessment, patients may be asked to complete electronic- or paper-based quantitative measures, either prior to the visit or upon arrival at the office (Harding et al. 2011; Allen et al. 2009; Trivedi et al. 2007; Trivedi 2009). Between or prior to visits, mobile technology may also be adaptable to obtaining quantitative measurements (Palmier-Claus et al. 2012). In other clinical contexts, such as acute inpatient settings, electronic modes of data capture may be more cumbersome and patients may need more assistance in completion of scales. As an alternative, proxy-based scales or clinician-rated scales may be used. Additional implementation considerations will depend upon whether an electronic health record or other technologies are used within the practice. Some electronic health records may include built-in measurement functionality, e.g., default forms for rating of symptoms, functioning, or quality of life. As electronic health records become more commonly used, electronic capture of quantitative measures can allow computerized decision-support systems to be used in guiding evidence-based treatment (Trivedi et al. 2004), thereby improving outcomes and quality of care.

A number of barriers have been described to implementing quantitative measures in routine clinical practice (Valenstein et al. 2009; Zimmerman & McGlinchey 2008a; Zimmerman et al. 2011; Harding et al. 2011). Patient-related barriers include problems in completing scales because of psychiatric symptom severity, low health literacy, or reading difficulties. Some individuals may be unwilling to complete quantitative measures, although available information suggests that ambulatory patients are generally cooperative (Zimmerman & McGlinchey 2008b; Narrow et al. 2013; Duffy et al. 2008).

Quantitative measures themselves present additional barriers to implementation. Most scales have been developed and used primarily in research settings, which can limit their generalizability, usability, and perhaps their reliability and validity in routine clinical use. There is limited consensus on the best measures to implement. Normative values are not always available, and it is even more uncommon to have normative values available based on factors such as educational level, age, race, ethnicity, culture, or comorbid conditions that can influence ratings. Variations in patient's health literacy, reading ability, and symptom severity can also lead patients to misinterpret questions. Other patients may bias the ratings that they record, either unintentionally (e.g., to please the clinician with their progress) or intentionally (e.g., to obtain controlled substances, to support claims of disability). Thus, the answers to questions and the summative scores on quantitative measures need to be interpreted in the context of the clinical presentation. Relying on a summative score can also be misleading when an overall scale score may be low, but an important rating (e.g., suicidal ideas) is noted to be severe or frequent. Since many scales ask the patient to rate symptoms over several weeks, they may not be sensitive to change. This can be problematic in acute care settings, where treatment adjustments and symptom improvement can occur fairly quickly. Some symptom-based quantitative measures focus either on symptom frequency over the observation period or on symptom severity. Although these features often increase or decrease in parallel, that is not invariably the case. Other quantitative measures ask the patient to consider both symptom frequency and severity, which can also make the findings difficult to interpret.

Finally, as described under “Potential Benefits and Harms,” cost may be a decisive barrier to the implementation of quantitative measures in usual clinical practice, particularly if the potential benefits are uncertain for the patients treated within a specific clinical practice. Costs may include time and resources needed to implement and administer measures (Veerbeek et al. 2012; Harding et al. 2011), including within existing electronic health records, as well as costs associated with obtaining permission or a license to use measures that are protected by copyright laws.

Guideline 8. Involvement of the Patient in Treatment Decision-Making

Guideline statements

Statement 1: APA recommends (1C) that the initial psychiatric evaluation of a patient who is seen include an explanation to the patient of the following: the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment.

Statement 2: APA recommends that the initial psychiatric evaluation of a patient who is seen include asking the patient about treatment-related preferences.

Statement 3: APA recommends that the initial psychiatric evaluation of a patient who is seen include collaboration between the clinician and the patient about decisions pertinent to treatment.

Rationale

The goal of these guidelines is to improve patient engagement, patient knowledge of diagnosis and treatment options, and collaborative decision-making between patients and clinicians about treatment-related decisions.

The strength of research evidence supporting the educational and collaborative approaches recommended in statements 1, 2, and 3 is low. A number of randomized, controlled trials have studied the utility of similar approaches in the evaluation and treatment of individuals with a psychiatric disorder. However, as described in "Review of Supporting Research Evidence," the majority of the studies were nonblinded and had many potential confounding factors, and the applicability of the studies for these guidelines is limited, e.g., because they studied individuals in a single setting or with a single diagnosis. Furthermore, the findings of these studies were weak and inconsistent. The positive studies demonstrated effects that were brief or small in magnitude. Positive outcomes were also indirectly related to treatment outcomes. For example, when patients were educated about their illness or treatment, measurements showed that their knowledge increased. Patient satisfaction tended to improve when information was conveyed through increased contact with the treatment team, but this was not necessarily the case when information was conveyed by printed materials only. Findings of studies on incorporating patient choices and on involving the patient in treatment decision-making were mixed in terms of improved treatment adherence and clinical outcomes, respectively. Notably, however, studies did not demonstrate any harms of the interventions.

A number of investigators have examined treatment outcomes in relation to the patient's previously stated preferences. Studies have been conducted in psychiatric and in primary care settings in individuals with major depressive disorder or chronic forms of depression. Interventions have included antidepressant medication as compared to forms of psychotherapy (e.g., cognitive behavior therapy, Cognitive Behavioral Analysis System of Psychotherapy. Supportive therapy) or combined treatment with antidepressant and psychotherapy. Findings of these studies are mixed with some (Kocsis et al. 2009; Mergl et al. 2011; Lin et al. 2005) but not all (Kwan et al. 2010; Steidtmann et al. 2012; Leykin et al. 2007; Dunlop et al. 2012) showing greater or more rapid symptom reduction among individuals who

received their preferred treatment. Other secondary analyses showed better reported therapeutic alliance among individuals who received their preferred treatment in some studies (Kwan et al. 2010; Iacoviello et al. 2007). Despite the variability of these results, these studies provide some indirect evidence that asking about patient preferences could influence the therapeutic alliance, adherence or outcomes, at least in individuals with depression (Gelhorn et al. 2011).

Other indirect evidence for benefit comes from limited findings of improvements with medical and surgical patients' knowledge related to use of personalized risk communications (Edwards et al. 2013) or decision aids (Knops et al. 2013). Decisional conflict also shows some reductions related to use of decision aids (Stacey et al. 2011).

Despite this lack of strong supporting research evidence, experts agree that including the approaches recommended in statements 1, 2 and 3 as part of the initial psychiatric evaluation has benefits for enhancing the therapeutic alliance, treatment adherence, and patient and clinician satisfaction, and these potential benefits clearly outweigh the few potential harms.

These guidelines are consistent with recommendations of the Institute of Medicine that patient-centered care be delivered as one element of high-quality health care (National Research Council 2001). Other organizations have promoted similar educational and collaborative approaches to care, often using the term “shared decision-making.” For example, the U.S. Preventative Services Task Force has described how shared decision-making may be incorporated into the delivery of preventative care (Sheridan et al. 2004). Shared decision-making and informed patient choice have also been described as principles for the ethical practice of medicine (Moulton & King 2010; Drake & Deegan 2009). In particular, the ethical principles of respect for persons (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979) and for autonomy (Beauchamp & Childress 2012) are well-established and provide clear support for involvement of the patient. Involvement of the patient in decisions about his or her care is also an integral part of the ethical and legal tenets of informed consent (AMA Council on Ethical and Judicial Affairs 2012, Beauchamp 2011). Opinion 8.08 of the *Code of Medical Ethics of the American Medical Association* (AMA Council on Ethical and Judicial Affairs 2012) provides further discussion of informed consent including the need to “sensitively and respectfully disclose all relevant medical information to patients” in a manner so that the “quantity and specificity of this information [is] tailored to meet the preferences and needs of individual patients.”

Potential Benefits and Harms

There are a number of potential benefits to discussing differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment with the patient at the time of an initial psychiatric evaluation. These include strengthening the therapeutic alliance and enhancing the patient’s satisfaction with the care received, by respecting the patient’s autonomy. Adherence may also be improved if the patient understands the reasoning behind a particular treatment approach. If an effective treatment is provided, improved adherence could be expected to be associated with reduced

symptoms and improved functioning. The safety of treatment may also be enhanced if patients are educated about potential side effects of treatment, as knowledge about these potential effects could facilitate earlier reporting of difficulties with treatment.

Obtaining information about the patient's treatment-related preferences may also contribute to improved adherence, a stronger therapeutic alliance, and greater satisfaction with care. Because such preferences may have arisen from personal or family experiences with a specific treatment, they may provide clues to a patient's therapeutic or adverse responses to a given treatment or mechanistically similar treatments. Thus, an additional benefit of eliciting patient preferences may relate to the efficacy or safety of treatment for the individual patient.

Collaborating with the patient about decisions pertinent to treatment also has the potential to improve the therapeutic alliance, satisfaction with care, and adherence with treatment. Such collaboration may also increase the likelihood that the patient's expressed preferences will be integrated into the treatment plan.

Potential harms of these recommendations are minimal. It is possible that some individuals will not be interested in receiving information on differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment. Patients may also prefer not to be involved in collaborative decision-making, feeling that the clinician is more knowledgeable or that the options are too overwhelming to consider.

It is difficult to estimate the cost of explaining the patient's differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment as well as inquiring about the patient's treatment-related preferences and collaborating with the patient in making decisions pertinent to treatment. The time required for each of these steps will differ with the patient and the clinical context. Such costs are also difficult to disentangle from the overall cost of an initial psychiatric evaluation. When factors including cost or model of payment constrain the amount of time available for an initial psychiatric evaluation, time that is used to focus on shared decision-making could reduce time available to address other issues of importance to the patient or of relevance to diagnosis and treatment planning.

Implementation

These guidelines apply to patients who have decision-making capacity. In general, individuals are presumed to have capacity unless there is compelling evidence to the contrary (Sessums et al. 2011; Appelbaum 2007). Capacity is presumed even in individuals who may have been admitted to a facility on an involuntary basis. Accordingly, the initial steps of a shared decision-making process are recommended for new patients, unless it is clear that the individual has severe cognitive impairment or disorganized thought processes that would impede his or her ability to process information. Even when disorganized thinking, delirium, or neurocognitive disorders are present, patients may still be able to understand some degree of information about their illness and its treatment and may be able to express some opinions about preferences. In individuals with delirium, such discussions may be able to occur

during periods of greater lucidity. Initial steps to shared decision-making include discussing the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment. To assess the patient's knowledge after this information is conveyed, it is often useful to ask for a summary of his or her understanding of the diagnosis and treatment options. Assessing the patient's ability to understand this information is one element of assessing decision-making capacity (Appelbaum 2007). If the patient does not seem to fully grasp the information that was conveyed, the clinician will want to determine if this reflects a true inability to understand the material or whether the explanation needs to be worded in more straightforward terms (Sessums et al. 2011; Epstein & Gramling 2013; Epstein & Peters 2009; Sheridan et al. 2004). Shifting to a different mode or format of presentation may also help improve the patient's understanding of the material (Covey 2007). With such adaptations, individuals with low health literacy, learning disabilities, or some cognitive impairment may still be able to learn key material and collaborate in their care. More detailed assessment for possible delirium or neurocognitive disorder is warranted if the patient has difficulty understanding the material when presented in a simpler format. With permission from the patient, the patient's family may also be involved to help the patient to understand treatment options and collaborate in care. In addition to determining whether the patient understands factual elements of the information that has been conveyed, it is also useful to inquire about any concerns, fears, preconceptions, or other beliefs that the patient has about the information. This can help in addressing miscommunications or in providing the patient with additional support if the fears or concerns are realistic.

A second element of assessing capacity is determining whether the patient can appreciate his or her condition and the likely outcomes of the possible treatment options. Some individuals may be able to understand key information but lack insight and ability to appreciate that a psychiatric condition is present (Appelbaum 2007; Owen et al. 2013). Other individuals may have unrecognized cognitive impairment that results in poor adherence or unwillingness to consider treatment. Still other individuals have delusions that compromise their ability to appreciate the true consequences of an intervention (e.g., medication is believed to be poisonous, imaging studies are believed to be capable of activating embedded transmitters).

Asking patients about treatment-related preferences provides information about the outcomes that are most important to them. Desired outcomes may be broad in scope and encompass social and functional outcomes as well as symptomatic outcomes (Klein et al. 2007; Deegan & Drake 2006). Inquiring about the patient's current quality of life and level of functioning can often serve as a starting point for discussing his or her overarching goals and preferences for achieving them. For some individuals, avoiding a specific side effect may be more important than a difference in possible benefits. For other individuals, preferences may relate to pragmatic issues such as medication or treatment costs or availability of transportation for follow-up visits. As another aspect of patient preference, it is helpful to ask whether or not the patient wishes to have family members or others (e.g., case managers, close friends) involved in discussions or decisions about aspects of care including treatment. The majority of individuals want family involvement, although there is significant heterogeneity in the extent and type

of involvement that is desired (Cohen et al. 2013). Increasing numbers of young adults reside with their parents (Vespa et al. 2013), suggesting the need to explore with patients the ways in which family members can help them meet their identified treatment goals (Dixon et al. 2014). In discussing the patient's preferences and choice of treatment, the clinician will be able to determine whether the patient is able to reason about treatment options and communicate a choice about treatment, which are the remaining elements of an assessment of decision-making capacity (Appelbaum 2007). For the majority of individuals (who have decision-making capacity), the clinician will have communicated key information through this process and will have engaged the patient in a collaborative approach to care.

Given that shared decision-making is intended to focus on and integrate the unique aspects of the patient's preferences and options for treatment (Makoul & Clayman 2006), some flexibility in implementing these recommendations will be essential. One proposed model of shared decision-making emphasizes the respectful exploration of "what matters most" to the patient (Elwyn et al. 2012). The dynamic and iterative aspects of discussion and decision-making are also useful to keep in mind (Elwyn et al. 2012, Makoul & Clayman 2006). Although the shared decision-making process is recommended to begin during the initial evaluation, it will also continue and evolve throughout the patient's therapeutic relationship with the clinician.

The exact content of discussions with the patient may also vary depending on the circumstances. For example, when obtaining and documenting informed consent for a procedure or treatment with significant risk, a greater level of detail will be needed that outlines the specific risk and benefits of the proposed treatment and other possible options, include no treatment. On the other hand, a detailed discussion of the risks of forgoing treatment may not be crucial in an individual who implicitly knows the problems with untreated illness and is actively seeking assistance. In other circumstances, a patient may not fulfill criteria for a specific diagnosis, or a final diagnosis may require additional history or review of information. Nevertheless, it may still be appropriate to initiate treatment based on what is already established. The clinician could discuss the likely diagnostic possibilities or explain why symptomatic treatment is still indicated, even in the absence of a clear diagnosis. Other elements of the proposed treatment approach may also contain uncertainties (Epstein & Gramling 2013), and gaps in available evidence may not allow estimates of risks and benefits of treatment. Again, the goal is a straightforward discussion of the therapeutic options as well as transparent mention of key areas of uncertainty that would be relevant to the patient's preferences and decisions. If electronic decision aids are available and relevant to the patient, these can be helpful (Sheridan et al. 2004; Stacey et al. 2011; Friedberg et al. 2013).

Communications with patients about their goals may involve a series of conversations rather than a single discussion. Patients may have additional questions and may make additional decisions about their care as their illness, their understanding of their symptoms, and their treatment options evolve. Family members and others who the patient chooses to involve in his or her care may also have questions that arise over the course of treatment. For patients who are being treated with a type of treatment (e.g., assertive community treatment) or in a setting (e.g., hospital) that has a multidisciplinary team approach

to care, other team members play an important role in discussing information with patients and families, clarifying issues of concern or confusion, and providing information in a format and level of detail that is appropriate to the patient's needs. In some settings, the multi-disciplinary team members will collaborate with the patient and involved family members in developing an individualized treatment plan.

When a patient lacks capacity or is experiencing acute symptoms (e.g., delusions, agitation) that compromise informed discussion, shared decision-making may not be possible or may need to be implemented more gradually as the patient's symptoms remit. Opinions 8.081 and 8.082 of the *Code of Medical Ethics of the American Medical* Association (AMA Council on Ethical and Judicial Affairs 2012) discusses circumstances in which informed consent discussions may need to be modified or delayed or in which surrogate consent may be needed. When individuals who lack capacity have a surrogate decision-maker, a similar process can be followed that incorporates explaining the diagnosis and treatment options, eliciting preferences, and collaborating in decisions about treatment.

Some individuals may have completed a psychiatric advance directive that provides information about their preferences with regard to medication or other interventions (Elbogen et al. 2007). Limited evidence suggests that such advance directives can improve patient adherence with treatment (Wilder et al. 2010). Individuals with cognitive impairment may also have developed an advance care plan that describes their future wishes (Dening et al. 2011; Robinson et al. 2012). Patients can be encouraged to consider completing a psychiatric advance directive, advance care plan or health care proxy at a time when they have the decisional capacity to do so (Srebnik et al. 2004; Moye et al. 2013).

A number of barriers exist to implementing these recommendations. Not all patients are interested in learning detailed information about diagnosis or treatment or they may not be psychologically able to process and come to terms with the information. Patients are not always comfortable with a shared decision-making approach. Some patients may be reluctant to engage in discussion and may be fearful of how they will be viewed by the clinician (Frosch et al. 2012). Studies of patients with medical or surgical conditions suggest that there is significant variability in patient preferences related to shared decision-making (Chewning et al. 2012; Singh et al. 2010). Furthermore, these preferences can be difficult to judge (Kon 2012) and may be culturally mediated (Charles et al. 2006). They are not absolute but may shift with the clinical context or type of decision that is being made (Epstein & Gramling 2013). Fewer studies are available in psychiatric patients, but these also suggest individual variations in preferences (Woltmann & Whitley 2010; Klein et al. 2007; Deegan & Drake 2006). Even for patients who are well-informed and have high health literacy, shared decision-making can sometimes impose an unrealistic burden on patients (Olthuid et al. 2013).

Other barriers relate to the amount of time that the clinician has available to engage in shared decision-making or the lack of other resources (e.g., reimbursement, decision aids, other health professional staff) to help support the shared decision-making process (Sheridan et al. 2004; Légaré et al. 2008; Friedberg et al. 2013; Légaré & Witteman 2013). Clinicians may also lack knowledge of how to

implement shared decision-making, may question its utility, or have concerns that it will complicate the therapeutic relationship (Sheridan et al. 2004; Légaré et al. 2008; Friedberg et al. 2013; Légaré & Witteman 2013). Some clinicians may be accustomed to interacting with patients in a paternalistic or authoritarian manner, which can present a barrier to open communication about patient preferences and values (Frosch et al. 2012). Thus, changes may be needed in clinician training and in the resources devoted to shared decision-making to promote the implementation of these recommendations.

Guideline 9. Documentation of the Psychiatric Evaluation

Guideline statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include documentation of the rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice.

Statement 2. APA suggests (2C) that the initial psychiatric evaluation of a patient include documentation of the rationale for clinical tests.

Rationale

The goal of these guidelines is to improve clinical decision-making and increase coordination of psychiatric treatment with other clinicians.

The strength of the research evidence supporting statements 1 and 2 is low. No prospective studies were identified that addressed whether decision-making about a patient's psychiatric diagnosis and treatment plan or coordination of psychiatric treatment with other clinicians are improved when the clinician documents the rationale for treatment selection and for clinical tests. However, some indirect information suggests that such a practice may be beneficial.

With the increasing use of electronic record systems, the structured but fragmented information that is common in electronic record notes can increase cognitive workload and reduce the quality of communication among those caring for the patient (Rosenbloom et al. 2011; Mamykina et al. 2012; Cusack et al. 2013; Embi et al. 2013). A greater emphasis on synthesizing information through documentation may ameliorate some of those difficulties. Clinical decision-making may also be enhanced. The thought process behind clinical decision making is frequently described as having 2 distinct components—one that is intuitive relying primarily on pattern recognition and rules-of-thumb whereas the other is more systematic and analytical (Croskerry et al. 2013; Bate et al. 2012). The intuitive process is faster but more likely to introduce cognitive biases and error than the more reflective process. Although documenting the rationale for treatment selection and testing in addition to the usual practice of documenting the differential diagnosis may require additional time to complete, it may also allow clinicians to avoid biases and errors in clinical judgment and think about whether other care approaches and testing strategies may be more concordant with evidence-based practices or with the patient's needs and preferences.

Potential Benefits and Harms

In an initial psychiatric evaluation, documenting the rationale for treatment selection and clinical tests is potentially beneficial in several respects. When a patient's care is being provided by multiple individuals using a shared treatment or treatment team approach, collaboration and coordination of care among involved health professionals is crucial. Delineating the reasons for selecting treatment(s) and obtaining clinical tests can enhance collaboration and minimize misunderstandings or errors in the delivered treatment. Whether a patient is being cared for by one clinician or by many, documentation of clinical

reasoning can be informative to review if questions arise later in treatment or if treatment is transitioned to different clinicians.

The amount of time available for an initial psychiatric evaluation is typically constrained by clinician availability, cost, and other factors. Under such circumstances, focusing on more detailed documentation of clinical decision-making could introduce harms by reducing time available to address other issues of importance to diagnosis, treatment planning, or the patient. The financial cost of documenting the rationale for treatment selection and clinical tests is difficult to disentangle from the overall cost of an initial psychiatric evaluation, which varies depending on the patient, the setting, and the model of payment.

Implementation

In describing the rationale for treatment selection and for clinical tests as part of the initial psychiatric evaluation, the breadth and depth of documentation will depend upon the clinical circumstances and complexity of the decision-making. Although some treatment or testing decisions may seem "intuitively obvious" (e.g., prescribing an antidepressant to a patient with depression, obtaining "routine" laboratory tests), the rationale for deciding among available therapeutic options almost always includes additional nuances. Thus, it is important to discuss the factors that influenced the treatment choice such as the target symptom or syndrome being addressed by the treatment, the patient's preferences regarding treatment, the potential side effects of treatment relative to other options, and the past responses of the patient to treatment (if applicable). If the evaluation is done at the request of another health professional (i.e., as a consultation), enough detail should be included to permit the requestor of the consultation to follow through with any recommended actions. More detailed consideration and documentation of the risks and benefits of treatment options may also be needed in the following circumstances: when the planned treatment is a relatively costly, non-standard treatment approach (e.g., multiple antipsychotic medications, "off-label" use of a medication) or has a heightened risk (e.g., use of clozapine or monoamine oxidase inhibitors); when involved parties disagree about the optimal course of treatment; when the patient’s motivation or capacity to benefit from potential treatment alternatives is in question; when the treatment would be involuntary or when other legal or administrative issues are involved; or when available treatment options are limited by external constraints (e.g., financial barriers, insurance restrictions, geographic barriers, service availability, the patient’s capacity to participate in the proposed treatment). In situations where informed consent is being obtained, the rationale for the therapeutic decision-making will typically include the elements of the informed consent discussion (e.g., risks and benefits of treatment options including reasonable alternatives to the planned treatment, the patient's understanding of and acceptance of the treatment plan). If interventions such as hospitalization are planned as a result of the evaluation, their rationale is important to include in the discussion. Although this recommendation is limited to the initial psychiatric evaluation, some clinicians find it helpful to document their reasons for starting or stopping treatments or contingency plans (e.g., to address side effects or non-response) at other patient encounters as well.

The decision to do laboratory studies and other clinical tests such as imaging studies, ECG, or EEG should

be based on the likelihood that the test result will alter diagnostic or treatment-related decision-making. The costs of "routine" testing, in financial terms and in unneeded evaluations for false positive results, are unlikely to offset the benefits of untargeted testing.

The documentation of the rationale for treatment and testing can be a natural outgrowth of a biopsychosocial formulation, or it can be recorded separately as part of the diagnostic impression and plan. The overarching goals of the documentation is a concise synthesis of the clinical thought process that permits ready access to important information in a manner that is reliable and consistent with the patient's clinical picture and helps in anticipating the patient's needs. These elements of documentation have been suggested as characteristics of quality in electronic record documentation (Hammond et al. 2010) but are equally relevant to paper-based formats.

Clinicians should be aware that the recommendations for assessment and documentation described in this guideline may differ from those outlined as part of a comprehensive evaluation according to the Current Procedural Terminology and the United States Center for Medicare and Medicaid Services (Schmidt et al., 2010; Centers for Medicare and Medicaid Services. Evaluation and Management Services Guide. Accessed on October 5, 2014).

Documentation of psychiatric evaluations in general and of the rationales for treatment and testing in particular should be sensitive to issues of confidentiality. Medical records may also be viewed by others in addition to the clinician writing the note or other members of an interdisciplinary treatment team. Individuals who may sometimes view documentation include the patient, third-party payers, quality assurance/peer review evaluators, and, in certain jurisdictions, the executor of an estate after a patient’s death. Furthermore, records may be part of future or current legal or administrative hearings, including disability litigation, divorce and custody adjudication, competency determinations, and actions of medical licensing boards. Electronic record systems have many different approaches to controlling access to records, with some restricting access of psychiatric notes to a small circle of individuals to optimize patient privacy while other systems allow broader access to notes with the aim of integrating medical and psychiatric care. Such factors need to be taken into consideration when documenting.

Although the additional time required for documentation can be an added cost, some practitioners find that use of transcription or voice recognition software is useful in reducing documentation times while still permitting the details of clinical decision-making to be captured. With electronic record systems, the use of copy/paste can improve the continuity of treatment plan documentation from visit to visit, but it must be used cautiously as copying and pasting of text can lead to inaccuracies in documentation.

II. Review of Available Evidence

Guideline 1. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History

Clinical Question

Development of these guidelines was premised on the following clinical question:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are accuracy of diagnosis and appropriateness of treatment selection improved when the initial psychiatric evaluation typically (i.e., almost always) includes review of the following?

Psychiatric systems, including mood, anxiety, thought content and process, perceptual and cognitive problems, and trauma history

Previous psychiatric diagnoses (both principal and working)

Past psychiatric treatment trials (type, duration and, where applicable, doses)

Adherence to past psychiatric treatments, including both pharmacological and non-pharmacological treatments

Response to past psychiatric treatments

Review of Supporting Research Evidence

Overview of Studies

There is no supporting research evidence that specifically addresses the above clinical question.

Grading of Quality of Individual Studies

Not applicable

Grading of Supporting Body of Research Evidence

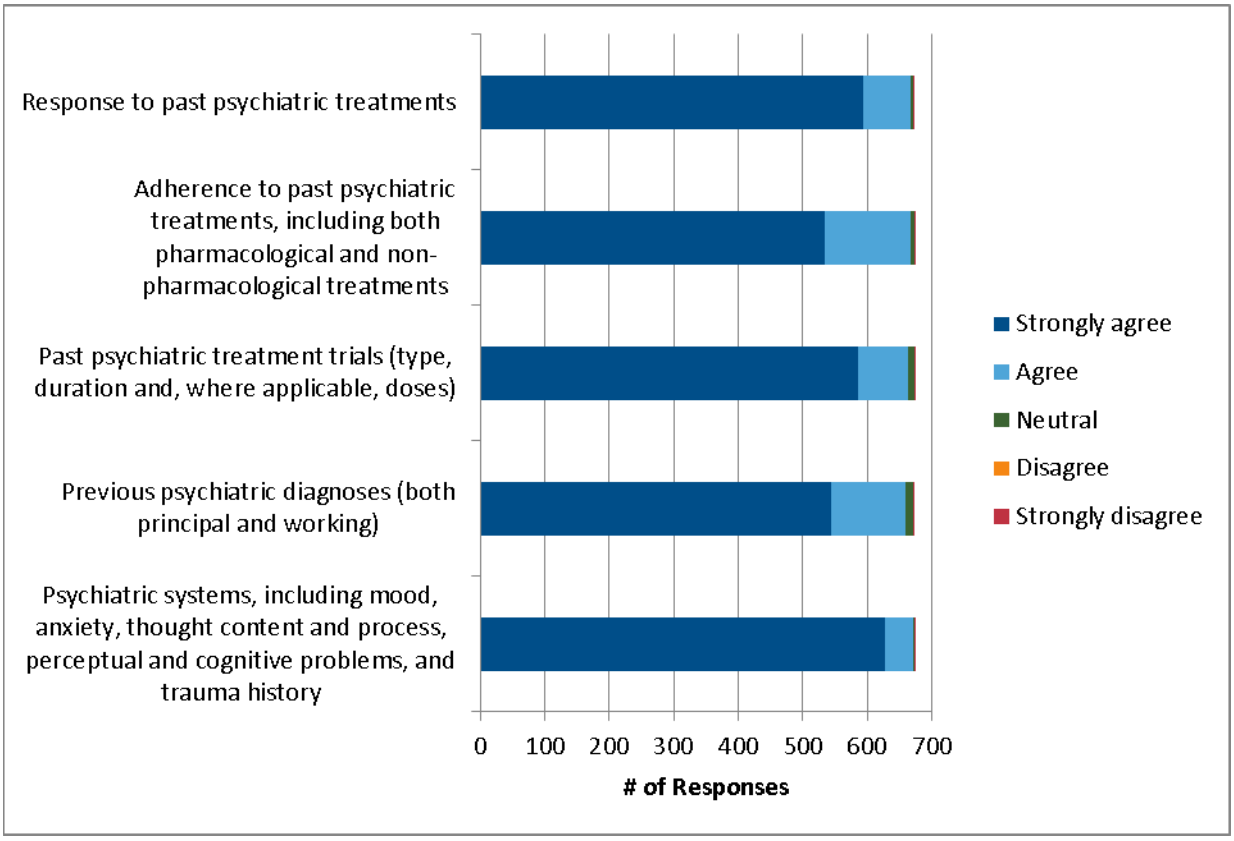
Not applicable

Differences of Opinion in Rating the Strength of Recommendations

None

Expert Opinion Data: Results

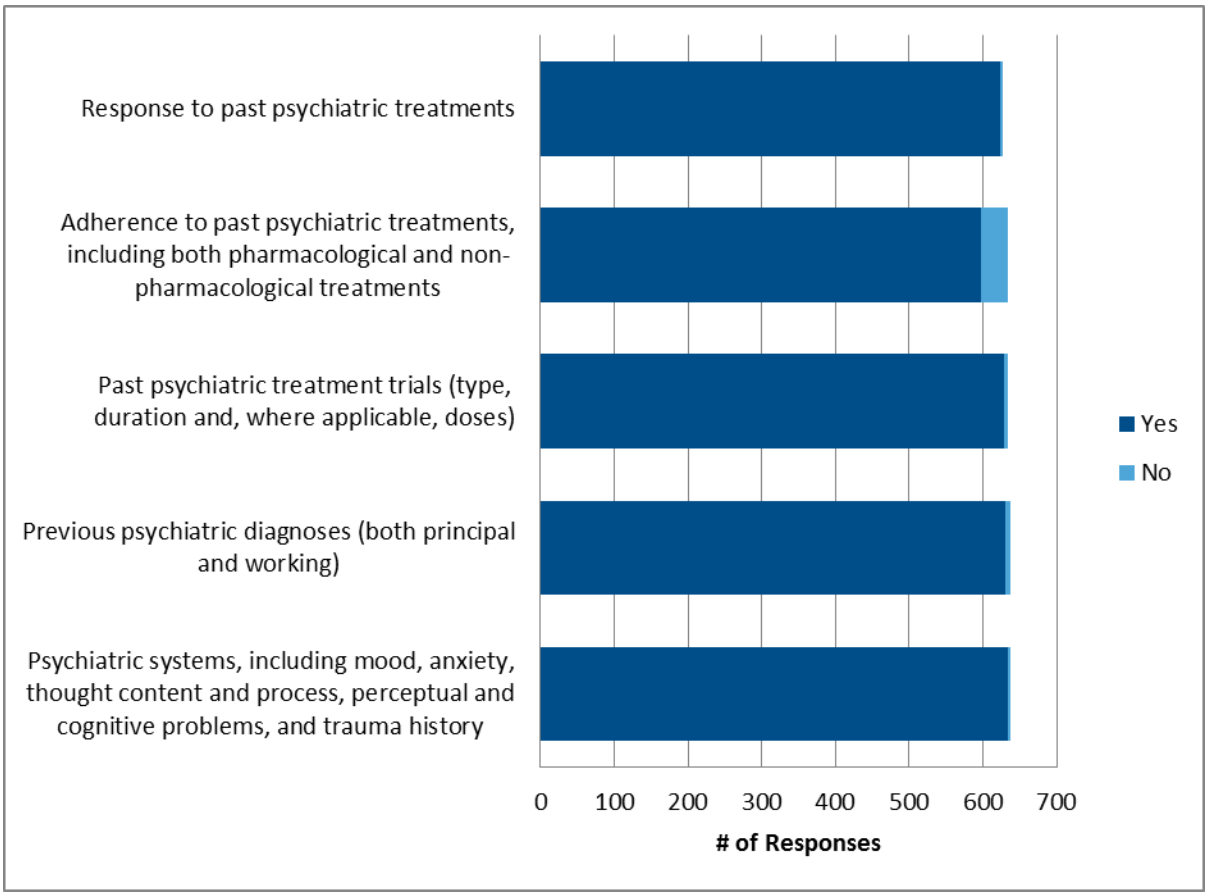
To what extent do you agree that accuracy of diagnosis and appropriateness of treatment selection are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes review of the following?



Percentage of experts who "strongly agreed" or "agreed" that accuracy of diagnosis and appropriateness of treatment selection are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes review of the following:

Response to past psychiatric treatments	99.1%
Adherence to past psychiatric treatments, including both pharmacological and non-pharmacological treatments	98.7%
Past psychiatric treatment trials (type, duration and, where applicable, doses)	98.4%
Previous psychiatric diagnoses (both principal and working)	97.8%
Psychiatric systems, including mood, anxiety, thought content and process, perceptual and cognitive problems, and trauma history	99.3%

Do you typically (i.e., almost always) review these items during initial psychiatric evaluations of your patients?



Guideline 2. Substance Use Assessment

Clinical Questions

Development of these guidelines was premised on the following clinical question:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are identification and diagnosis of substance use disorders improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessments of the following? (1) Current tobacco use, (2) Current alcohol use, (3) Current use of other substances (e.g., marijuana, cocaine, heroin, psychomimetics), (4) Current misuse of prescribed or over-the-counter (OTC) medications or supplements, (5) Past tobacco use, (6) Past alcohol use, (7) Past use of other substances (e.g., marijuana, cocaine, heroin, psychomimetics), (8) Past misuse of prescribed or OTC medications or supplements?

Review of Supporting Research Evidence

Overview of Studies

Author, Ref.	Subjects / Method	N	Duration	Outcomes
R. Agabio et al., Alcohol and Alcoholism, 42 (6): 575-81, 2007	Patients with mood disorders treated in the outpatient clinic of the University of Cagliari, Italy, filled out alcohol-related questionnaires to determine the prevalence of alcohol use disorders and at-risk drinking, and to compare the sensitivity and specificity of the questionnaires.	56	Cross-sectional study design; subjects were recruited from May – November, 2006	Fourteen subjects (25%) met the criteria for alcohol use disorders according to SCID-I; 17 (30.4%) achieved a score ≥ 1 in CAGE questionnaire; 12 (21.4%) reached AUDIT scores of ≥ 8 and 4 for men and women, respectively; 12 (21.4%) provided positive answers to NIAAA Guide. Despite these prevalence rates, no diagnosis of alcohol use disorders had previously been registered in their medical records. The CAGE questionnaire achieved the highest values of sensitivity and specificity in detecting alcohol use disorders tested against that of the SCID-I.
Hill KP and Chang G., Am J Addict 16 (3):222-6, 2007	Patients in a psychiatric outpatient clinic completed T-ACE, AUDIT, clinician interview, and SCID, to determine if the T-ACE and AUDIT improved identification of at-risk drinking.	50	Cross-sectional study design; subjects were recruited from January 2004-February 2005	Compared to the SCID, the sensitivities and specificities for T-ACE were 0.88 and 0.59 and for AUDIT were 0.63 and 0.85. Brief screening instruments improved the identification of risky drinking in this psychiatry clinic.
K. L. Barry et al., Psychiatr Serv 57(7):1039-42, 2006	Patients at a psychiatry emergency service completed an alcohol-related questionnaire to determine the prevalence of at-risk	390	Cross-sectional design; subjects recruited from 2001 - 2005	23% of pts with schizophrenia and bipolar and 22% of patients with depression and anxiety drank more than the recommended limits. Those with schizophrenia or bipolar disorder reported experiencing significantly more

	drinking. Patients with schizophrenia or bipolar disorder were compared to those with depression or anxiety.			consequences from drinking than those with depression or anxiety.
P. R. Stasiewicz et al., Psychol Addict Behav 22(1):78-87, 2008	Patients at a community mental health clinic with either schizophrenia-spectrum or bipolar disorder and an alcohol use disorder completed assessments including self-reports of recent alcohol use. This information was compared to collateral reports and to urine drug screens.	167		Overall, there was poor subject-collateral agreement, though better for subjects (n=97) with negative urine drug screens. The most consistent predictor of subject-collateral discrepancy scores was subjects' recent drug use. This study emphasizes the need to enhance the validity of self-reports of substance use.

Grading of Quality of Individual Studies

Citation: Agabio R et al. Alcohol use disorders, and at-risk drinking in patients affected by a mood disorder, in Cagliari, Italy: sensitivity and specificity of different questionnaires. Alcohol and Alcoholism, 42 (6): 575-81, 2007

Population: A non-stratified sample of 200 medical records was randomly selected (every third record) from among those of outpatients admitted to the Division of Psychiatry, University of Cagliari, for mood disorders from May to November 2006. Each patient was invited by phone to participate in the study. 56 patients participated.

Intervention: Patients were interviewed for about an hour and completed several alcohol-related questionnaires. Patients were informed about the size of a standard drink, then requested to answer questions of the first step of the NIAAA Guide, the Alcohol Use Disorders Identification Test (AUDIT), and the “Cut down,” “Annoyed,” “Guilty,” Eye Opener” (CAGE) questionnaires. The SCID-I application forms for mood and alcohol disorders were also administered.

Comparators: This study uses a prior study (Grant et al., *Archives of General Psychiatry* 61:807-816, 2004) and meta-analysis (Sullivan et al., *American Journal of Medicine* 118:330-341, 2005) as comparator data.

Outcomes: 14 subjects (25%) met the criteria for alcohol use disorders according to SCID-I; 17 (30.4%) achieved a score ≥ 1 in CAGE questionnaire; 12 (21.4%) reached AUDIT scores of ≥ 8 and 4 for men and women, respectively; 12 (21.4%) provided positive answers to NIAAA Guide. Despite these prevalence rates, no diagnosis of alcohol use disorders had previously been registered in the medical records of patients who met SCID-I criteria for current alcohol use disorders. The CAGE questionnaire achieved the highest values of sensitivity and specificity in detecting alcohol use disorders tested against that of the

SCID-I.

Timing: The interview for each subject lasted about one hour. Data was collected from May to November, 2006.

Setting: Outpatients from the Division of Psychiatry, University of Cagliari, Italy

Study Design: Cross-sectional

Overall risk of study bias: Moderate Risk

Selection bias: High Risk: Not all patients who were asked agreed to be part of the study, and those who chose to participate may have had different drinking patterns from those who refused.

Performance bias: Low Risk: There is no evidence of systematic differences in the treatment of participants or of protocol deviation.

Attrition bias: Low Risk: This does not apply to this study, because of the cross-sectional design. Data was collected once with no follow-up.

Detection bias: High Risk: Patients are likely to under-report their drinking when directly asked in questionnaires, and the in-person interview may have increased this likelihood. There was no effort to verify the information reported by the subjects.

Reporting bias: Low Risk: Since an in-person interview was conducted, it is possible the interviewer recorded only information which fit within set parameters. However, since standardized, validated instruments were used, this risk is low.

Sponsor-related bias: Low Risk: Article was published in a peer-reviewed journal with no obvious source of industry, institutional or investigator bias.

Applicability: This study was performed in Italy in a mood-disorder clinic and only addresses alcohol use. This may limit its generalizability to the United States, to individuals with other psychiatric diagnoses and to individuals using other substances. Also, the assessment of drinking behavior was performed in a separate interview, rather than as part of the initial assessment, which may reduce applicability to the clinical question.

Citation: Hill KP and Chang G. Brief screening instruments for risky drinking in the outpatient psychiatry clinic. The American Journal on Addictions 16 (3):222-6, 2007

Population: The Health and Habits Survey was given to 149 adult patients initiating psychiatric care in the psychiatric clinic of the Brigham and Women's Hospital in Boston, Massachusetts between January, 2004 and February, 2005. These patients were invited to return on a separate visit to complete a SCID and the AUDIT; 50 patients agreed and were enrolled in the study. Ability to complete the Health and Habits Survey and willingness to participate in the study were the inclusion criteria.

Intervention: Patients were screened for alcohol use with the Health and Habits Survey, which contained questions about diet, smoking, exercise, stress, and usual drinking, and the T-ACE, a four-item alcohol

screening instrument. Patients who agreed to enroll in the study completed a SCID and the AUDIT. All SCID interviews were administered by the same physician, who also obtained informed consent.

Comparators: Sensitivity and specificity of the T-ACE were compared to those of the AUDIT, using the SCID as a reference, for the 50 patients who went on to complete the AUDIT after the initial survey.

Outcomes: Brief screening instruments improved the identification of risky drinking in an outpatient psychiatry clinic compared to clinician interviews. The AUDIT identified risky drinking with a moderate sensitivity (0.63) and a high specificity (0.85). The T-ACE was less specific (0.59), but more sensitive (0.88) than the AUDIT.

Timing: Data was collected between January, 2004 and February, 2005. Potential subjects first completed the Health and Habits Survey and the T-ACE. Then, those who agreed to complete the SCID and the AUDIT returned at a later date, within a few weeks and as close as possible to the clinician intake interview

Setting: Outpatient psychiatric clinic of Brigham and Women's Hospital, Boston, Massachusetts.

Study Design: Cross-sectional

Overall risk of study bias: High Risk

> Selection bias: High Risk: Patients selected themselves for the study after learning about it. It is probable that those who consumed larger amounts of alcohol would be less likely to agree to participate in the study.
>
> Performance bias: High Risk: There was no blinding in this study; the clinician who performed the SCID was aware of the patients' T-ACE scores.
>
> Attrition bias: High Risk: Although the study defines enrolled subjects as the ones who completed the survey and then agreed to return to complete the SCID and the AUDIT, there is a potential for attrition bias in that only 50 of the initial 149 who completed the survey agreed to return. Those who chose not to proceed in the full study may have had different characteristics than those who did proceed.
>
> Detection bias: High Risk: Patients tend to under-report their drinking on surveys and interviews, and there was no attempt to verify information that was being given by self-report.
>
> Reporting bias: Low Risk: Since standardized instruments were used, and the same clinician was used for every SCID, the likelihood of reporting bias is low.
>
> Sponsor-related bias**:** Low Risk: This research was supported in part by grants from the American Psychiatric Institute for Research and Education and from the National Institute on Alcohol Abuse and Alcoholism, Bethesda, Md.as well as by the Dupont Warren Fellowship from Harvard Medical School, Boston, MA. There is no obvious source of bias from these sponsors.

Applicability: This study identifies "risky drinking" which may or may not constitute an alcohol use disorder. Also, subjects were assessed outside of a standard psychiatric evaluation, which may limit the applicability of the study findings to the identification and diagnosis of substance use disorders as part

of the initial psychiatric evaluation.

Citation: Barry KL et al. Screening psychiatric emergency department patients with major mental illnesses for at-risk drinking. Psychiatric Services 57(7): 1039-42, 2006

Population: All eligible adult psychiatric emergency service patients aged 18 years and older were asked to complete the informed consent form. Patients were excluded from the study if they were intoxicated, incarcerated, had acute psychosis, were being seen for an overdose, had suicide attempts, had a legal guardian or were too medically ill to participate. A total of 460 psychiatric emergency service patients were approached; 390 (80%) agreed to participate and completed questionnaires. An additional 214 patients did not meet inclusion criteria.

Intervention: Participants completed a questionnaire adapted from the Health Screening Survey, including quantity or frequency items for alcohol use, dieting, tobacco, and exercise in the previous three months; perceptions of a past or current alcohol problem; and seven past-year alcohol consequence items from the Alcohol Use Disorders Identification Test (AUDIT).

Comparators: Analyses compared at-risk drinkers who had a serious mental illness (schizophrenia or bipolar disorder) with those who had depression or anxiety.

Outcomes: 34 persons with schizophrenia or bipolar disorder (23%) and 53 with depression or anxiety (22%) drank heavily, according to NIAAA guidelines, engaged in binge drinking, reported a perception of a current problem with alcohol, or reported two or more alcohol-related consequences. Among the at-risk drinkers, the group with schizophrenia or bipolar disorder drank an average of 23.7±34.1 drinks per week; the group with depression or anxiety drank 24.3±27.8 drinks per week. There was a significant difference between the two diagnostic groups in use of any alcohol (62 persons with schizophrenia or bipolar disorder, or 42%, compared with 140 persons with depression or anxiety, or 58%). In the group with schizophrenia or bipolar disorder, 31 (91%) of the at-risk drinkers reported a past problem with alcohol, and 20 (59%) reported a current problem. In contrast, in the group with depression or anxiety, 34 (64%) of the at-risk drinkers reported a past problem, and 34 (64%) reported a current problem. Other differences were found between the patients with schizophrenia or bipolar disorder and those with depression or anxiety, including differences in education level and smoking status.

Timing: The study was conducted from 2001 to 2005.

Setting: Psychiatric emergency room in Ann Arbor, Michigan.

Study Design: Cross-sectional

Overall risk of study bias: High Risk

> Selection bias: High Risk: There were several exclusion criteria involving medical illness, psychiatric symptoms, and legal status. This led to excluding 214 people and including 390. Also, 20% of those approached for the study refused to participate, and the characteristics of those who refused may be different from participants.
>
> Performance bias: High Risk: There was no blinding in this study, and so both participants and

researchers knew who was in the study. Answers to questions may have been affected by knowledge of being in the study. The study compares different diagnostic groups (i.e., those with schizophrenia or bipolar disorder to those with depression or anxiety) researchers knew participants' diagnoses

Attrition bias: This is not applicable to this study because there was no follow-up.

Detection bias: High Risk: The study conducted a self-report questionnaire with no attempt to verify the information. Patients are likely to under-report drinking behavior in surveys that are based only on self-report. Additionally, the assessment included questions about past alcohol use, which participants answered by recall from memory.

Reporting bias: Low Risk: There is no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: The study was sponsored by the Flinn Family Foundation. There is no obvious source of bias from the investigators or the sponsor of this study.

Applicability: This study reports findings from a questionnaire given to psychiatric emergency patients, which may limit the applicability of this study to other clinical settings. The study also examined whether participants exhibited “at risk drinking”, which may limit the applicability of the study in terms of identification and diagnosis of substance use disorders.

Citation: Stasiewicz PR et al. Factors affecting agreement between severely mentally ill alcohol abusers' and collaterals' reports of alcohol and other substance abuse. Psychology of Addictive Behaviors 22 (1):78-87, 2008

Population: The subjects were 207 men and women seeking outpatient dual-diagnosis treatment from a university-affiliated community mental health center. Forty (19%) subjects were excluded from analyses because of missing baseline collateral data. Subjects were eligible if they had lived at their current address for at least 6 months or could provide two persons as locators, scored at least 23 (with scores of 22 considered on a case-by-case basis) on the Mini-Mental State Exam to ensure adequate cognitive functioning for study participation, and met DSM-IV criteria for a current (i.e., past 12 months) alcohol use disorder and a current schizophrenia-spectrum and/or bipolar disorder.

Intervention: Subjects were recruited within 2 weeks of treatment entry and completed measures of cognitive functioning, alcohol dependence severity, psychiatric symptoms, and quantity and frequency of substance use over the previous 60 days using the Timeline Follow-Back interview (L. C. Sobell & M. B. Sobell, 1996). They also provided a urine sample, which was screened for recent substance use. Collateral interviews were conducted by phone and included an assessment of the subject’s alcohol and substance use over the same 60-day period. Collaterals also reported their confidence in the accuracy of their reports.

Comparators: Subject reports of substance use were compared with reports from collateral interviews and with the results of urine toxicology screens. Collateral interview reports and urine toxicology screen results were also compared.

Outcomes: Overall, the results indicated generally poor subject–collateral agreement. Collateral report

rarely provided more information on substance use than subject report, which as the authors note, "calls into question the value of routine use of collateral informants." The most consistent predictor of subject–collateral discrepancy scores was subjects' recent drug use; subject–collateral agreement appeared better for those individuals (n = 97) with negative urine drug screens. In contrast, there was high agreement between subjects' self-report and results of the urine toxicology screen. Agreement was lower, though still in an acceptable range, between collateral report and urine toxicology screen results.

Timing: Subjects were recruited within 2 weeks of treatment entry. There were two study visits: a diagnostic interview to determine diagnosis and study eligibility, and a main visit approximately 1 week later at which the measures of substance use were performed.

Setting: Dual-diagnosis program of a university-affiliated community mental health center.

Study Design: Cross-sectional

Overall risk of study bias: High Risk

Selection bias: High Risk: This study examines the concordance among self- and collateral reports of substance use, and urine toxicology screen results. Subjects who chose to be part of the study and allow collateral interviews may be more likely to discuss their substance use accurately, which may make them a non-representative sample.

Performance bias: High Risk: This was a non-blinded cross-sectional study design. Participants knew they were being interviewed and raters knew subjects' clinical characteristics, which may affect results.

Attrition bias: Unknown: There were two study visits, one for a diagnostic interview and determination of eligibility, and one for the baseline interview to collect substance use information. The authors note that if a subject had a positive breath test for alcohol, the visit was rescheduled. No information is provided on rates of attrition between the two study visits.

Detection bias: High Risk: Subjects and collateral sources may under or over report substance use. The authors note the possibility that subject reports may be influenced by the knowledge that collateral report and urine toxicology screening would be used for corroboration. Also, while the study measures had acceptable reliability and validity, reports of drug use were based on recall from memory.

Reporting bias: Low risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: This study was sponsored by the National Institute on Alcohol Abuse and Alcoholism Grant R01 AA12805 to Clara M. Bradizza. There was no evidence that the sponsors or authors introduced bias into the results of the study.

Applicability: This study covers use of alcohol and other substances, but the setting was a specialized dual diagnosis program and the subjects would be expected to have extremely high rates of substance use disorders, limiting its applicability to other settings. The main goal of the study was to determine the agreement between different methods of substance use assessment, which makes its finding less

applicable to the question of whether such assessment improves identification and diagnosis.

Grading of Supporting Body of Research Evidence

Risk of bias: High Risk: The body of evidence is made up of only observational studies, of varying quality.

Consistency: Consistent: The studies report that standardized questionnaires and collateral information are helpful in identifying risky drinking, alcohol use disorders, and substance use.

Directness: Direct: In these studies, using enhanced detection methods (questionnaires or collateral sources) improved detection and diagnosis of alcohol disorders.

Precision: Not applicable.

Dose-response relationship: Not applicable

Magnitude of effect: Strong: Using various enhancements to the standard clinical interview, whether a questionnaire or contacting a collateral source of information, appears to improve diagnosis, compared to clinical interviews or routine care.

Confounding factors (including likely direction of effect): Patients who are willing to participate in studies about alcoholism and substance use may not be representative of all patients, because they may, on average, have lower amounts of substance use than those who do not wish to participate. Also, patients filling out questionnaires may not accurately represent their own alcohol or substance use. The expected effects of these issues is that the rates of drinking found in the studies is likely an underestimate of the amount of alcohol use disorders in the general public, or among patients who present with psychiatric complaints.

Publication bias: not able to be assessed.

Applicability: The body of evidence only addresses use of alcohol and some substances; it does not address misuse of over-the-counter and prescription medications. In addition, the settings in which the studies were conducted did not include the full scope of psychiatric settings. Two of the studies identified “at risk drinking” rather than a diagnosis of an alcohol use disorder per se. In one study, the questioning about alcohol use was not done in the context of an initial psychiatric interview, which limits the applicability of this study to the clinical question.

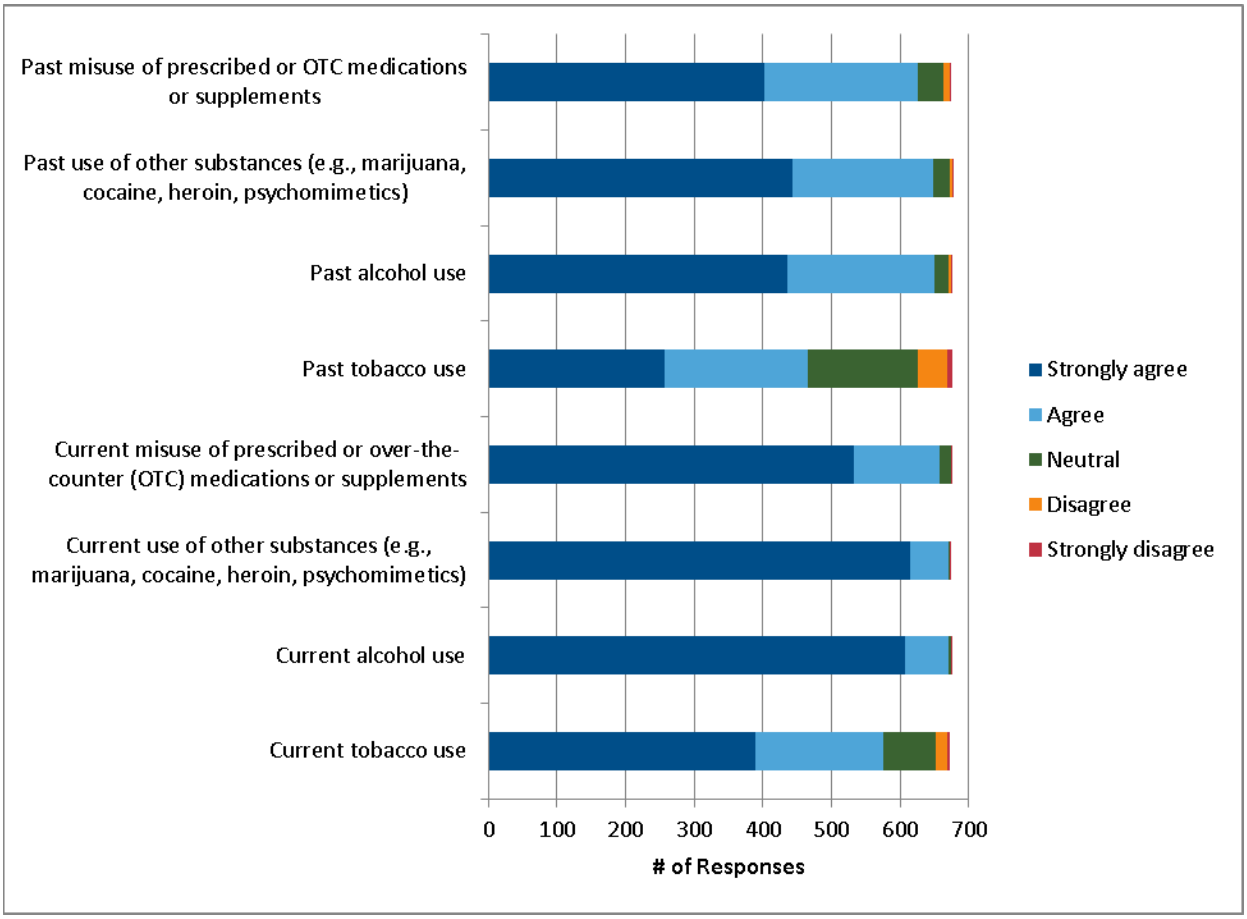
Overall strength of research evidence: Low

Differences of Opinion in Rating the Strength of Recommendations

None

Expert Opinion Data: Results

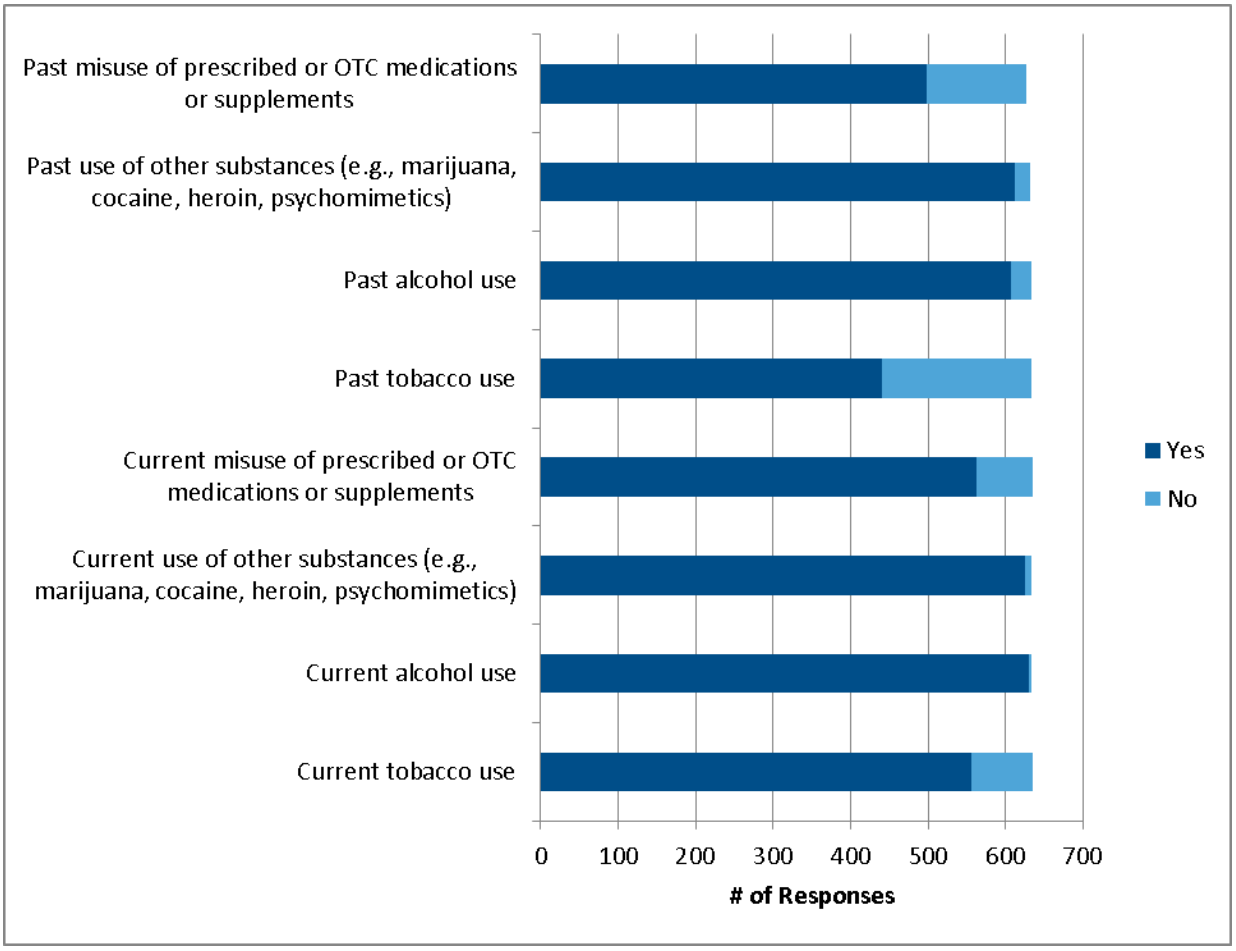
To what extent do you agree that the identification and diagnosis of substance use disorders is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following?



Percentage of experts who "strongly agreed" or "agreed" that the identification and diagnosis of substance use disorders is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following:

Past misuse of prescribed or OTC medications or supplements	92.6%
Past use of other substances (e.g., marijuana, cocaine, heroin, psychomimetics)	95.9%
Past alcohol use	96.2%
Past tobacco use	68.8%
Current misuse of prescribed or over-the-counter (OTC) medications or supplements	97.2%
Current use of other substances (e.g., marijuana, cocaine, heroin, psychomimetics)	99.7%
Current alcohol use	99.4%
Current tobacco use	85.6%

Do you typically (i.e., almost always) assess for the presence or absence of these items during initial evaluations of your patients?



Guideline 3. Assessment of Suicide Risk

Clinical Questions

Development of these guidelines was premised on the following clinical questions:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is identification of risk for suicide improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of the following? (1) Current suicidal ideas, including active or passive thoughts of suicide or death, (2) Current suicidal plans, (3) Current suicidal intent, (4) Intended course of action if current symptoms worsen, (5) Prior suicide ideas or plans, (6) Prior suicide attempts, (7) Prior aborted or interrupted suicide attempts (in which an attempt was stopped by the individual or by someone else), (8) Prior intentional self-injury without suicide intent, (9) History of psychiatric hospitalization, (10) History of suicidal behaviors in biological relatives, (11) Anxiety symptoms, including panic attacks, (11) Hopelessness, (12) Impulsivity, (13) Accessibility of suicide methods, including firearms, (14) Current or recent dependence, abuse, or increased use of alcohol or other substances, (15) Presence of possible motivations for suicide (e.g., attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations), (16) Presence or absence of psychosocial stressors (e.g., financial, housing, legal or school/occupational problems; lack of social support), (17) Presence or absence of reasons for living (e.g, sense of responsibility to children or others, religious beliefs), (18) Quality and strength of the therapeutic alliance?

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of the patient's suicide risk, including factors influencing risk? Is coordination of psychiatric treatment with other clinicians improved?

Review of Supporting Research Evidence

Overview of Studies

Few studies have systematically assessed the benefits of a suicide risk assessment in reducing rates of suicide or suicide attempts.

A study by Pokorny et al. (1983) examined the ability of multiple potential risk factors to predict later suicide or suicide attempts in 4,800 individuals who had been psychiatrically admitted to a Veterans Administration hospital in the United States and were followed for 4 to 6 years. Although some factors seemed to correlate with an increase in suicide risk, the ability of these risk factors (considered singly or together) to predict suicide or suicide attempts in particular individuals was low. This low positive predictive ability resulted in high numbers of false positives and false negatives, in part related to low sensitivity and specificity of the risk factors and in part related to the relatively low population rates of suicide and suicide attempts. A re-analysis of these same data by Pokorny (1993) used logistic regression, and confirmed that the positive predictive value of the identified risk factors was low.

Author, Ref.	Subjects / Method	N	Duration	Outcomes
Pokorny, Arch Gen Psychiatry 1983; 40:249–257	Patients consecutively admitted to a VA hospital were part of the study. These patients underwent a series of risk assessment batteries at admission, and then they were followed for 4-6 years.	4800 patients	Patients followed for 4-6 years after the incident admission.	Despite using assessment instruments which were previously reported to be predictive of suicide, the authors conclude that because of the low sensitivity and specificity of the instruments, and the low base rate of suicide itself, prediction of persons who will later commit suicide is not feasible.

No studies have addressed the benefits of documenting suicide risk in the medical record.

Grading of Quality of Individual Studies

Pokorny AD. Prediction of suicide in psychiatric patients. Report of a prospective study. Arch Gen Psychiatry 40:249–257, 1983

Population: 4800 Patients consecutively admitted to a VA hospital in Houston, TX, USA

Intervention: risk assessment batteries administered at the time of index admission

Comparators: N/A

Outcomes: Prediction of suicide or attempted suicide in particular individuals during a 4-6 year follow-up period.

Timing: Risk assessment at index admission with follow-up for 4-6 years

Setting: Veterans Hospital, inpatient psychiatric service

Study design: Prospective cohort study

Study sponsorship: National Institute of Mental Health and VA research funds

Overall risk of study bias: Low risk

Selection bias: Low risk, as all patients were included in the sample and followed longitudinally.

Performance bias: Low risk, given longitudinal nature of the study, there is no reason to postulate a systematic difference in the care given to participants and the initial interviewers were unaware of the subjects' ultimate outcome

Attrition bias: Low risk, all 4800 patients continued to be followed throughout the study

Detection bias: Low risk, as there was no attrition and multiple approaches were used to

determine whether patients had died during the study period (including by suicide) and/or had made a suicide attempt

Reporting bias: Low risk, initial assessments were done without knowledge of outcome and outcomes are binary in nature.

Sponsor-related bias: Low risk, non-commercial funding source, no obvious sources of other investigator bias.

Applicability: The study population consists of only psychiatric inpatients. There are some limits on generalizability given the differences between VA hospital populations and general psychiatric inpatient unit populations

Grading of Supporting Body of Research Evidence

Risk of bias: High, the body of evidence consists of only one observational study with a sample size that was too small to overcome issues with the low base rate of suicide.

Consistency: Consistency cannot be determined because there is only one study.

Directness: Direct, the study examined the effect of a risk assessment battery on prediction of suicide in psychiatric patients

Precision: Imprecise, due to the low base rate of suicide, and small sample size, the estimate of effect does not suggest a clinically useful conclusion.

Dose-response relationship: Not applicable

Magnitude of effect: Weak

Confounding factors (including likely direction of effect): Absent

Publication bias: Not able to be assessed.

Applicability: The study involved VA hospital inpatients, who were mostly male.

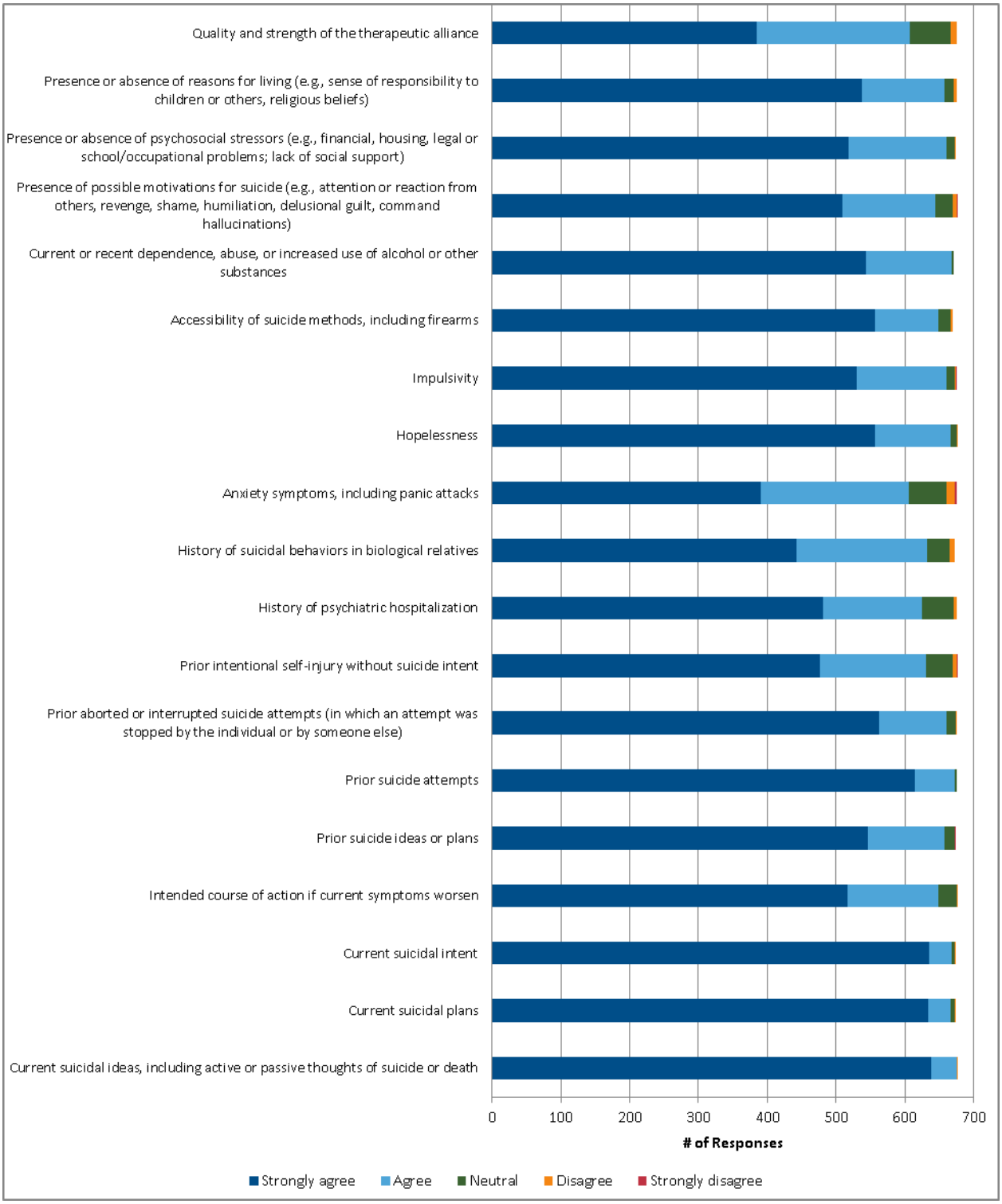
Overall strength of research evidence: Low.

Differences of Opinion in Rating the Strength of Recommendations

One member of the work group was uncertain about the value of assessing two risk factors, hopelessness and impulsivity. In patients who report current suicidal ideas, one member of the work group was uncertain about the value of assessing the patient's reasons for living. These are considered to be minor differences of opinion.

Expert Opinion Data: Results

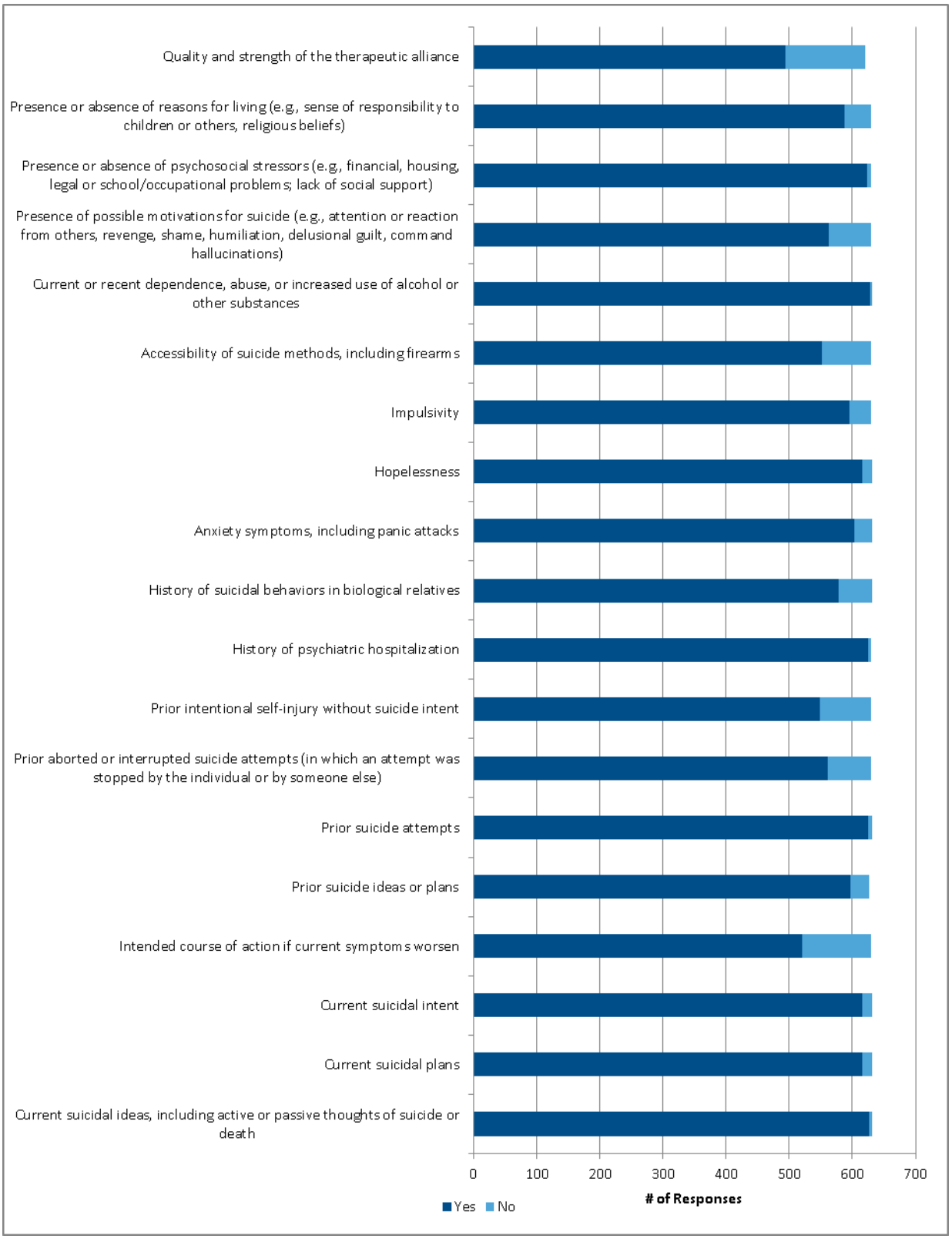
To what extent do you agree that identification of patients at risk for suicide is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following?



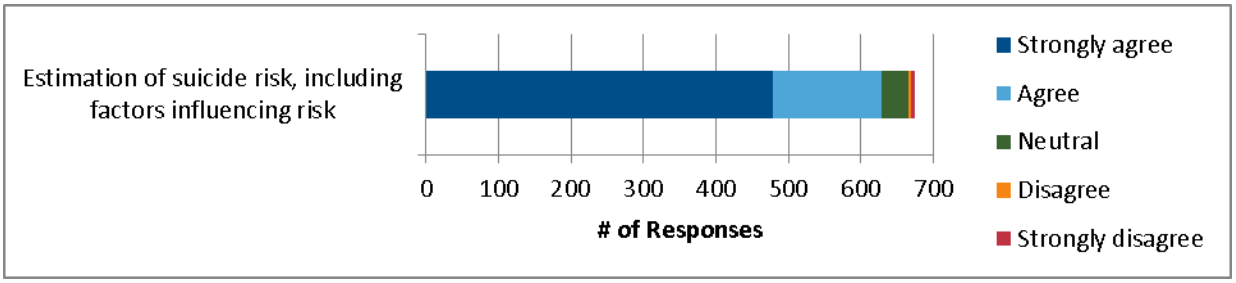
Percentage of experts who “strongly agreed” or “agreed” that identification of patients at risk for suicide is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following:

Quality and strength of the therapeutic alliance	89.9%
Presence or absence of reasons for living (e.g., sense of responsibility to children or others, religious beliefs)	97.3%
Presence or absence of psychosocial stressors (e.g., financial, housing, legal or school/occupational problems; lack of social support)	98.1%
Presence of possible motivations for suicide (e.g., attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations)	95.3%
Current or recent dependence, abuse, or increased use of alcohol or other substances	99.6%
Accessibility of suicide methods, including firearms	96.7%
Impulsivity	97.8%
Hopelessness	98.7%
Anxiety symptoms, including panic attacks	89.6%
History of suicidal behaviors in biological relatives	94.0%
History of psychiatric hospitalization	92.5%
Prior intentional self-injury without suicide intent	93.2%
Prior aborted or interrupted suicide attempts (in which an attempt was stopped by the individual or by someone else)	97.8%
Prior suicide attempts	99.7%
Prior suicide ideas or plans	97.6%
Intended course of action if current symptoms worsen	96.0%
Current suicidal intent	99.1%
Current suicidal plans	99.1%
Current suicidal ideas, including active or passive thoughts of suicide or death	99.7%

Do you typically (i.e., almost always) assess these items during initial evaluations of your patients?



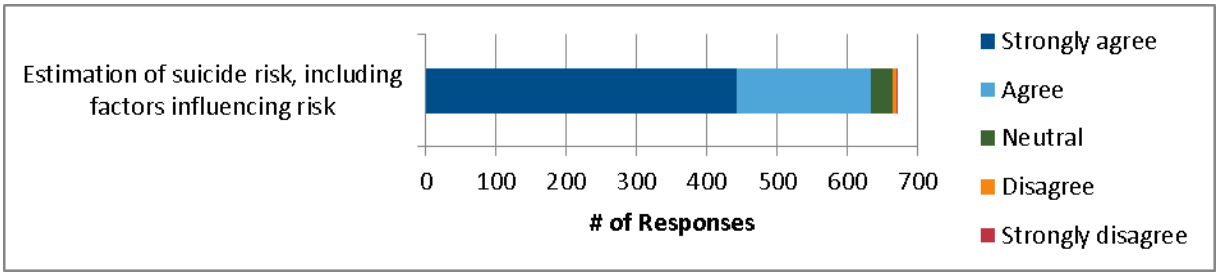
To what extent do you agree that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of suicide risk, including factors influencing risk?



Percentage of experts who “strongly agreed” or “agreed” that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of suicide risk, including factors influencing risk:

93.2%

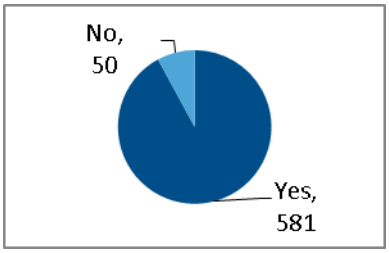
To what extent do you agree that coordination of psychiatric treatment with other clinicians is improved when an estimation of risk is typically (i.e., almost always) documented?



Percentage of experts who “strongly agreed” or “agreed” that coordination of psychiatric treatment with other clinicians is improved when an estimation of risk is typically (i.e., almost always) documented:

94.5%

Do you typically (i.e., almost always) document an estimation of risk in the medical record of your patients?



Guideline 4. Assessment of Risk for Aggressive Behaviors

Clinical Question

Development of these guidelines was premised on the following clinical question:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is identification of risk for aggressive behaviors improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of the following?

- Current aggressive ideas, including thoughts of physical or sexual aggression or homicide
- Prior homicidal or aggressive behaviors, including domestic or workplace violence or other physically or sexually aggressive threats or acts
- Prior homicidal or aggressive ideas
- History of psychiatric emergency visits or psychiatric hospitalization
- Legal or disciplinary consequences of aggressive behaviors, including school expulsion, arrests, or orders of protection
- Current or recent dependence, abuse, or increased use of alcohol or other substances
- Impulsivity, including anger management issues
- Access to firearms
- Psychosocial stressors (e.g., financial situation, housing/homelessness, lack of social support)
- Family history of abuse or violence
- Exposure to violence or aggressive behavior, including combat exposure
- Neurological disorder (e.g., traumatic brain injury, seizure)

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of risk of aggressive behavior (including homicide), including factors influencing risk? Is coordination of psychiatric treatment with other clinicians improved?

Review of Supporting Research Evidence

Overview of Studies

Author, Ref.	Subjects / Method	N	Duration	Outcomes
Abderhalden C, et al., British J of Psychiatry 2008, 193:44-50	14 acute psychiatric units in Switzerland were randomized to provide a structured nursing risk assessment for all new admissions (4 units) vs. waiting-list control (5 units). 5 other units elected to provide the assessment without entering randomization. The assessment produces a risk score from 0 to 12.	2364 patients in 14 different psychiatric units	June 2002 through April 2004	In the units performing the risk assessments, there was a 41% reduction in severe aggressive incidents and a 27% decline in the use of coercive measures. The severity of incidents did not decrease. The authors conclude that structured risk assessment during the first days of treatment may contribute to reduced violence and coercion in acute psychiatric wards.
Van de Sande et al., British J of	4 acute psychiatric units in a single hospital in the	597 patients in 4	10 weeks pre-randomization	In the units performing structured risk assessments, there was a 68%

Psychiatry 2011, 199:473-478.	Netherlands were randomized to use either a structured risk assessment on all admitted patients (2 units) or clinical judgment of risk (2 units).	different psychiatric units	lead-in period and 30 week study period; dates unreported	decrease in the number of aggressive incidents. Hours spent in seclusion also declined in the intervention group (by 45%). The authors conclude that structured risk assessment may help reduce aggressive incidents and use of restraint and seclusion in acute psychiatric wards.

Grading of Quality of Individual Studies

Citation: Abderhalden C, et al. Structured risk assessment and violence in acute psychiatric wards: randomized controlled trial. BJP 2008; 193:44-50.

Population: Patients in psychiatric units in Switzerland. There were 324 psychiatric units in in the area that were screened on eligibility criteria (i.e., majority of patients have an acute psychiatric disorder, patients are admitted directly onto the unit, patients usually stay less than 3 months, patients are 18-65 years old, and the unit admits all potential patients and is not specialized for the treatment of specific disorders). Out of the 324 units, 86 met these criteria and were invited to participate. Sixty-two units declined participation. Nine units were randomized to the intervention or wait-list control; five units elected to use the intervention without being randomized. A total of 2,364 patients were admitted across the 14 units (46.6% female, mean age=39.5 years, SD=14.2, range 14-95). Of these patients, 56% were admitted voluntarily, which is typical for the area. Approximately 24% of patients had disorders due to psychoactive substance use; 31% had schizophrenia, schizotypal, and delusional disorders; and 16% had mood disorders.

Intervention: All patients in the intervention units received a nurse-administered structured short-term risk assessment within 3 days of admission to the unit. The assessment was the previously validated extended Swiss version of the Broset Violence Checklist (BVC-CH). The checklist rates six patient behaviors (confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects) and includes an overall subjective assessment of the risk of imminent violence using a slide-rule visual analogue scale. The ratings are combined to produce a score between 0 (very low risk) and 12 (high risk).

Comparators: Wait-list control, and preference group. Data from the 3-month baseline period was compared to that of the 3-month intervention period for each group.

Outcomes: Incidence rates of aggressive behaviors decreased in the intervention units, but were unchanged in control units. The overall incidence rate of severe aggressive events was 1.09 (95% CI 0.96-1.24) per 100 hospitalization days during the 3-month baseline period as compared to 0.75 (95% CI 0.65-0.87) during the 3-month intervention period. For the use of coercive measures (e.g., emergency medication treatment, seclusion, restraint) the overall incidence rate was 1.57 (95% CI 1.41-1.75) per 100 hospitalization days during the baseline and 1.20 (95% CI 1.07-1.35) during the intervention period. Decline in severe aggressive events in the intervention units (Adjusted risk ratio=0.59, 95% CI 0.41-0.83)

was significantly larger (P<0.001) than the decline in the control units (RR=0.85, 95% CI 0.63-1.13). Rates declined more in intervention units than in control units for both secondary outcomes: attacks (41% vs. 7%; p<0.001), and use of coercive measures (27% vs. increase of 10%; p<0.001). Effects were larger in the preference units than in the randomized units (attacks: 64% decline, coercive measures: 60% decline).

Timing: June 2002-April 2004. Baseline data was collected in all units over a 3-month period, followed by a 3-month intervention period.

Setting: Psychiatric in-patient units in the German-speaking area of Switzerland.

Study Design: Randomized controlled trial (psychiatric units served as the unit of randomization)

Overall risk of study bias: Moderate risk.

Selection bias: High risk. The investigators conducted a survey of all units in the area prior to the study in order to control for recruitment bias. Survey questions inquired about unit size, staffing, facilities for managing aggression and violence, leaders' ratings of the severity of the problem and the resources for aggression management. The leaders of intervention units rated aggression as a greater problem than leaders of other units. The baseline rates of aggression were higher in the intervention units than in the control units. The preference units had significantly fewer patients with diagnoses of schizophrenia, schizotypal, and delusional disorders than the randomized units. The distribution of diagnoses across the intervention and control arms was comparable. No other differences reported.

Performance bias: Moderate risk. Neither raters nor patients were blinded to intervention condition. There is no evidence of systematic differences in treatment of the study groups.

Attrition bias: Moderate risk. Sixty-two psychiatric units declined participation. It is possible that these units differed systematically from those who agreed to participate.

Detection bias: Low risk. All patients were included and all aggressive incidents and rates of use of coercive measures were recorded. Two of the investigators regularly visited the units on randomly selected dates to review study data and ensure accurate recording. Underreporting of less severe incidents appeared to be more common as the study progressed but no under-reporting of severe incidents was noted.

Reporting bias: Low risk. There is no evidence of selective outcome reporting.

Sponsor-related bias: Low risk. The study was funded by a grant from the Swiss National Science Foundation. There is no evidence of sponsor-related bias.

Applicability: This study was conducted in acute inpatient psychiatric units in Switzerland, thus limiting generalizability to other treatment settings and to patients in the U.S.

Citation: van de Sande R, et al., Aggression and seclusion on acute psychiatric wards: effect of short-term risk assessment. British J of Psychiatry 2011, 199:473-478.

Population: Patients in psychiatric units in the Netherlands. Four acute wards of a hospital in Rotterdam

were randomized to conduct structured risk assessments on all admissions (2 units) or to use standard clinical judgments of risk (2 units). There were 597 patients admitted during the trial of whom 62% were admitted involuntarily. Diagnostically, 58% of patients had a psychotic disorder and 18% had a personality disorder. The average age was 38.8 years and 60% of the patients were male.

Intervention: All patients in the intervention units received a nurse-administered structured short-term risk assessments (the Broset Violence Checklist and the Kennedy Axis V short version) on a daily basis, with the full version of the Kennedy Axis V scale, the Brief Psychiatric Rating Scale (BPRS), Dangerousness Scale and Social Dysfunction and Aggression scale administered on a weekly basis and discussed during meetings of the staff. Ratings were used to recognize early patterns of symptom evolution and behavioral escalation.

Comparators: Clinical judgment only. Data from the 10 week baseline period was compared to that of the 30 week intervention period for each group.

Outcomes: In the intervention period, as compared to the baseline, there was a significant decrease in the numbers of aggressive incidents (relative risk reduction compared to controls of -68%, $P<0.001$), number of patients engaging in aggression (RRR =-50%, $P<0.05$), and time spent in seclusion (RRR =-45%, $P<0.05$). The weekly rate of aggressive incidents also decreased on the intervention unit with an average of 4.9 incidents per week during the baseline period and an average of 1.7

incidents per week during the intervention period. In contrast, the number of aggressive incidents on the control unit did not change significantly during the baseline and intervention periods and were 3.5 incidents per week and 3.9 incidents per week, respectively. The number of seclusion episodes and the number of patients receiving seclusion did not differ between the intervention and control groups.

Timing: Study dates were not reported. Baseline data was collected in all units over a 10 week period, followed by a 30 week intervention period.

Setting: Psychiatric in-patient units in Rotterdam, The Netherlands.

Study Design: Randomized controlled trial (psychiatric units served as the unit of randomization)

Overall risk of study bias: Moderate risk.

> Selection bias: High risk. The units in the intervention group had statistically greater rates of patients with personality disorders, psychosis and involuntary admission during the baseline and intervention periods.
>
> Performance bias: Moderate risk. Neither raters nor patients were blinded to intervention condition. There is no evidence of systematic differences in treatment of the study groups.
>
> Attrition bias: Low risk. All units continued to participate throughout the study and patients on each unit remained in the study throughout their hospital stay.
>
> Detection bias: Low risk. All patients were included and all aggressive incidents and episodes of seclusion were recorded. Clinical nurse specialists visited all units on a daily basis to assure that events were recorded consistently.

Reporting bias: Low risk. There is no evidence of selective outcome reporting.

Sponsor-related bias: Low risk. The study was funded by a grant from the Dutch Ministry of Health. There is no evidence of sponsor-related bias.

Applicability: This study was conducted in acute inpatient psychiatric units in the Netherlands, thus limiting generalizability to other treatment settings and to patients in the U.S.

Grading of Supporting Body of Research Evidence

Risk of bias: High. The body of evidence consists of two nonblinded studies, with a total of 13 psychiatric units randomized to intervention or control.

Consistency: Consistent. Both studies showed reductions in incidents of aggressive behavior and in use of seclusion and/or restraint.

Directness: Indirect. Although the studies did measure specific aggressive behaviors as one outcome, the specific risk assessment elements used in the study were not the same as those outlined in the clinical question.

Precision: Precise. Confidence intervals reported in the studies were fairly narrow.

Dose-response relationship: Not applicable

Magnitude of effect: Weak. Although there were significant declines in aggressive events, some or all of this change could have resulted from other unmeasured changes (e.g., staff behavior) that would have also affected rates of aggressive events.

Confounding factors that would decrease the magnitude of the effect: Absent.

Publication bias: Not able to be assessed.

Applicability: There were two studies of psychiatric inpatients at European hospitals, limiting the applicability to other settings. Also, the assessment did not address all assessment items in the clinical question.

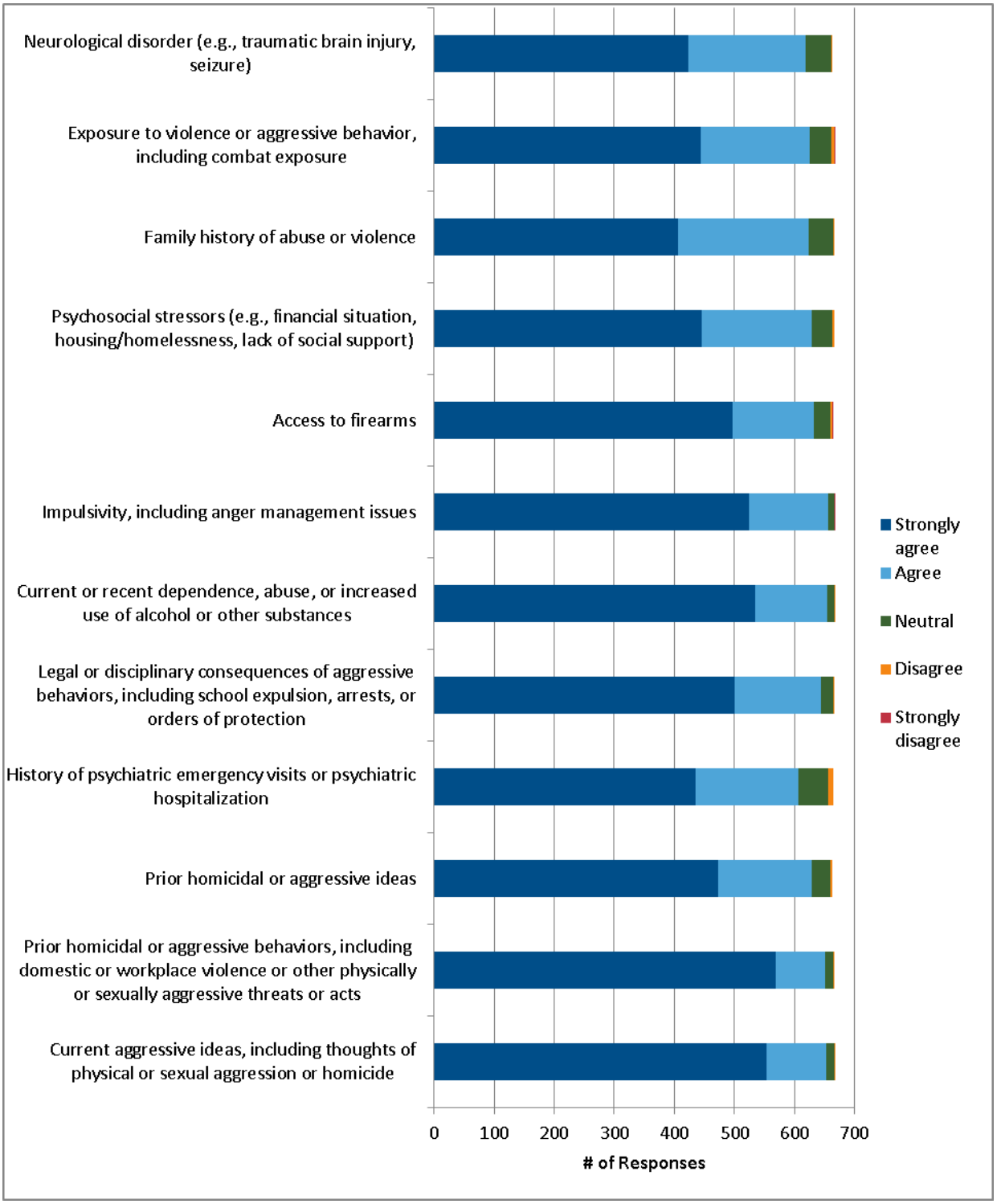
Overall strength of research evidence: Low.

Differences of Opinion in Rating the Strength of Recommendations

One work group member was uncertain about the benefits of assessing for neurological disorder. On all other aspects of these recommendations, work group opinion was unanimous.

Expert Opinion Data: Results

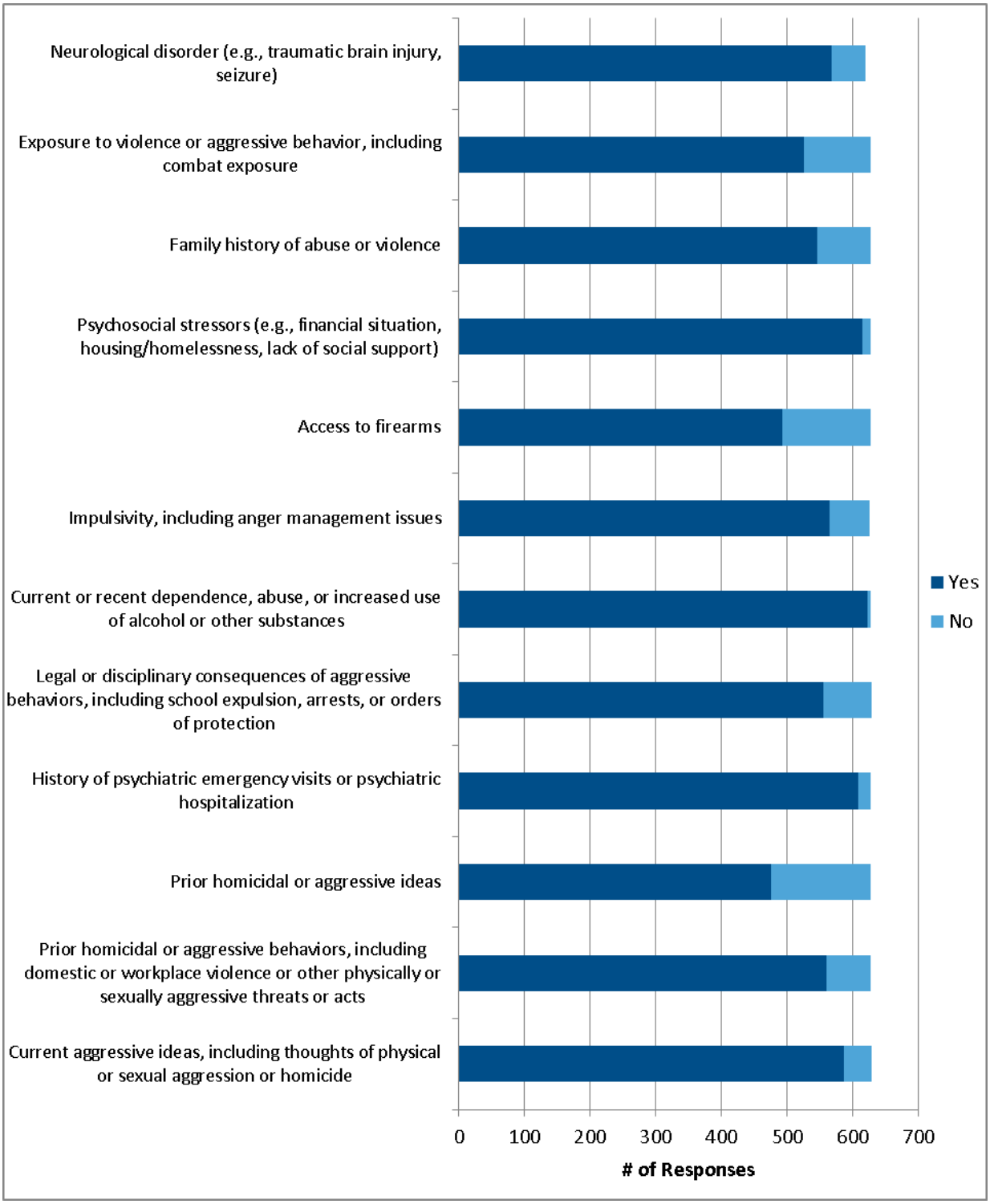
To what extent do you agree that identification of patients at risk for aggressive behaviors is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following?


Neurological disorder (e.g., traumatic brain injury, seizure)
Exposure to violence or aggressive behavior, including combat exposure
Family history of abuse or violence
Psychosocial stressors (e.g., financial situation, housing/homelessness, lack of social support)
Access to firearms
Impulsivity, including anger management issues
Current or recent dependence, abuse, or increased use of alcohol or other substances
Legal or disciplinary consequences of aggressive behaviors, including school expulsion, arrests, or orders of protection
History of psychiatric emergency visits or psychiatric hospitalization
Prior homicidal or aggressive ideas
Prior homicidal or aggressive behaviors, including domestic or workplace violence or other physically or sexually aggressive threats or acts
Current aggressive ideas, including thoughts of physical or sexual aggression or homicide
0
100
200
300
400
500
600
700
# of Responses
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

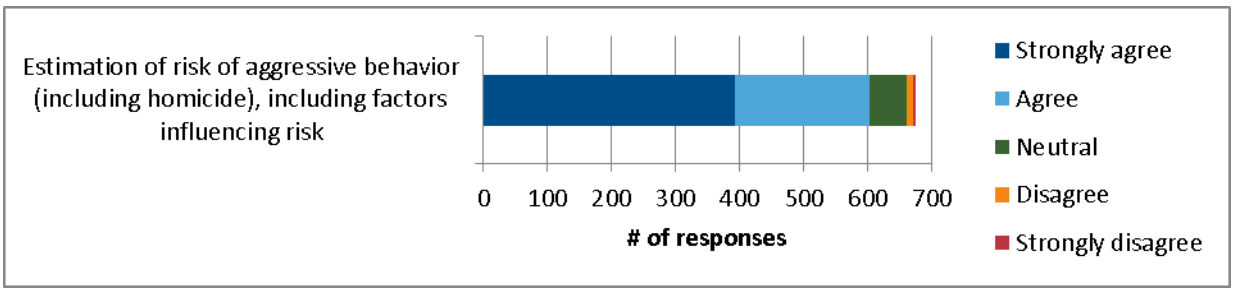
Percentage of experts who “strongly agreed” or “agreed” that identification of patients at risk for aggressive behaviors is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following

Neurological disorder (e.g., traumatic brain injury, seizure)	93.5%
Exposure to violence or aggressive behavior, including combat exposure	93.7%
Family history of abuse or violence	93.7%
Psychosocial stressors (e.g., financial situation, housing/homelessness, lack of social support)	94.3%
Access to firearms	95.3%
Impulsivity, including anger management issues	98.4%
Current or recent dependence, abuse, or increased use of alcohol or other substances	98.1%
Legal or disciplinary consequences of aggressive behaviors, including school expulsion, arrests, or orders of protection	96.7%
History of psychiatric emergency visits or psychiatric hospitalization	91.4%
Prior homicidal or aggressive ideas	94.7%
Prior homicidal or aggressive behaviors, including domestic or workplace violence or other physically or sexually aggressive threats or acts	97.9%
Current aggressive ideas, including thoughts of physical or sexual aggression or homicide	97.8%

Do you typically (i.e., almost always) assess these items during initial evaluations of your patients?


Neurological disorder (e.g., traumatic brain injury, seizure)
Exposure to violence or aggressive behavior, including combat exposure
Family history of abuse or violence
Psychosocial stressors (e.g., financial situation, housing/homelessness, lack of social support)
Access to firearms
Impulsivity, including anger management issues
Current or recent dependence, abuse, or increased use of alcohol or other substances
Legal or disciplinary consequences of aggressive behaviors, including school expulsion, arrests, or orders of protection
History of psychiatric emergency visits or psychiatric hospitalization
Prior homicidal or aggressive ideas
Prior homicidal or aggressive behaviors, including domestic or workplace violence or other physically or sexually aggressive threats or acts
Current aggressive ideas, including thoughts of physical or sexual aggression or homicide
Yes
No
0
100
200
300
400
500
600
700
# of Responses

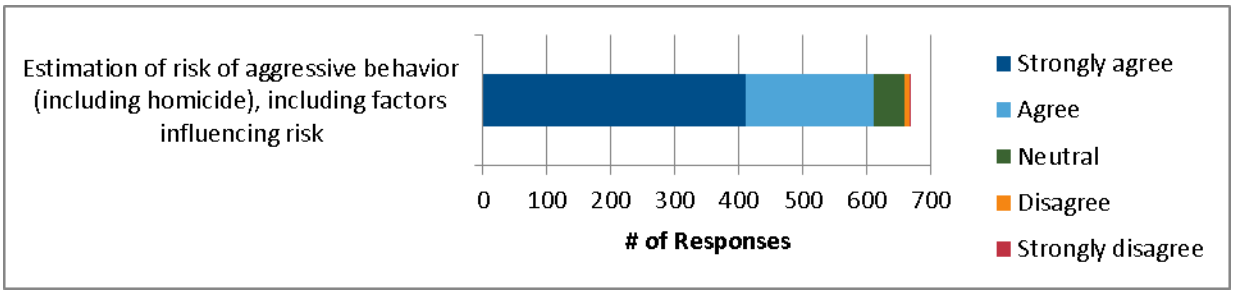
To what extent do you agree that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of risk of aggressive behavior, including factors influencing risk?



Percentage of experts who “strongly agreed” or “agreed” that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents in the patient's medical record an estimation of risk of aggressive behavior, including factors influencing risk:

89.3%

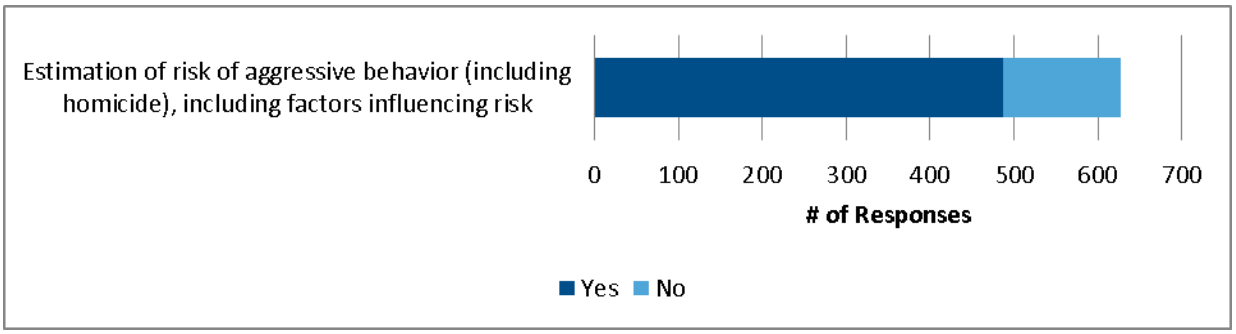
To what extent do you agree that coordination of psychiatric treatment with other clinicians is improved when an estimation of risk of aggressive behavior, including factors influencing risk, is typically (i.e., almost always) documented?



Percentage of experts who “strongly agreed” or “agreed” that coordination of psychiatric treatment with other clinicians is improved when an estimation of risk of aggressive behavior, including factors influencing risk, is typically (i.e., almost always) documented:

91.3%

Do you typically (i.e., almost always) document an estimation of risk of aggressive behavior, including factors influencing risk, in the medical record of your patients?



Guideline 5. Assessment of Cultural Factors

Clinical Questions

Development of these guidelines was premised on the following clinical questions:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is formulation of an appropriate treatment plan improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of his or her language needs (i.e., basic language ability and need for an interpreter)?

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are the therapeutic alliance, accuracy of diagnosis, and formulation of an appropriate treatment plan improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of his or her personal/cultural beliefs?

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are the therapeutic alliance, accuracy of diagnosis, and formulation of an appropriate treatment plan improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of his or her cultural explanations of psychiatric illness?

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are the therapeutic alliance, accuracy of diagnosis, and formulation of an appropriate treatment plan improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of cultural factors related to his or her social environment (e.g., family network, work place, religious group, community, or other psychosocial support network)?

Review of Supporting Research Evidence

Overview of Studies

There is no supporting research evidence that specifically addresses the above clinical questions.

Grading of Quality of Individual Studies

Not applicable

Grading of Supporting Body of Research Evidence

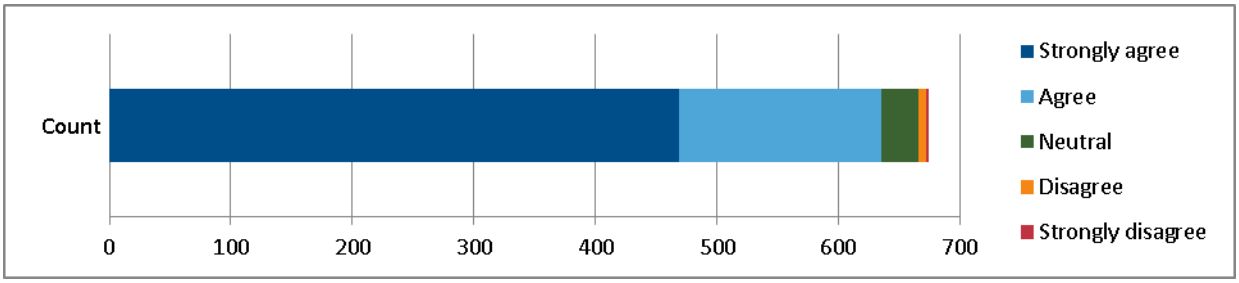
Not applicable

Differences of Opinion in Rating the Strength of Recommendations

One member of the work group was uncertain that potential benefits of assessing cultural factors related to the patient's social environment clearly outweigh harms. This difference of opinion is considered minor.

Expert Opinion Data: Results

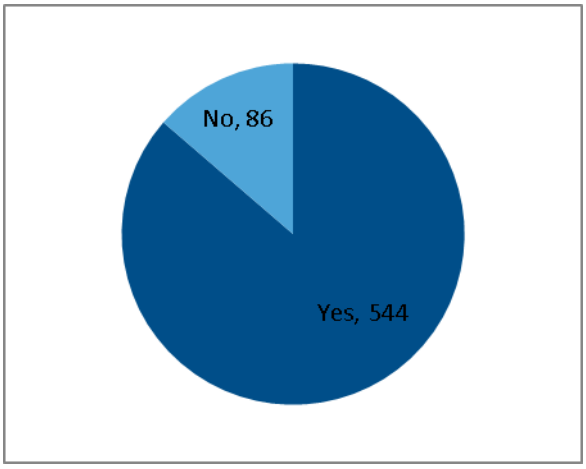
To what extent do you agree that formulation of an appropriate treatment plan is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the patient's language needs (i.e., basic language ability and need for an interpreter)?



Percentage of experts who “strongly agreed” or “agreed” that formulation of an appropriate treatment plan is improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the patient's language needs:

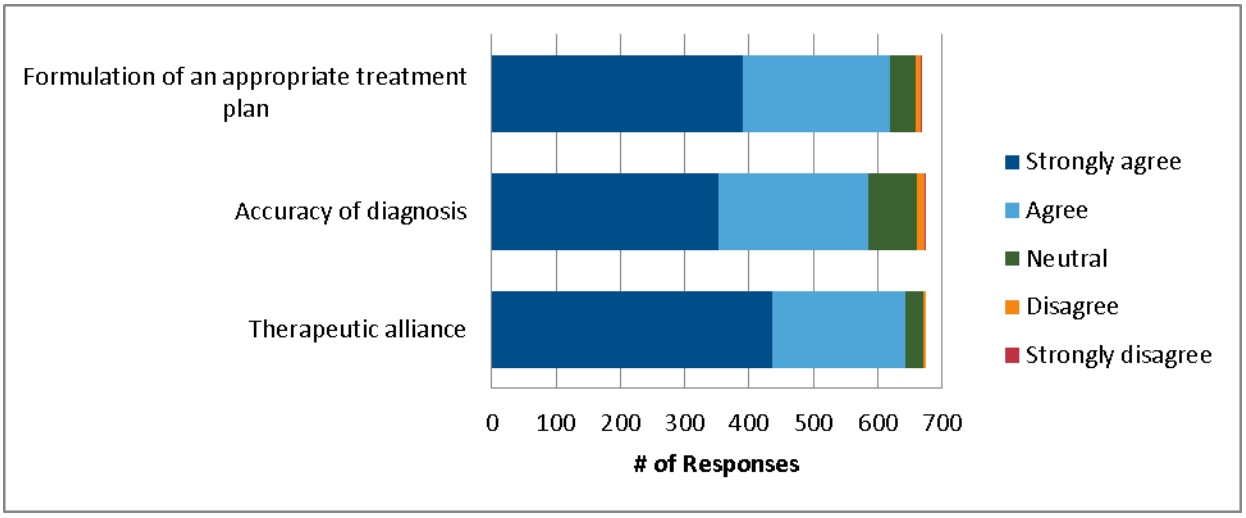
94.2%

Do you typically (i.e., almost always) assess your patients' language needs during initial psychiatric evaluations?



To what extent do you agree that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of his or her personal/cultural beliefs?

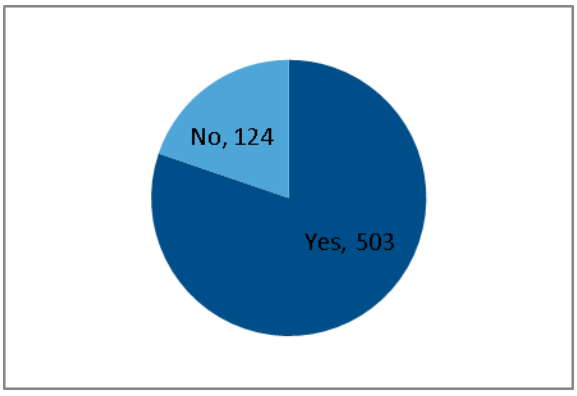
Personal/cultural beliefs are defined as beliefs related to the patient’s personal/cultural characteristics and identity, including but not limited to beliefs about age, ethnicity, gender, race, religion, and sexuality.



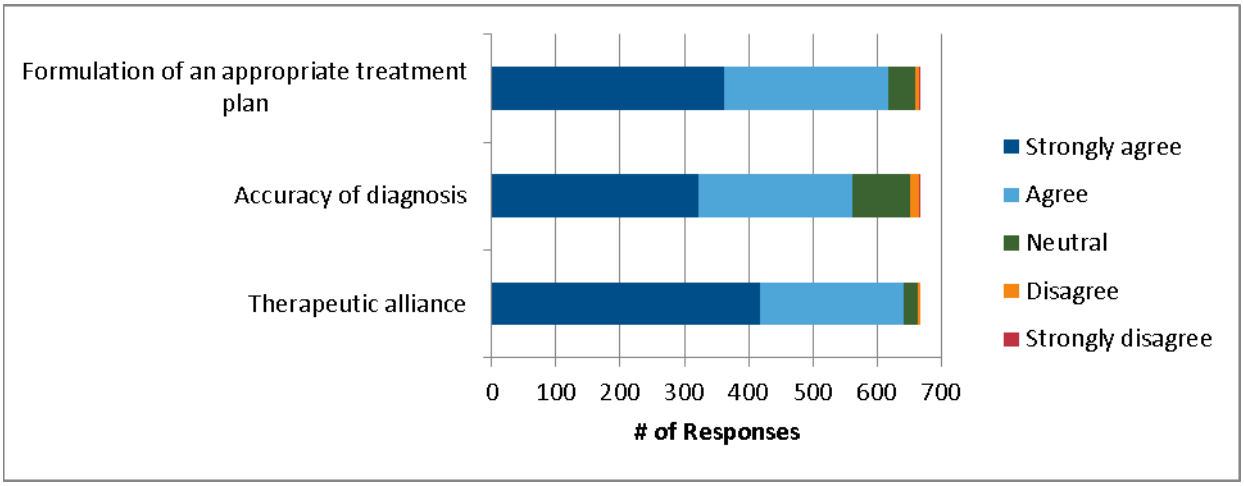
Percentage of experts who "strongly agreed" or "agreed" that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of his or her personal/cultural beliefs:

Therapeutic alliance	95.3%
Accuracy of diagnosis	86.6%
Formulation of an appropriate treatment plan	92.7%

Do you typically (i.e., almost always) assess your patients' personal/cultural beliefs during initial psychiatric evaluations?



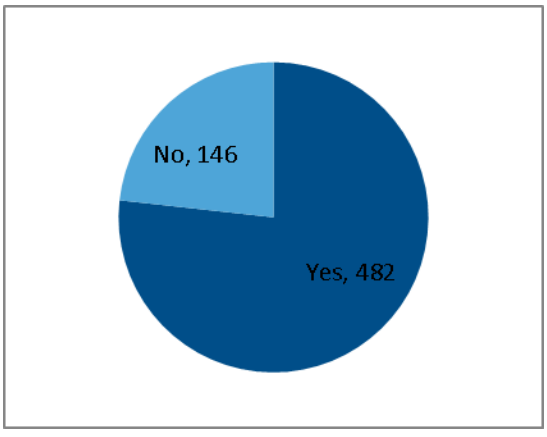
To what extent do you agree that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of his or her cultural explanations of psychiatric illness?



Percentage of experts who “strongly agreed” or “agreed” that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of his or her cultural explanations of psychiatric illness:

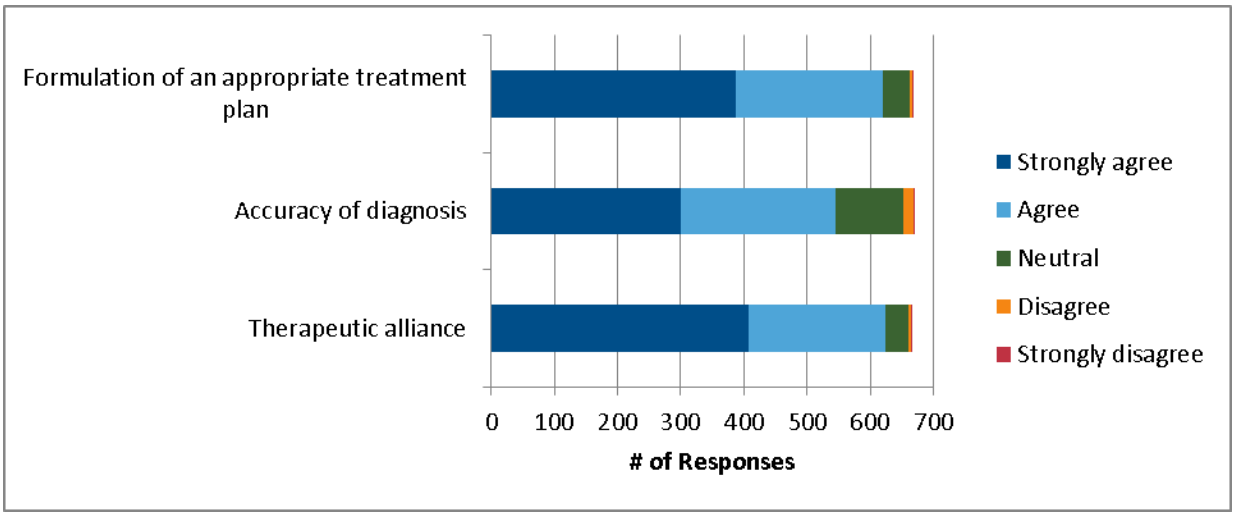
Formulation of an appropriate treatment plan	92.7%
Accuracy of diagnosis	84.1%
Therapeutic alliance	96.0%

Do you typically (i.e., almost always) assess your patients' cultural explanations of their psychiatric illness during initial psychiatric evaluations?



To what extent do you agree that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of cultural factors related to his or her

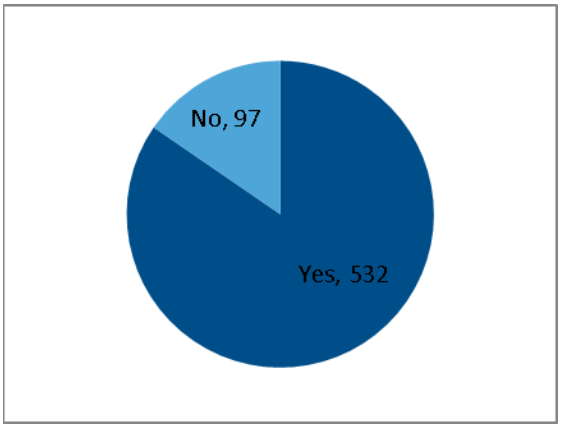
social environment (e.g., family network, religious group, community, or other social support network)?



Percentage of experts who "strongly agreed" or "agreed" that the following are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of cultural factors related to his or her social environment:

Formulation of an appropriate treatment plan	92.7%
Accuracy of diagnosis	81.5%
Therapeutic alliance	93.7%

Do you typically (i.e., almost always) include in initial psychiatric evaluations assessment of cultural factors related to your patients' social environment?



Guideline 6. Assessment of Medical Health

Clinical Questions

Development of these guidelines was premised on the following clinical questions:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, should an initial psychiatric evaluation typically (i.e., almost always) include assessment of whether or not the patient has an ongoing relationship with a primary care health professional?

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are diagnostic accuracy and treatment safety improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of the following aspects of his or her *current general medical status*? "Assessment" is defined here as (a) performing a physical examination on the patient, (b) directing another clinician (e.g., a resident) to perform the exam, or (c) reviewing the results of a recent physical examination performed by another clinician.

a. General appearance and nutritional status

b. Height, weight, body mass index (BMI)

c. Vital signs

d. Skin, including any stigmata of trauma, self-injury, or drug use

e. Cardiopulmonary status

f. Involuntary movements or abnormalities of motor tone

g. Coordination and gait

h. Speech, including fluency and articulation

i. Cranial nerves, including sight and hearing

j. Reflexes and peripheral motor and sensory functions

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are diagnostic accuracy and treatment safety improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of the following aspects of his or her *general medical history*? Assessment may occur directly or by review of the results of a recent assessment by another clinician.

a. Physical trauma, including head injuries

b. Past or current general medical illnesses and related hospitalizations

c. Important past or current treatments or procedures, including complementary and alternative medical treatments

d. Allergies or drug sensitivities

e. Past or current endocrinological disease

f. Past or current infectious disease, including but not limited to sexually transmitted diseases, HIV, tuberculosis, and hepatitis C

g. Past or current neurological disorders or symptoms

h. Sexual and reproductive history

i. Past or current sleep disorders, including sleep apnea

j. Past or current symptoms or conditions associated with significant pain and discomfort

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are diagnostic accuracy and treatment safety improved when the initial psychiatric evaluation typically (i.e., almost always) includes review of all medications he or she is currently or recently taking and the side effects of these medications? "All medications" means both prescribed and non-prescribed medications, herbal and nutritional supplements, and vitamins.

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are diagnostic accuracy and treatment safety improved when the initial psychiatric evaluation typically (i.e., almost always) includes the following elements of a review of systems?

a. General/systemic

b. Skin

c. HEENT (head, ears, eyes, nose, throat)

d. Respiratory

e. Cardiovascular

f. Gastrointestinal

g. Genitourinary

h. Musculoskeletal

i. Neurologic

j. Hematologic

k. Endocrine

Review of Supporting Research Evidence

Overview of Studies

Few studies have examined the role of medical assessment in improving diagnostic accuracy or treatment safety within the context of an initial psychiatric evaluation, i.e., across a broad range of patient characteristics or settings. Available studies have typically examined the ability of a screening history, physical examination or battery of tests on the identification of medical causes of psychiatric symptoms.

Author, Ref.	Subjects / Method	N	Duration	Outcomes
Hall RC et al., American J of Psychiatry 138 (5): 629-635, 1981	100 state hospital psychiatric patients consecutively admitted to a research ward were screened for physical illness prior to admission.	100	Not specified in the study	46% of these patients had an unrecognized medical illness that either caused or exacerbated their psychiatric illness. 80% had physical illness requiring treatment, and 4% had precancerous conditions or illnesses. The authors suggest that a physical exam and a battery of medical screening tests be part of a routine workup for all hospitalized psychiatric patients.
Henneman PL et al., Ann Emerg Med 24 (4): 672-677, 1994	A medical history, physical examination, lab work, CT scan, LP if febrile, and a psychiatric evaluation were completed on 100 consecutive patients with new psychiatric symptoms, aged 16-65, who presented in an urban, county hospital. Exclusion criteria: obvious alcohol or drug intoxication, prior psychiatric diagnosis, patients with medical complaints who overdosed or attempted suicide.	100	9 month period	Results were considered significant when they diagnosed the cause of the symptoms or resulted in medical admission. 63 of the 100 patients had an organic etiology of their psychiatric symptoms. The medical history was significant in 27, physical examination in 6, CBC in 5, SMA-7 in 10, CPK in 6, alcohol and drug screen in 28, CT in 8, and LP in 3. Authors conclude: “Most alert, adult patients with new psychiatric symptoms have an organic etiology.” This particular battery of tests was recommended to obtain medical clearance.
Bartsch DA et al., Hospital &	175 patients from two community mental health centers in Colorado	175	February – May, 1985	46% had physical conditions or laboratory test results warranting further medical evaluation, 20% had a

Community Psychiatry 41(7): 786-790, 1990	received physical exams and lab work.			previously undiagnosed physical health problem, 16% had conditions that could cause or exacerbate their mental disorder. The authors conclude that public mental health systems should ensure routine assessment of the physical health of psychiatric outpatients.

Grading of Quality of Individual Studies

Citation: Hall RC et al. Unrecognized physical illness prompting psychiatric admission: a prospective study. Am J Psychiatry 138:629–635, 1981

Population: 100 consecutive involuntary patients who had been brought to an "urban psychiatric receiving unit" in Texas who "in all probability would have been committed to the state hospital" but were offered voluntary admission to a research unit for the study. Patients with known physical disorders were excluded, as were patients with "sociopathic personality disorders" and significant histories of drug or alcohol abuse.

Intervention: Physical examination by a general practitioner, tests of sight and hearing, computerized medical questionnaire, SMA-12 lab work, and an ECG. Within 24 hours of voluntary admission to the research unit, two additional detailed physical exams and a separate structured neurological exam were completed along with SMA-34 blood chemistry, EEG, urine drug screen, and routine urinalysis. Within 5 days of admission, a detailed life history questionnaire and a battery of psychological tests. Patients were referred to a university-based diagnostic group for complete workup if any diagnostic confusion existed.

Comparators: None.

Outcomes: Proportion of individuals who were found to have a previously unrecognized and undiagnosed medical illness that was felt to be specifically causing or exacerbating their psychiatric symptoms. Such an illness was detected in 46 patients (46%) of whom 28 were noted to have experienced "dramatic and rapid" clearing of their psychiatric symptoms when appropriate medical treatment was instituted.

Timing: Assessment occurred after arrival at an urban psychiatric receiving unit and after consenting to voluntary admission to a research unit. Patients had been brought to the receiving unit on a mental health warrant.

Setting: Urban psychiatric receiving unit in Texas followed by voluntary admission to a research unit.

Study design: Observational study

Study sponsorship: Not listed

Overall risk of study bias: Medium risk

Selection bias: High risk, the patients selected were brought on a mental health warrant, and so they are likely more seriously mentally ill with associated poorer medical health, than the general population – or even the general psychiatric population. Also, the study appears to indicate that patients were offered voluntary admission to a research unit, and it is unclear if patients may have had a legal incentive to do this, given the warrant they were brought in under. There is also a risk that the most severely ill patients were unable to provide informed consent, and thus not analyzed in the study. The authors note that the patients would have been admitted to the state hospital if not admitted to the research unit and may have had a different expectation of care or facilities.

Performance bias: Low risk, the assessments were performed consistently with the entire study population.

Attrition bias: Low risk, patients were admitted and kept for the duration of the assessment. There is no mention of attrition in the study.

Detection bias: High risk, determination of whether a test result is causally related to a patient's psychiatric presentation is a subjective clinical judgment and could be biased by investigators' hypotheses.

Reporting bias: Low risk, there is no evidence of systematic differences between reported and unreported findings. The authors listed disorders that were detected but did not seem related to the psychiatric symptoms in addition to those judged to be causing or exacerbating psychiatric symptoms, which reduces unseen bias.

Sponsor-related bias: Unclear, as sponsorship is not specified.

Applicability: Limited by setting (urban psychiatric receiving unit) and patient population (involuntary patients). The age of the study may also limit its applicability in terms of changes in the healthcare delivery system, laboratory assessments and the typical characteristics of individuals who present for an involuntary admission.

Citation: Henneman PL et al., Ann Emerg Med 24 (4): 672-677, 1994

Population: 100 consecutive patients (aged 16-65, 63 men and 37 women with 40 Caucasian, 28 African American and 30 Hispanic individuals) who presented with new psychiatric symptoms (hallucinations in 49%, agitation in 66%, disorientation in 60%) and who did not have obvious alcohol or drug intoxication, a prior psychiatric diagnosis, medical complaints or a presentation with an overdose or attempted suicide.

Intervention: A medical history, physical examination, alcohol level; urine screen for cocaine, amphetamine, and phencyclidine; CBC; electrolytes, blood urea nitrogen, creatinine, and glucose (collectively referred to as SMA-7); calcium; creatinine phosphokinase (CPK) if a urine dipstick was positive for blood without RBCs on microscopic examination; prothrombin time; LP if febrile, and a CT scan if symptoms not explained by laboratory results.

Comparators: None.

Outcomes: Proportion of patients with a medical condition that appeared to be related to their psychiatric symptoms, which was true in 63 of the 100 patients. The medical history was significant in 27, physical examination in 6, CBC in 5, SMA-7 in 10, CPK in 6, alcohol and drug screen in 28, CT in 8, and LP in 3. A greater proportion of individuals had abnormalities noted on these tests that were not judged to be clinically significant or relevant to the etiology of the psychiatric presentation.

Timing: Assessment occurred after arrival at an emergency department

Setting: Adult emergency department in an urban, county hospital

Study design: Cohort study

Study sponsorship: Not described

Overall risk of study bias: Medium risk

Selection bias: Low risk, authors used log book of ED patients to identify consecutive patients.

Performance bias: Low risk, the assessments were performed consistently with the entire study population

Attrition bias: Low risk, study was retrospective and cross-sectional so no problems with dropouts

Detection bias: High risk, determining the relationship between a test result and a patient's psychiatric presentation is a subjective clinical judgment, which could be biased by investigators' hypotheses.

Reporting bias: Low risk, the battery of tests was pre-specified.

Sponsor-related bias: Low risk, sponsorship unclear but not a pharmaceutical or device related trial.

Applicability: The patient population constitutes a relatively small proportion of individuals who present to a psychiatric emergency service. Individuals presenting for outpatient treatment are likely to have a very different set of risk factors for medical conditions. The age of the study may also limit its applicability in terms of changes in the healthcare delivery system, laboratory assessments and the

typical characteristics of individuals who present for an emergency evaluation.

Citation: Bartsch DA et al., Hospital & Community Psychiatry 41(7): 786-790, 1990

Population: 175 outpatients from one urban and one rural community mental health center in Colorado

Intervention: Health history, review of system questionnaire, physical examination, laboratory tests (urinalysis, SMAC-26 chemistry panel, vitamin B12, folate levels).

Comparators: One control group at each site who did not receive medical screening. The control group at the urban center was comprised of patients who were not approached for participation in the study. The control group at the rural center was comprised of patients who were approached but did not participate in the study. The authors explain that there was a smaller number of patients available at the rural center than at the urban center; the proportion of control patients from each center was equal to the proportion of intervention patients from each center.

Outcomes: Proportion of individuals with medical conditions or laboratory abnormalities that were previously undiagnosed, could cause or exacerbate their psychiatric condition and/or were judged to warrant additional evaluation. For the combined sample, 46% had physical conditions or laboratory test results that were judged to warrant further medical evaluation, 20% had a previously undiagnosed physical health problem, and 16% had conditions that could cause or exacerbate their mental disorder.

Timing: Individuals at various stages of outpatient psychiatric treatment assessed between February and May, 1985.

Setting: One urban and one rural community mental health center in Colorado

Study design: Non-blinded observational study with a comparison "control" group to assess the representativeness of the sample as compared to the clinic population and individuals treated in CMHCs statewide.

Study sponsorship: Unclear, no specific study sponsorship is noted although study funding is mentioned.

Overall risk of study bias: High risk

> Selection bias: High risk, although individuals were randomly selected for the intervention group at the urban center, all patients at the rural center were asked to participate and the control group included some individuals who had refused to participate in the intervention group. The fact that the intervention and control groups differed in their characteristics suggests that allocation was not ideal.
>
> Performance bias: Low risk, the assessments were performed consistently with all study participants
>
> Attrition bias: High risk, a substantial proportion (36%) of individuals who were randomly

selected for screening did not participate.

Detection bias: High risk, judgments about relationship of abnormalities to psychiatric disorder are subjective and potentially influenced by investigators' a priori hypotheses. However, the study did attempt to reduce the risk of bias by using 2 raters for each determination and calculating the relative rates of agreement between raters.

Reporting bias: Low-risk, the battery of tests being used was pre-specified

Sponsor-related bias: Unclear, study funding is mentioned as restricting the sample size but the funding source is not identified.

Applicability: The patient population reflects individuals attending 2 CMHCs in Colorado and demographic characteristics of the sample differ from individuals seen at that CMHC and at CMHCs across the state. Individuals presenting for outpatient CMHC treatment in Colorado are likely to have a different set of risk factors for medical conditions than individuals in other states or presenting to other psychiatric treatment settings. The age of the study may also limit its applicability in terms of changes in the healthcare delivery system, laboratory assessments and the typical characteristics of individuals who are followed in an outpatient CMHC setting.

Grading of Supporting Body of Research Evidence

Risk of bias: High, studies are unblinded and observational, with judgments about the relationship between screening results and medical causes of psychiatric symptoms being a subjective determination and associated with potential for bias.

Consistency: Consistent, medical conditions related to psychiatric symptoms were consistently found for a sizeable portion of patients studied.

Directness: Indirect, uses intermediate outcomes such as diagnosis rather than patient-specific health benefits. Also, the outcomes are indirectly related to those of the overarching key questions regarding assessment of medical health to improve diagnostic accuracy and treatment safety.

Precision: Imprecise, due to the prominent variability across study findings, even among studies done in comparable settings of care.

Dose-response relationship: Not applicable

Magnitude of effect: Not applicable

Confounding factors (including likely direction of effect): Depending on the investigators' a priori hypotheses, the lack of blinding could influence the judgments about contributors to psychiatric symptoms and the clinical significance of laboratory abnormalities. This could produce confounding effects in either direction.

Publication bias: Not able to be assessed.

Applicability: The studies range from 18-31 years old and were conducted in private outpatient settings, which limits applicability to current treatment methods and other types of settings. Also, the outcomes measured in the studies are not directly related to the outcomes in our key questions. This body of evidence examines the proportion of psychiatric patients who have a medical condition that causes or exacerbates psychiatric symptoms, whereas the outcome of interest is whether assessment of certain aspects of medical health improves diagnostic accuracy and treatment safety.

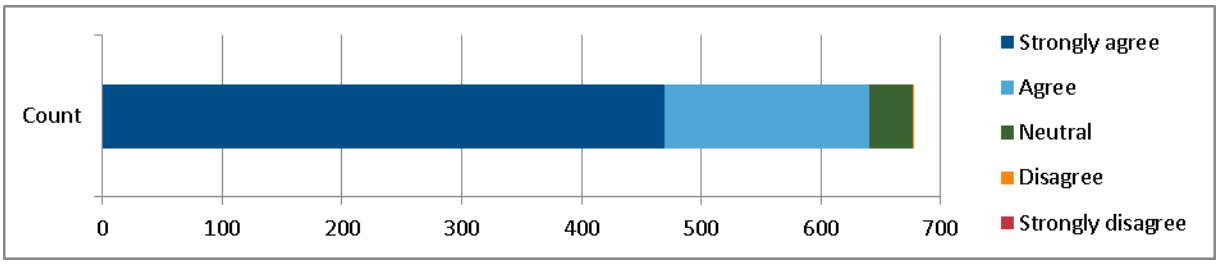
Overall strength of research evidence: Low

Differences of Opinion in Rating the Strength of Recommendations

There were minor differences of opinion among the members of the work group with respect to assessing aspects of patient's medical health. Some members of the group thought that the potential benefits of assessment of some of the recommended items were closely balanced with the potential harm that crucial aspects of the evaluation of an individual patient might go unaddressed, particularly when the evaluation is time constrained. Another concern raised was that assessment of the recommended items might not be important for all patients or necessary to include at the initial evaluation (as compared to follow-up visits). The recommended items for which there was disagreement on the basis of these concerns by one to two members of the group were as follows: involuntary movements or abnormalities of motor tone; speech, including fluency and articulation; sight and hearing; physical trauma, including head injuries; past or current medical illnesses and related hospitalizations; important past or current treatments or procedures, including complementary and alternative medical treatments; sexual and reproductive history; and past or current sleep abnormalities, including sleep apnea. The work group was unanimous in agreeing to recommend assessment of general appearance and nutritional status, coordination and gait, and allergies or drug sensitivities.

Expert Opinion Survey Results

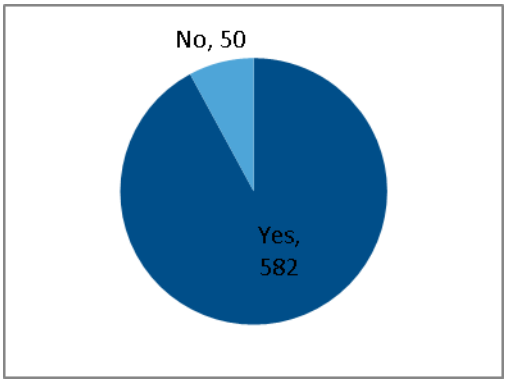
To what extent do you agree that the initial psychiatric evaluation of any patient should typically (i.e., almost always) include assessment of whether or not the patient has an ongoing relationship with a primary care health professional?



Percentage of experts who “strongly agreed” or “agreed” that the initial psychiatric evaluation of any patient should typically (i.e., almost always) include assessment of whether or not the patient has an ongoing relationship with a primary care health professional:

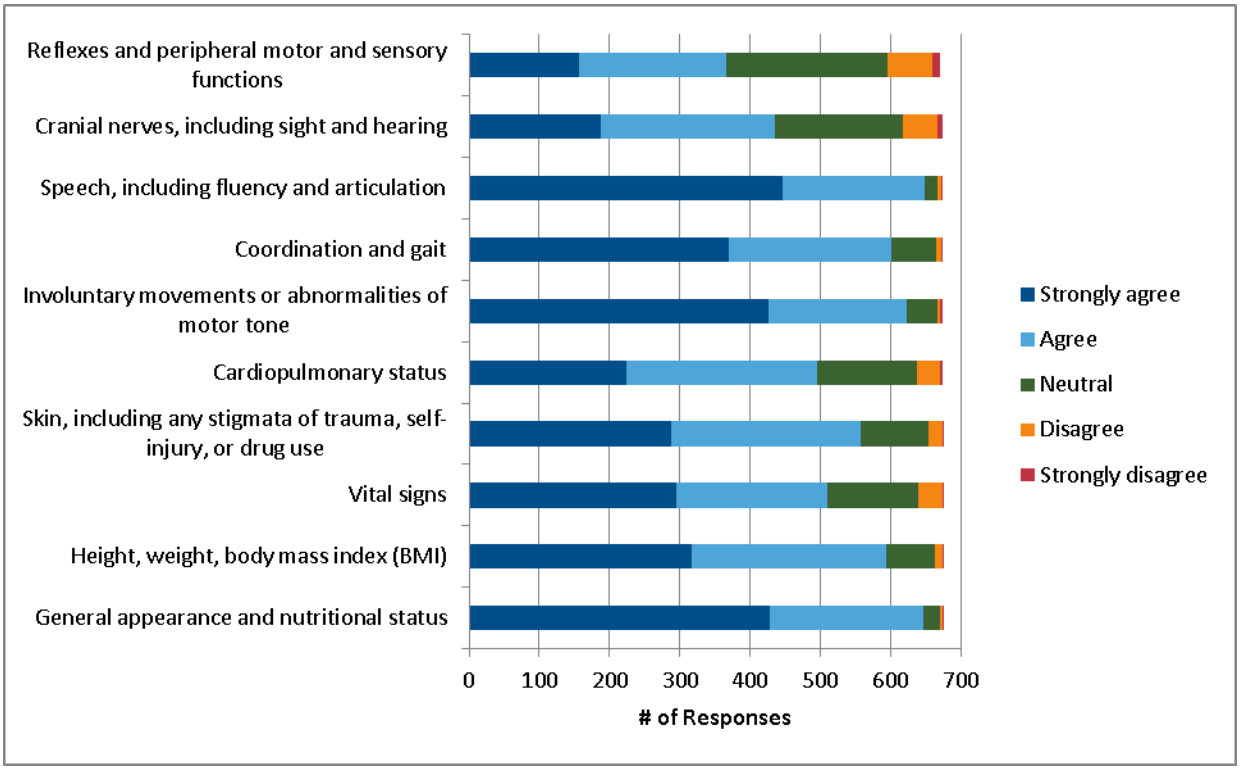
94.6%

In your initial psychiatric evaluations, do you typically (i.e., almost always) assess whether or not your patients have an ongoing relationship with a primary care health professional?



To what extent do you agree that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following aspects of his or her current general medical status?

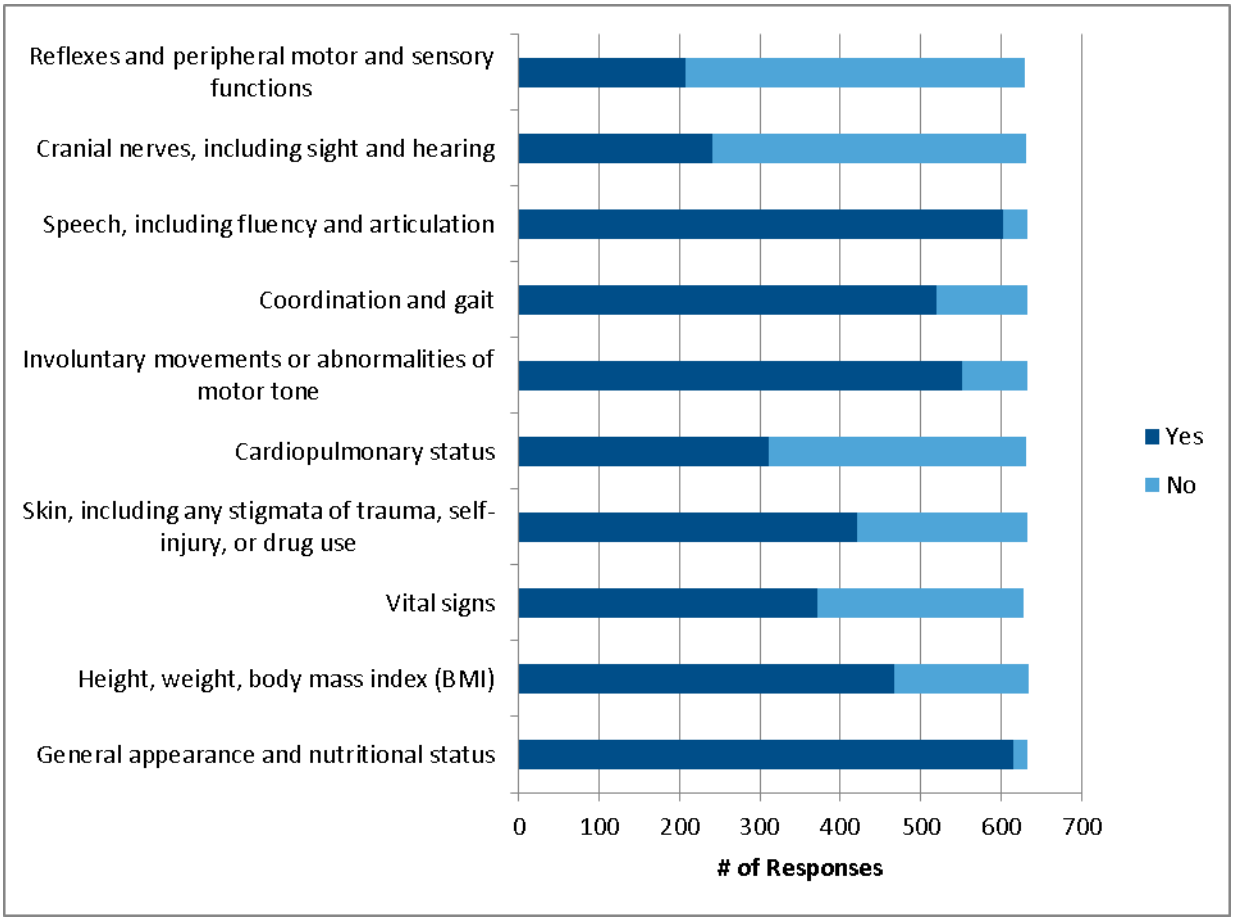
“Assessment” is defined here as (a) performing a physical examination on the patient, (b) directing another clinician (e.g., a resident) to perform the exam, or (c) reviewing the results of a recent physical examination performed by another clinician.



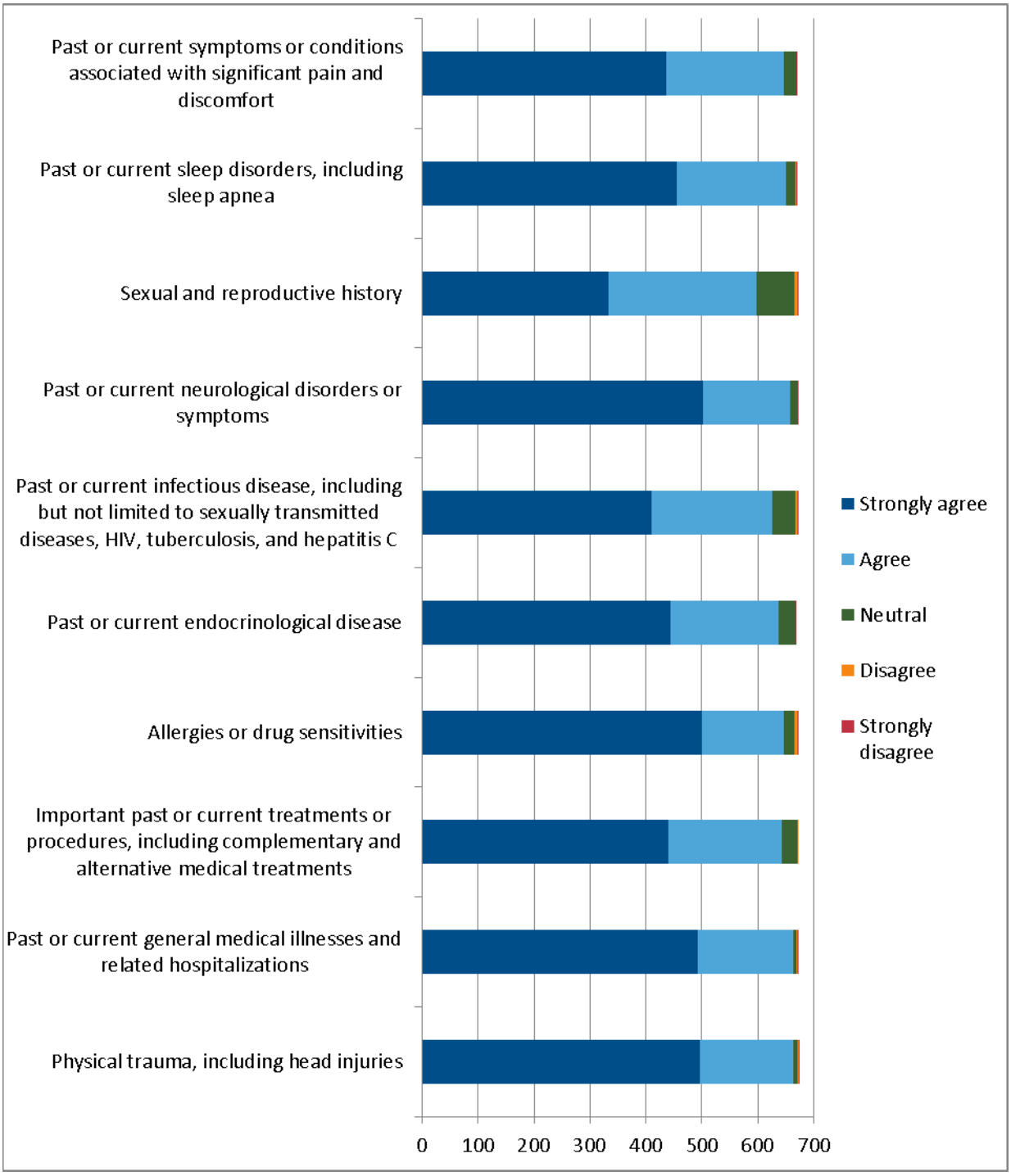
Percentage of experts who "strongly agreed" or "agreed" that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following aspects of his or her current general medical status:

Reflexes and peripheral motor and sensory functions	54.5%
Cranial nerves, including sight and hearing	64.8%
Speech, including fluency and articulation	96.3%
Coordination and gait	89.2%
Involuntary movements or abnormalities of motor tone	92.4%
Cardiopulmonary status	73.6%
Skin, including any stigmata of trauma, self-injury, or drug use	82.5%
Vital signs	75.6%
Height, weight, body mass index (BMI)	87.9%
General appearance and nutritional status	95.8%

Do you typically (i.e., almost always) assess these items during initial psychiatric evaluations of your patients, either by direct examination or by review of the results of a recent examination by another clinician?



To what extent do you agree that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes assessment of the following aspects of his or her general medical history? Assessment may occur directly or by review of the results of a recent assessment by another clinician.

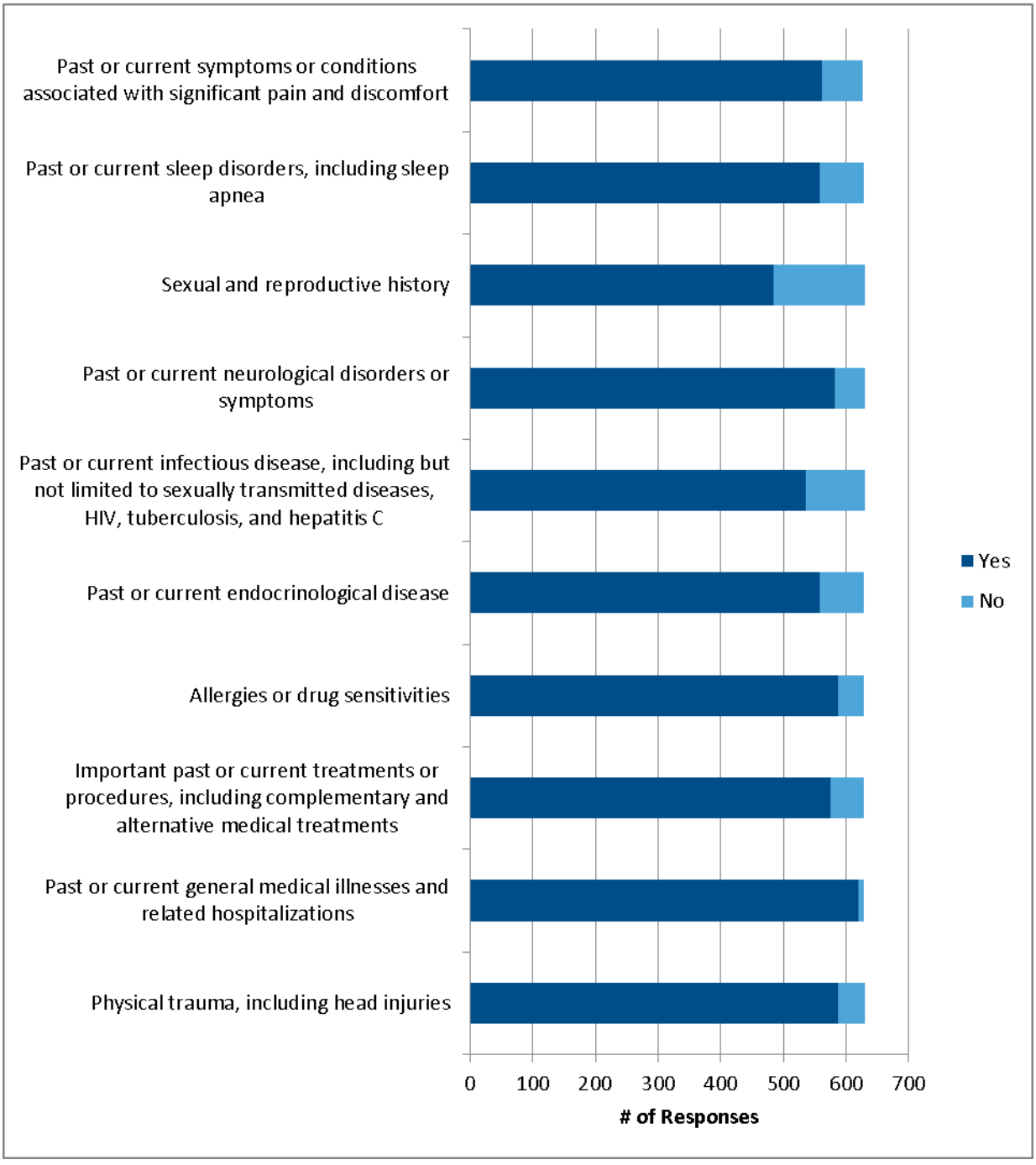


Percentage of experts who “strongly agreed” or “agreed” that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes

assessment of the following aspects of his or her general medical history? Assessment may occur directly or by review of the results of a recent assessment by another clinician:

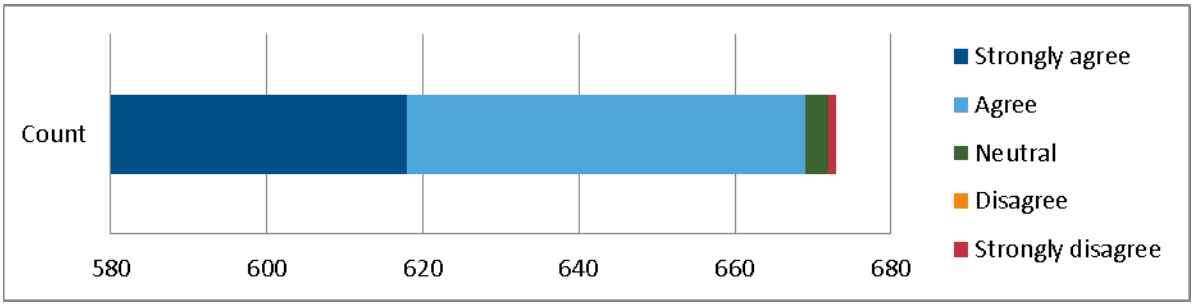
Past or current symptoms or conditions associated with significant pain and discomfort	96.3%
Past or current sleep disorders, including sleep apnea	97.0%
Sexual and reproductive history	89.0%
Past or current neurological disorders or symptoms	97.9%
Past or current infectious disease, including but not limited to sexually transmitted diseases, HIV, tuberculosis, and hepatitis C	93.2%
Past or current endocrinological disease	95.2%
Allergies or drug sensitivities	96.3%
Important past or current treatments or procedures, including complementary and alternative medical treatments	95.4%
Past or current general medical illnesses and related hospitalizations	98.7%
Physical trauma, including head injuries	98.4%

Do you typically (i.e., almost always) assess these items during initial psychiatric evaluations of your patients?

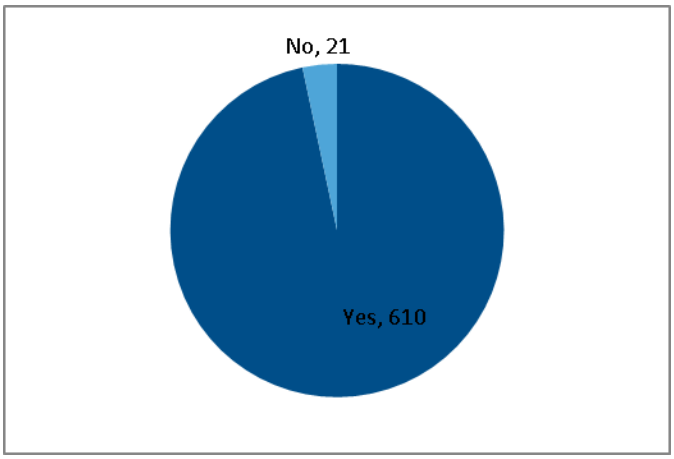


To what extent do you agree that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes review of all medications he or she is currently or recently taking and the side effects of these medications?

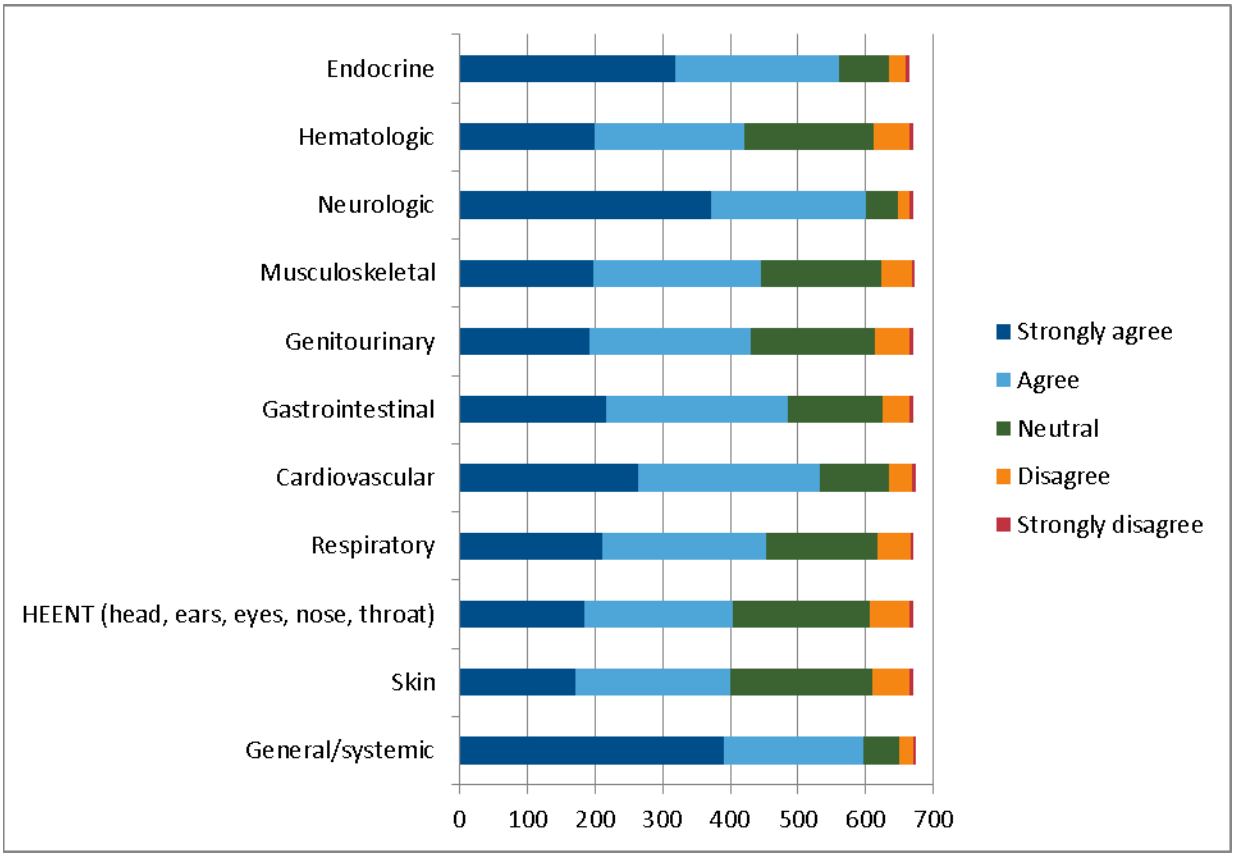
"All medications" means both prescribed and non-prescribed medications, herbal and nutritional supplements, and vitamins.



During initial psychiatric evaluations, do you typically (i.e., almost always) review all medications your patients are currently or recently taking and the side effects of these medications?



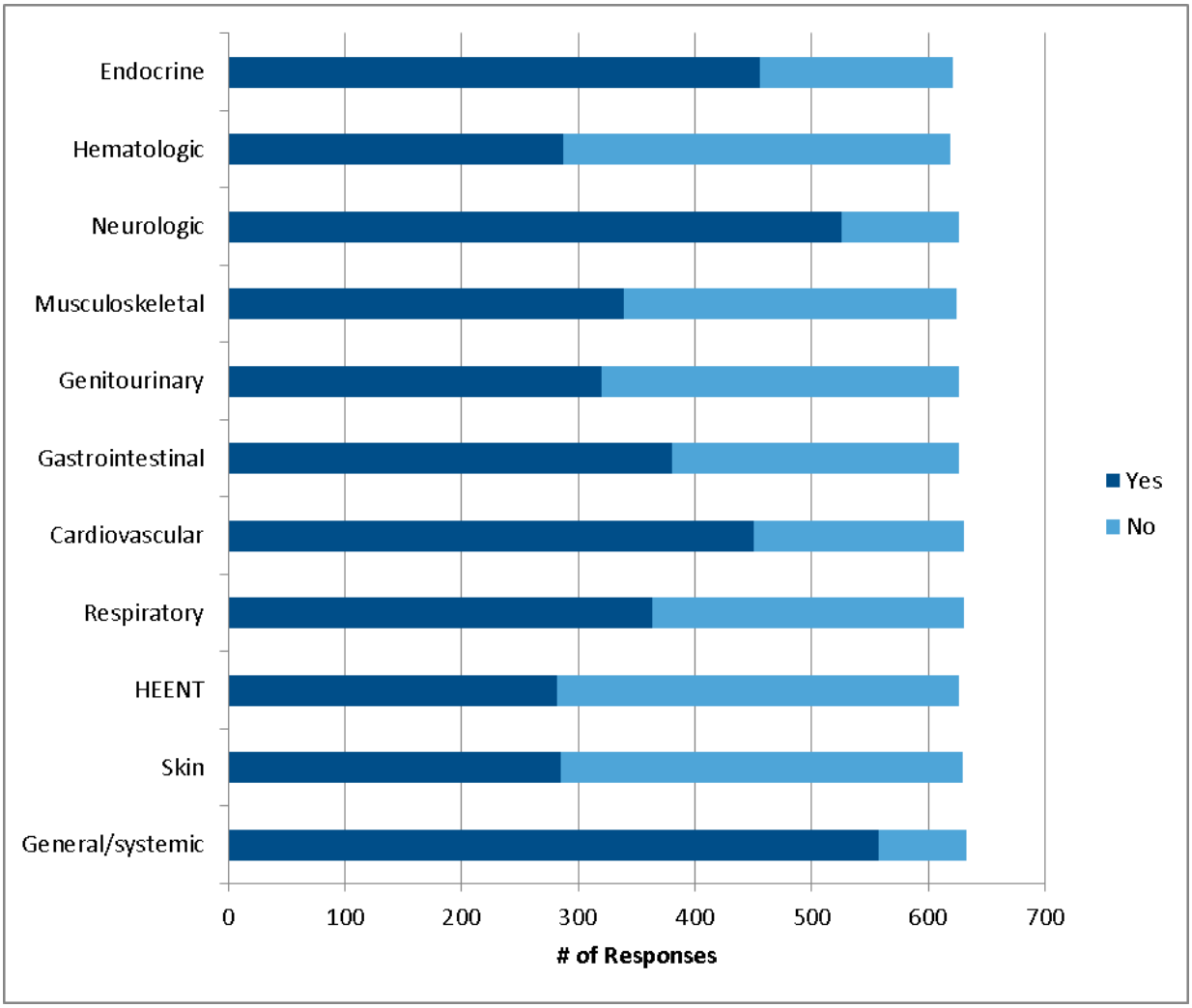
To what extent do you agree that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes the following elements of a review of systems?



Percentage of experts who "strongly agreed" or "agreed" that diagnostic accuracy and treatment safety are improved when the initial psychiatric evaluation of any patient typically (i.e., almost always) includes the following elements of a review of systems:

Endocrine	84.2%
Hematologic	62.7%
Neurologic	89.6%
Musculoskeletal	66.1%
Genitourinary	64.3%
Gastrointestinal	72.4%
Cardiovascular	78.9%
Respiratory	67.4%
HEENT (head, ears, eyes, nose, throat)	60.1%
Skin	59.7%
General/systemic	88.6%

Do you typically (i.e., almost always) review these items during initial psychiatric evaluations of your patients?


Endocrine
Hematologic
Neurologic
Musculoskeletal
Genitourinary
Gastrointestinal
Cardiovascular
Respiratory
HEENT
Skin
General/systemic
0
100
200
300
400
500
600
700
# of Responses
Yes
No

Guideline 7. Quantitative Assessment

Clinical Questions

1. For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is clinical decision-making improved when quantitative measures of the following are typically (i.e., almost always) obtained within the scope of the initial psychiatric evaluation, as compared to non-quantitative clinician assessment?

   "Quantitative measures" are defined as clinician- or patient-administered tests or scales that provide a numerical rating of features such as symptom severity, level of functioning, or quality of life and have been shown to be valid and reliable.

   a. Symptoms

   b. Level of functioning

   c. Quality of life

2. For patients who present with a psychiatric symptom, sign, or syndrome in any setting, are clinical decision-making and treatment outcomes improved when quantitative measures of the following are typically (i.e., almost always) obtained on at least one occasion after the initial psychiatric evaluation, compared to non-quantitative clinician assessment?

   a. Symptoms

   b. Adverse effects of treatment

   c. Level of functioning

   d. Quality of life

Review of Supporting Research Evidence

Overview of Studies

Author, Ref.	Subjects / Method	N	Duration	Outcomes
M. M. van Eijk et al., Crit Care Med 37 (6):1881-5, 2009	Patients admitted to a mixed medical and surgical ICU were assessed by trained ICU nurses using CAM-ICU or the ICDSC; by the ICU physician; and by a psychiatrist, geriatrician, or neurologist as a reference rater.	126 patients	8 month period	The CAM-ICU showed superior sensitivity and negative predictive value (64% and 83%) compared with the ICDSC (43% and 75%). The ICDSC showed higher specificity and positive predictive value (95% and 82% vs. 88% and 72%). The sensitivity of the physicians view was only 29%, indicating that ICU physicians

				underdiagnose delirium.
M. van den Boogaard, Crit Care 13 (4):R131, 2009	A delirium screening instrument, CAM-ICU, was implemented in a 40-bed ICU. Adoption of the instrument and frequency and duration of haloperidol use were assessed.	641 patients March - June post CAM-ICU implementation compared to 512 and 589 patients in prior two years	Haloperidol use assessed over a 4 month period and compared to 4 month periods in prior 2 years	Almost two times more delirious patients were detected with the use of the CAM-ICU. More patients were treated with haloperidol (9.9% to 14.8%, P less than 0.001), however with a lower dose (18 to 6 mg, P equals 0.01) and for a shorter time period (5 [IQR:2-9] to 3 [IQR:1-5] days, P equals 0.02).
C. Thomas, J Am Geriatrics Society 60(8): 1471-1477, 2012	The German version of the CAM was used to identify individuals with delirium.	102 patients admitted to an academic geriatric hospital in Germany	6 month study duration	CAM had a sensitivity of 0.74 and a specificity of 1.0 relative to clinical diagnosis using DSM-IV criteria and a sensitivity of 0.82 and specificity of 0.91 compared to clinical diagnosis using ICD-10. Adding ratings of psychomotor activity to the CAM approach, enhanced specificity but reduced sensitivity.

Grading of Quality of Individual Studies

Citation: M. M. van Eijk et al. Comparison of delirium assessment tools in a mixed intensive care unit. Critical Care Medicine 37 (6):1881-5, 2009

Population: During an 8-month period, 126 patients (mean age 62.4 years, sd 15.0; mean Acute Physiology and Chronic Health Evaluation II score 20.9, sd 7.5) admitted to a 32-bed mixed medical and surgical ICU were studied. Excluded were deeply sedated patients (defined as a Ramsay score [22] >4), comatose patients (defined as a Glasgow Coma Score [23] <8), patients in whom no informed consent was obtained, patients who did not speak or understand Dutch or English, or patients who were deaf.

Intervention: The included patients were assessed independently by trained ICU nurses using either the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) or the Intensive Care Delirium Screening Checklist (ICDSC). Furthermore, the ICU physician was asked whether a patient was delirious or not. A psychiatrist, geriatrician, or neurologist serving as a reference rater diagnosed delirium using established criteria.

Comparators: Both the standardized assessment instruments and the ICU physician's impression during standard care were compared to a neuropsychiatric assessment performed by an expert (geriatrician, psychiatrist, or neurologist) who served as a reference rater.

Outcomes: The reference raters identified 34% of the patient sample as meeting diagnostic criteria for delirium whereas the CAM-ICU, ICDSC and ICU physicians identified delirium in 29%, 19% and 13% of

patients respectively. The CAM-ICU showed superior sensitivity and negative predictive value (64% and 83%) compared with the ICDSC (43% and 75%). The ICDSC showed higher specificity and positive predictive value (95% and 82% vs. 88% and 72%). The sensitivity and specificity of the physicians' clinical impression were 29% and 96% respectively.

Timing: 8 month period during which assessments took place, from November 2006 to July 2007

Setting: The study was performed in a 32-bed multidisciplinary intensive care unit of the University Medical Center Utrecht, the Netherlands, with adult medical, surgical, neurologic, neurosurgical, and cardiothoracic surgical patients.

Study Design: Cross-sectional

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: All patients in the ICU were included in the study other than sedated and comatose patients, deaf patients, or patients who did not speak English or Dutch. It is unlikely that these exclusion criteria would have introduced bias in the study.

Performance bias: Moderate Risk: The delirium evaluations were administered by different investigators who were blinded to each other's assessments, thus limiting the chance of systematic differences in the treatment of the participants. There is a risk of co-interventions since medical treatment while in the ICU was not controlled. Some patients received psychotropic medications between evaluations; the study investigators analyzed these patients separately and did not find any differences from the study population as a whole.

Attrition bias: Not applicable.

Detection bias: Moderate Risk: The reference assessment was used as a gold standard and, depending on the training and experience of the raters, there could be detection bias in this reference. There was no attempt to verify these reference assessments with a second rater. Also, evaluations were not performed at the same time and since delirium is by nature a fluctuating disorder, a bias in the diagnosing of delirium was possible.

Reporting bias: Low Risk: There was no indication of selective outcome reporting.

Sponsor-related bias: Low: The authors did not disclose any potential conflicts of interest. The authors were all affiliated with the University Medical Center Utrecht, The Netherlands.

Applicability: This study is limited to the diagnosis of delirium in medical and surgical ICU patients. Also, the assessments were performed by ICU nurses and physicians, rather than by psychiatrists.

Citation: M. van den Boogaard, Implementation of a delirium assessment tool in the ICU can influence haloperidol use. Critical Care 13 (4):R131, 2009

Population: ICU patients in a large medical center in the Netherlands. Patients were excluded from screening when they had a Richmond agitation sedation score of -4 or -5, were unable to understand Dutch, were severely mentally disabled, or suffered from a serious receptive aphasia.

Intervention: The study evaluated the effects of integrating the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) into the daily management of ICU patients. A CAM-ICU algorithm was incorporated into the patient data management system, which was available at all bedside computers. Pop-up reminders would prompt nurses to perform the CAM-ICU at least once in every eight-hour nursing shift, and nurses received computerized feedback about the results of the assessment. Nurse leaders were committed to supporting the implementation, which included training the nurses on use of CAM-ICU tool.

Comparators: Comparisons were made before and after the implementation of the CAM-ICU assessment tool in the ICU. Before the introduction of the CAM-ICU, diagnoses of delirium were made based on the judgment of the attending ICU physician, without use of quantitative measures.

Outcomes: Compliance on using CAM-ICU assessments increased from 77% in the first month after implementation to 92% at 4 months. Knowledge about delirium and inter-rater reliability on the CAM-ICU assessment also increased over that period. After the intervention, more patients were treated with haloperidol (9.9% to 14.8%, $P < 0.001$) than in 4 month blocks during the prior 2 years, however haloperidol was given at a lower dose (18 to 6 mg, $P = 0.01$) and for a shorter time period (5 [IQR:2–9] to 3 [IQR:1–5] days, $P = 0.02$) after the CAM-ICU was implemented.

Timing: Routine CAM-ICU assessments were implemented and, in the subsequent 4-month period (March until June, 2008), haloperidol use was compared to the same 4-month period in the prior two years (March – June, 2007 and March – June, 2006).

Setting: This study was conducted in the Radboud University Nijmegen Medical Centre, the Netherlands, a 960-bed university hospital that includes a level 3 (highest level) ICU with 40 beds divided over four adult wards and one pediatric ward. Annually 2000 to 2500 (cardiothoracic surgery, neurosurgical, medical, surgical, and trauma) patients are admitted.

Study Design: Non-blinded, non-randomized intervention study

Overall risk of study bias: Moderate Risk

> Selection bias: Low Risk: There did not appear to be any selection bias in terms of the inclusion of either nurses or patients. All ICU nurses were trained in the use of the CAM-ICU, and the CAM-ICU algorithm was incorporated into the computerized patient management system on every bed-side computer. Patients were only excluded from the study because of natural barriers in communication or participation.

Performance bias: High Risk: There was no blinding in the study, and so nurses knew they were being monitored and assessed in their use of the CAM-ICU. It is possible also that physicians were aware that haloperidol use was also being monitored, which may have affected the dose or timing of these prescriptions. These issues present the potential for systematic differences in the treatment of the study groups (i.e., patients before and after the implementation of the CAM-ICU).

Attrition bias: This did not apply to this study because there was no follow-up for particular patients. Instead, overall use of haloperidol after the intervention was compared to use prior to it, and nursing compliance with the test was assessed before and after the training.

Detection bias: Low Risk: With the presence of a computerized patient management system, rates of haloperidol use and compliance with CAM-ICU assessments could be collected reliably.

Reporting bias: Low Risk: There was no indication of selective outcome reporting.

Sponsor-related bias: The authors declared that they had no competing interests. The authors are all affiliated with the Radboud University Nijmegen Medical Centre in the Netherlands.

Applicability: This study only concerns diagnosis of delirium in ICU patients, thus limiting its applicability to other psychiatric populations and settings. The assessments were performed by ICU nurses, rather than by psychiatrists. Also, the proxy of haloperidol use must be used to determine whether use of the CAM-ICU improves clinical decision-making. The study authors argue that the increased use of haloperidol indicates that the CAM-ICU improved identification of delirium and facilitated the opportunity to begin treatment earlier.

C. Thomas et al. Diagnosing delirium in older hospitalized adults with dementia: Adapting the confusion assessment method to International Classification of Diseases, Tenth Revision, diagnostic criteria. Journal of the American Geriatrics Society 60(8): 1471-1477, 2012.

Population: During a 6-month period, 102 patients aged 80 and older were screened who were admitted on Tuesdays or Fridays to an academic geriatric center in Heidelberg Germany. Excluded were patients who had a terminal condition or global aphasia. Fourteen individuals refused to participate. Informed consent was obtained from the individual, if deemed to have capacity, or the legal guardian.

Intervention: The included patients were assessed independently by a physician in training or gerontologist using either the Confusion Assessment Method, Delirium Index, cognitive testing including the MMSE, logic questions and an interview with nursing staff about the patients symptoms and sleep pattern. A psychologist or geriatrician independently performed cognitive testing for establishing a reference consensus diagnosis using DSM-IV or ICD-10 criteria.

Comparators: The CAM was compared to a neuropsychiatric assessment performed by an independent

psychologist or geriatrician who served as a reference rater.

Outcomes: Delirium was diagnosed in 28% of participants according to DSM-IV and 14% according to ICD-10. For individuals with a known diagnosis of dementia, the proportion with a diagnosis of delirium using DSM-IV or ICD-10 criteria was 14% and 19%, respectively. Adding information on the presence of psychomotor changes to the CAM findings improved the ability to identify delirium according to ICD-10.

Timing: 6 month period during which assessments took place, from October 2003 to March 2004

Setting: The study was performed in an academic geriatric center in Heidelberg Germany among individuals admitted for a variety of problems, including falls, infections, metabolic disease, cardiovascular or cardiopulmonary conditions, and psychiatric diagnoses with comorbid medical problems.

Study Design: Cross-sectional

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: Since only patients admitted on Tuesdays or Fridays were included, it is possible that patients admitted on a weekend have different characteristics than those admitted during the week.

Performance bias: Moderate Risk: The delirium evaluations were administered by different investigators who were blinded to each other's assessments, thus limiting the chance of systematic differences in the treatment of the participants. There is a risk of co-interventions since medical treatment while in the unit was not controlled.

Attrition bias: Not applicable.

Detection bias: Moderate Risk: The reference assessment was used as a gold standard and, depending on the training and experience of the raters, there could be detection bias in this reference. There was no attempt to verify these reference assessments with a second rater. Also, evaluations were not performed at the same time and since delirium is by nature a fluctuating disorder, a bias in the diagnosing of delirium was possible.

Reporting bias: Low Risk: There was no indication of selective outcome reporting.

Sponsor-related bias: Low: The authors did not disclose any potential conflicts of interest.

Applicability: This study is limited to the diagnosis of delirium in hospitalized geriatric patients. Also, the assessments were performed by gerontologists, psychologists and in-training physicians, rather than by psychiatrists.

Grading of Supporting Body of Research Evidence

Risk of bias: High: The body of evidence is made up of only observational studies of varying quality.

Consistency: Consistent: In all studies, using a quantitative assessment tool aided diagnosis.

Directness: Indirect: Both studies indicate that use of a quantitative measurement improves clinical diagnosis. Diagnostic accuracy is indirectly related to clinical decision-making and treatment outcomes.

Precision: Not applicable.

Dose-response relationship: Not applicable

Magnitude of effect: Weak: Both studies showed that evaluations based on a quantitative assessment are superior to non-quantitative assessments, although one study showed benefit for one specific assessment scale but not another.

Confounding factors (including likely direction of effect): Absent.

Applicability: Two of the studies were done in an ICU and the other study was done in an inpatient geriatric facility. The assessments were performed by non-psychiatrist health, although quantitative assessment of delirium would be similar to that done by psychiatric consultants. Also, the studies were only about delirium and not about psychiatric symptoms or diagnoses in general.

Overall strength of research evidence: Low

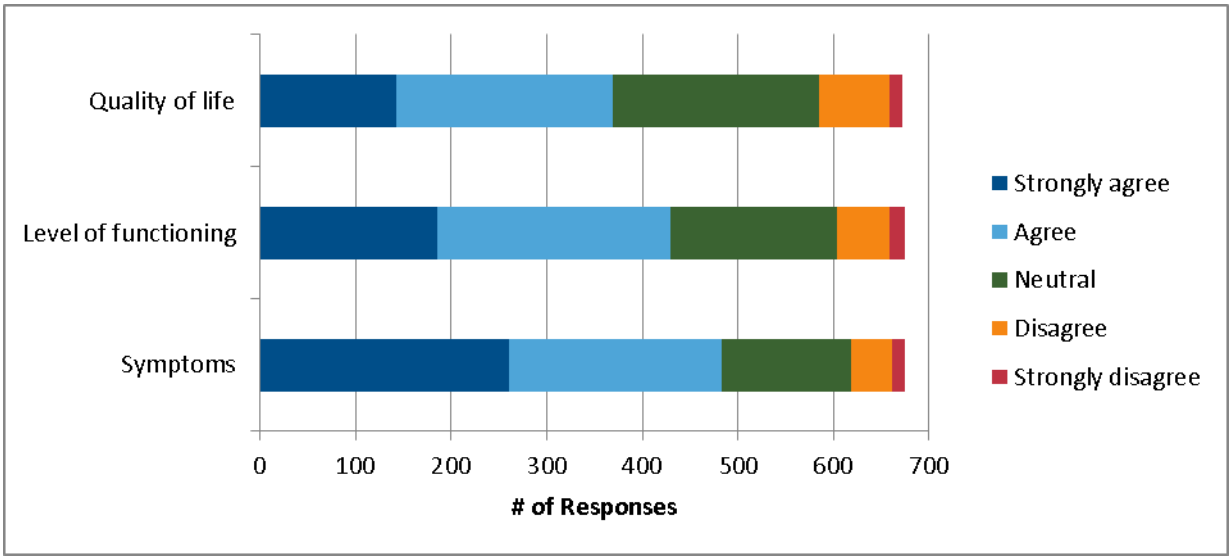
Differences of Opinion in Rating the Strength of Recommendations

Four members of the work group voted to recommend the use of quantitative measures, but the other four members of the group thought that the potential benefits of using measures were uncertain. As a result, a suggestion rather than a recommendation was made.

Expert Opinion Survey Results

To what extent do you agree that clinical decision-making is improved when quantitative measures of the following are typically (i.e., almost always) obtained within the scope of the initial psychiatric evaluation of any patient, as compared to non-quantitative clinician assessment?

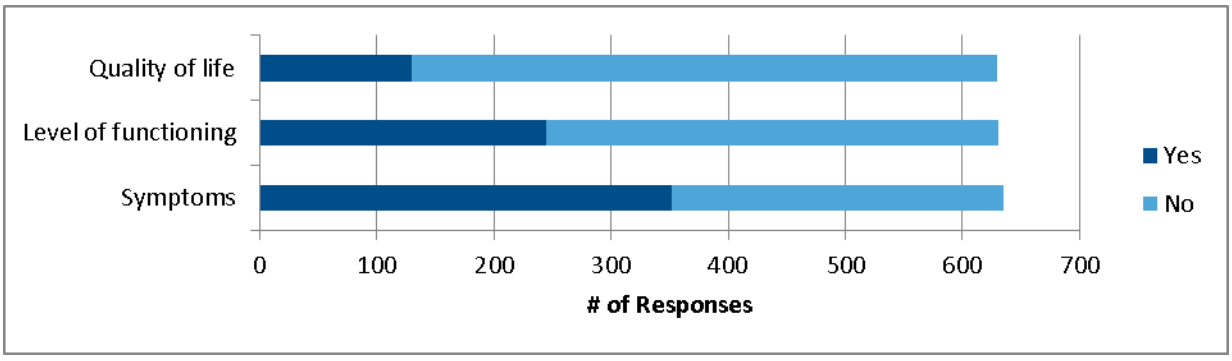
“Quantitative measures” are defined as clinician- or patient-administered tests or scales that provide a numerical rating of features such as symptom severity, level of functioning, or quality of life and have been shown to be valid and reliable.



Percentage of experts who "strongly agreed" or "agreed" that clinical decision-making is improved when quantitative measures of the following are typically (i.e., almost always) obtained within the scope of the initial psychiatric evaluation of any patient, as compared to non-quantitative clinician assessment:

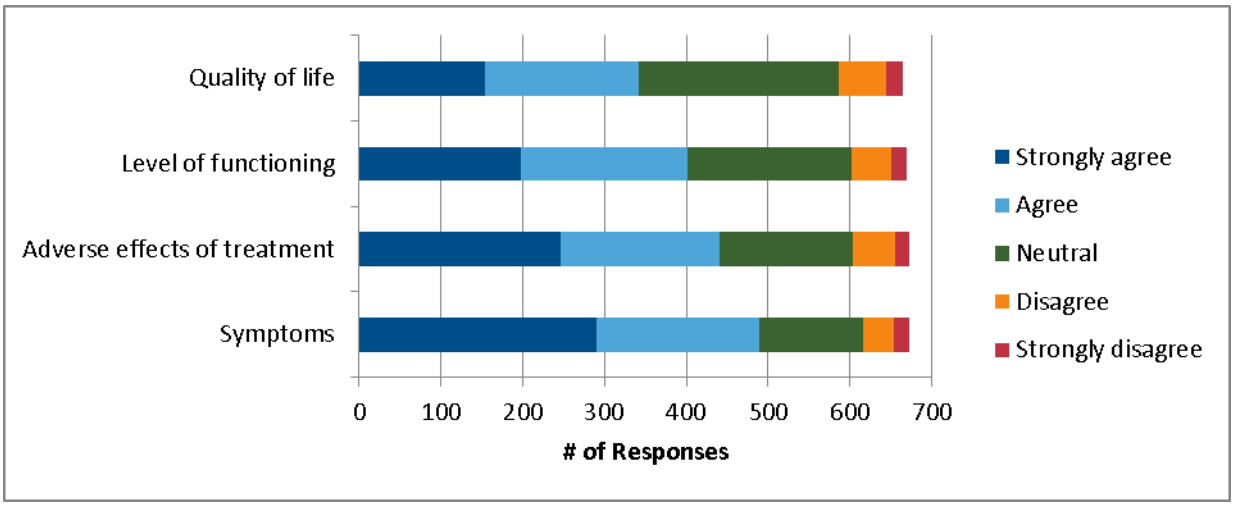
Quality of life	54.9%
Level of functioning	63.8%
Symptoms	71.7%

Do you typically (i.e., almost always) obtain quantitative measures of these items from your patients within the scope of an initial psychiatric evaluation?



To what extent do you agree that clinical decision-making and treatment outcomes are improved when quantitative measures of the following are typically (i.e., almost always) obtained on at least one

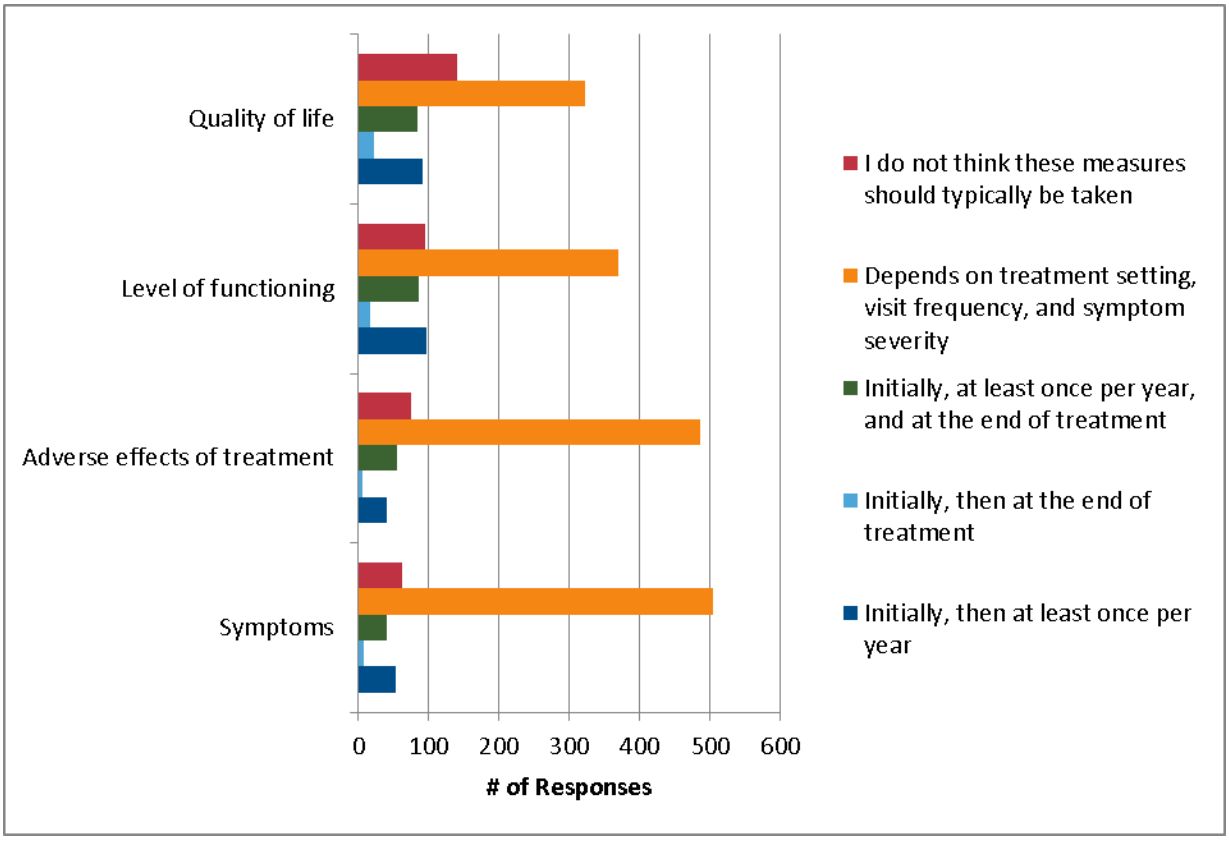
occasion after the initial psychiatric evaluation of any patient, compared to non-quantitative clinician assessment?



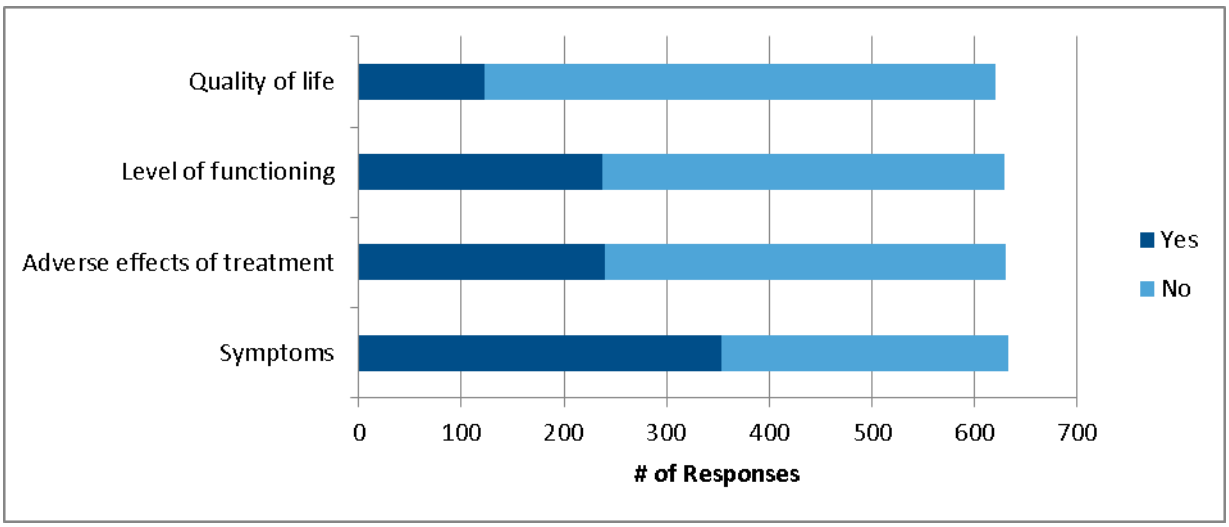
Percentage of experts who "strongly agreed" or "agreed" that clinical decision-making and treatment outcomes are improved when quantitative measures of the following are typically (i.e., almost always) obtained on at least one occasion after the initial psychiatric evaluation of any patient, compared to non-quantitative clinician assessment:

Quality of life	51.5%
Level of functioning	60.0%
Adverse effects of treatment	65.4%
Symptoms	72.8%

How frequently do you think these measures should be taken?



Do you typically (i.e., almost always) obtain quantitative measures of these items on at least one occasion after initial evaluations of your patients?



Guideline 8. Involvement of the Patient in Treatment Decision-Making

Clinical Questions

Development of these guidelines was premised on the following clinical questions:

1. For patients who present with a psychiatric symptom, sign, or syndrome in any setting and have the capacity for decision-making, are the therapeutic alliance and treatment adherence improved by explaining the following?

    a. The diagnosis

    b. Risks of untreated illness

    c. Treatment options

    d. Benefits and risks of treatment

2. For patients who present with a psychiatric symptom, sign, or syndrome in any setting and have the capacity for decision-making, are the therapeutic alliance and treatment adherence improved by asking about treatment-related preferences?

3. For patients who present with a psychiatric symptom, sign, or syndrome in any setting and have the capacity for decision-making, are the following improved by "shared decision-making"?

    Shared decision-making is defined as collaboration between clinicians and patients about decisions pertinent to treatment, when the patient has capacity for decision-making.

    a. Treatment adherence

    b. Therapeutic alliance

    c. Clinician satisfaction

    d. Patient satisfaction

Review of Supporting Research Evidence

Overview of Studies

Author, Ref.	Subjects / Method	N	Duration	Outcomes
Buchkremer G, et al., Acta psychiatrica Scandinavica (6): 483-91, 1997	Outpatients with schizophrenia were randomized to receive psychoeducational medication management training (PMT) alone, or combined with cognitive psychotherapy (CP) and/or	191 subjects, randomized to combinations of treatments or to a non-specifically treated control group	132 subjects assessed at 2 years post treatments (intention-to-treat used)	The PMT+CP+KP group had a significant reduction in rehospitalization rates compared to controls. The relapse rate in all treatment groups was lower than in the non-specifically treated control group, but there were no statistically significant

	key-person counseling (KC).			differences among the treatment groups. Since psychoeducation was included in all treatment groups, this intervention may help with lowering relapse.
Wilder CM, et al., Psychiatr Serv 61 (4): 380-5, 2010	Patients with severe mental illness recorded medication preferences in advanced directives. Authors compared prescribed medications to patient preferences.	123 subjects	12 months	Patients requested a median of two medications, and refused a median of one medication on advanced directives. There was a 27% increase in the number of requested medications prescribed after 12 months. Receiving at least one requested medication predicted higher adherence.
Degmecic D, et al., Coll Antropol 31 (4):1111-5, 2007	Inpatients with schizophrenia were educated about the illness and treatment, then compared with control subjects at admission, discharge, and 3 months post discharge. Groups were rated for adherence, attitudes toward treatment, symptoms, and social functioning.	30 subjects in education group and 30 controls	3 months post discharge from hospital	Authors conclude that education improves adherence and attitudes toward pharmacotherapy. More specific results are unavailable for review.
Pitschel-Walz G, et al., J Clin Psychiatry 67 (3):443-52, 2006	Inpatients with schizophrenia and schizoaffective disorder were randomized to a psychoeducational intervention and a control group. The intervention consisted 8 sessions for patients and 8 sessions for their relatives.	236 subjects randomized into 2 groups	4-5 month intervention with assessments at 12 and 24 months	The intervention group had significantly lower rehospitalization rates at 12 and 24 months and had better compliance. The authors conclude that a relatively brief intervention of 8 psychoeducational sessions with systematic family involvement in simultaneous groups can considerably improve the treatment of schizophrenia.
Gray R, Journal of Psychiatric and Mental Health Nursing (3): 285-6, 2000	Outpatients taking clozapine were randomly assigned to 3 sessions of patient education vs. a control group of standard care.	44 patients, 22 in intervention group, 22 controls	Assessed at baseline and at 5 weeks post-intervention	No significant difference found on drug-attitude inventory or the insight scale. Results did not support the hypothesis that brief patient education would be superior to standard of care; it would therefore be unlikely improve adherence.
Hamann J, et al., Acta Psychiatrica Scandinavica	Inpatients with schizophrenia in 12 hospital wards were randomized into a shared decision making intervention,	49 in intervention group, 58 controls	Data collected on admission and discharge.	Patients in the intervention group reported significantly greater sense of involvement in medical decisions after the

114 (4): 265-273, 2006	or to a control group. The intervention group was given psychoeducational material, completed a booklet, and participated in treatment planning meetings.			initial planning talk, but this difference was not found at discharge. There was no difference in overall satisfaction with treatment, but there was a trend toward more positive attitudes toward medication in the intervention group, and doctors in this group were more satisfied with overall treatment results.
Hamann J, et al., The Journal Of Clinical Psychiatry 68 (7): 992-997, 2007	Inpatients with schizophrenia were randomized to a shared decision making (SDM) group and a control group. The SDM group received psycho-educational material and a planning talk between patient and physician.	107	6 month and 18 month assessments post discharge	No significant differences were found in any outcome measure, but multivariate analysis showed that SDM recipients had a positive trend of fewer rehospitalizations, but no clear beneficial effect on long-term compliance.
Hornung WP, et al., Acta psychiatrica Scandinavica (3): 213-9, 1998	Schizophrenic outpatients randomized to control vs. psychoeducational medication training (PMT) alone or in combination with cognitive psychotherapy (CT) and/or key-person counseling (KC).	32 in PMT group, 34 in PMT + CP, 35 in PMT + KC, 33 in PMT + CP + KC, 57 controls	Assessments at baseline, after intervention, and at 1-year follow-up.	Psychoeducation improved patient attitudes toward treatment, including reduced fear of side effects and more confidence in their medication and physician, but there was no significant difference in compliance at 1 year followup. Intervention had no effect on medication management.
Hornung WP, et al., Patient Education and Counseling (3): 257-68, 1996	Schizophrenic outpatients randomized to control vs. psychoeducational medication training (PMT) alone or in combination with cognitive psychotherapy (CT) and/or key-person counseling (KC).	32 in PMT group, 34 in PMT + CP, 35 in PMT + KC, 33 in PMT + CP + KC, 57 controls	Assessments at baseline, after intervention, and at 1-year follow-up.	Medication compliance increased in both groups but was greater in the training group vs. controls. There was no significant difference in patients' satisfaction of their knowledge of medication, but more patients in the training group did not did not feel capable of dosing their own medications after the intervention.
Iacoviello BM, et al., Journal Of Consulting And Clinical Psychology 75 (1): 194-198, 2007	Patients with major depressive disorder were asked what treatment they preferred, then randomized to supportive-expressive psychotherapy (PT), sertraline (S), or pill-placebo (P).	Of the 39 preferring psychotherapy: 17 received PT, 12 S, 10 P. Of the 36 preferring medication, 8 received PT, 15 S, 13 P.	Assessments given before treatment, and during 3rd, 5th, and 9th weeks of treatment.	In patients who preferred psychotherapy, therapeutic alliance showed positive development over the course of the study if treatment was congruent with their preferences, while patients who received treatment incongruent with their preference showed a decrease in alliance over time. Patients who preferred pharmacotherapy showed no

				differences regardless of treatment.
Merinder LB, et al., Social psychiatry and psychiatric epidemiology (6): 287-94, 1999	Patients with schizophrenia were randomized to an 8-session educational intervention or standard care. The patients' relatives were also invited to participate, though not all subjects had relatives involved.	46 patients, with 23 in intervention group, 23 in control group	8 weeks of educational sessions. Assessments post intervention and 1 year later	A statistically significant increase in knowledge of schizophrenia in both relatives and patients was demonstrated after the intervention with a non-significant trend for increased knowledge at 1-year follow-up. Patients and relatives were more satisfied with relatives' involvement in the intervention group. There was a tendency for an increased time to relapse and improvements in symptoms in the intervention group. No differences were found between the groups regarding compliance, insight into psychosis, GAF score or in relatives' expressed emotion scores after the intervention or at 1-year follow-up.
Mundt JC, et al., Depression And Anxiety 13 (1): 1-10, 2001	Outpatients with major depressive disorder receiving antidepressant pharmacotherapy were randomized to receive, or not receive, psychoeducational materials by mail (RHYTHMS program). Patients were then paid to provide self-evaluations of response and satisfaction with treatment, and their prescription records were analyzed for medication compliance.	246 subjects, randomized into two groups	Assessments at baseline, 4, 12, and 30 weeks.	Patients in control group initially responded better than the intervention group, but this trend did not last. Treatment did not affect the duration of compliance.
Myers ED, et al., The British Journal Of Psychiatry: The Journal Of Mental Science 160 83-86, 1992	Outpatients with depression were randomized to one of three groups: group A received one dose of medication at night; group B received 3 doses of medication during the day; group C were allowed to choose either A or B above. Compliance, symptoms, and side effects were assessed at 3, 6, 9, and 12 weeks by interrogation and pill count	89 subjects	12 weeks, with assessments at 3, 6, 9, and 12 weeks	Compliance improved in cases when patients were allowed to choose their regimen, but only when they chose the 3 times per day regimen. Other groups did not experience the same improvement. Compliance decreased over time in all groups. There was no evidence that compliance produced a better therapeutic result.
Robinson GL, et al., The	Patients ready for discharge at a state hospital in Ohio	150 subjects	Subjects assessed at	Subjects who received the hand-out, with or without

Psychiatric Quarterly 58 (2): 113-118, 1986	were randomized to usual care, receiving a 1-2 page hand-out about medications, or receiving the handout plus a review of -the information.		discharge and at 1st follow-up appointment post discharge	verbal explanation, showed improvement in understanding of treatment. Subjects who received written information with verbal reinforcement, but not those who only received the handout, were significantly more compliant than the control subjects.
Sterling RC, et al., The American Journal on Addictions, 6: 168-176, 1997	Patients seeking treatment for cocaine dependence received either 12 weeks of weekly individual therapy (IND), or an intensive 3-hour, 3 times per week treatment program (INT). Half the subjects were given their choice of treatment, and the other half were randomized into one or the other.	127 total subjects, 67 given choice of treatment, 34 of these chose IND, 33 INT. 30 were randomized to each group.	12 weeks of treatment, with a 9-month follow-up	Patients who chose IND differed from those who chose INT only in 2 of 41 comparisons: number of previous treatment experiences and ASI Alcohol composite score. Allowing patients to choose their course of treatment did not significantly enhance retention, the proportion of appointments kept, or completion of the 12 week intervention.
Vandereycken W, and Vansteenkiste M, Eur Eat Disord Rev 17 (3):177-83, 2009	On a specialized inpatient unit for treatment of eating disorders, patients who underwent a new admission strategy that emphasized patent choice were compared to controls who were admitted prior to the new strategy.	87 patients in the intervention arm, 87 controls who were prior admissions	Admission strategy involves a 5-day introductory period prior to entering treatment	The results indicate that the provision of choice at the beginning of treatment significantly reduced drop-out during the first weeks of inpatient treatment. No differences between both strategies on later drop-out and weight change (in anorexia nervosa patients) during inpatient treatment were found.
Vreeland B, et al., Psychiatric Services (Washington, D.C.) 57 (6): 822-828, 2006	Patients with schizophrenia or schizoaffective disorder were randomized to a 24-week comprehensive, modularized, psychoeducational intervention focused on illness management called Team Solutions, or to standard care.	71 patients	24-week intervention	Significant improvement was observed in knowledge about schizophrenia and client satisfaction in the intervention group. No changes were observed in symptoms, treatment adherence, or global functioning.

Grading of Quality of Individual Studies

Citation: Buchkremer G et al., Psychoeducational psychotherapy for schizophrenic patients and their key relatives or care-givers: Results of a 2-year follow-up. Acta psychiatrica Scandinavica (6): 483-91, 1997

Population: A total of 191 patients (80 female and 111 male subjects) from the outpatient departments of nine psychiatric hospitals and a number of psychiatric practices were recruited between May 1989 and February 1990. Patients were eligible for inclusion in the study if they fulfilled the following criteria: (i) schizophrenia diagnosed according to DSM- III-R (exclusion of schizoaffective disturbances); (ii) at least two acute psychotic episodes within the past *5* years; (iii) at least 4 weeks of psychopathological stabilization; (iv) indication for long-term neuroleptic medication on an outpatient basis; (v) no secondary psychiatric diagnosis. A total of 147 patients took part in the scheduled therapeutic approach, with hospitalization data being obtained from 132 of these subjects at the 2- year follow-up. In total 29% of the patients dropped out of the control group, and 20% dropped out of the treatment group.

Intervention: Psychoeducational medication management training (PMT), cognitive psychotherapy (CP) and key-person counseling (KC) were carried out in various combinations

Comparators: The control group were patients undergoing routine care.

Outcomes: In the second follow-up year, all treatment groups had lower but not significantly different relapse rates compared to the control group. The most intensive treatment (PMT+CP+KC) produces a clinically relevant reduction in rehospitalization with a 24% rate of rehospitalization compared to a rate of 50% in the control group, although the statistical significance of this effect was nominal. When the treatment groups were considered as a whole and compared with patients in the control group, patients who received any of the interventions showed greater social functioning and confidence in the therapist and medications at the two-year followup but did not differ on measures of rehospitalization, psychopathological symptoms or medication adherence.

Timing: Patients recruited from May 1989 to February 1990. The interventions were carried out on different schedules, based on the intervention. The PMT group was carried out in 10 sessions (first 5 weekly, second 5 every other week). The CP group was 15 sessions (7 weekly, 8 every other week). KC group was 20 sessions. There was follow-up at 2 years after the intervention(s).

Setting: Outpatients from the outpatient departments of nine psychiatric hospitals and a number of psychiatric practices in Germany.

Study Design: Randomized, controlled non-blinded intervention study

Overall risk of study bias: Low Risk

Selection bias: Low Risk: The exclusion criteria do not appear to introduce bias, and patients were randomized into the various treatment arms (or control group).

Performance bias: Low Risk: There is no evidence of systematic differences in the treatment of patients or of protocol deviation.

Attrition bias: Moderate Risk: An intention-to-treat analysis was used for drop outs, which constituted 20-30% of participants. However, patients who drop out may be more likely to be rehospitalized (e.g. if the subject dropped out due to worsening symptoms).

Detection bias: Low Risk: The authors note that rehospitalization data was obtained directly from the

institution, with patient consent.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low risk. There is no conflict of interest statement in the study. This study was funded by the German Ministry of Research and Technology.

Applicability: This study measures rehospitalization rates as a proxy for overall clinical outcome. However, the clinical question is concerned with whether education improves adherence, alliance, and satisfaction. Participants had a diagnosis of schizophrenia and received treatment in an outpatient setting, which limits applicability to other diagnoses and settings. Also, the study population is German, which limits applicability to patients in the United States.

Citation: C. M. Wilder et al. Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. Psychiatric Services 61 (4): 380-5, 2010

Population: Participants were outpatients receiving community-based treatment in one of two county-based programs who were 18 to 65 years old and had a chart diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder with psychotic features, or major depressive disorder with psychotic features.. Eighty-three percent of participants (N=390) were randomly drawn from deidentified client lists of the two mental health programs that had been prescreened for eligibility. The remaining 17% of participants (N=79) were randomly assigned after being identified from sequential admissions from the mental health programs to the regional state hospital with the goal of increasing the proportion of individuals with severe mental illness and potential decisional incapacity.

Intervention: A total of 123 persons with severe mental illness recorded medication preferences in psychiatric advance directives and were reassessed after 12 months of followup. The intervention was adapted from several medical and psychiatric advance directive planning tools and included an approximately two-hour, semistructured, manualized interview and guided discussion of choices for planning mental health care during future periods of incapacity. The facilitator also assisted participants in completing legal psychiatric advance directive documents, obtaining witnesses, getting documents notarized, and filing forms in the medical record and electronic registry.

Comparators: The control group was provided with general information about psychiatric advance directives, copies of standard psychiatric advance directive forms, and a toll-free number for the local consumer organization that provides consultation on psychiatric advance directives.

Outcomes: The authors compared patient's stated medication preferences in advanced directives to prescribed medications over 12 months, determined concordance between preferred and prescribed medications, and examined the effect of concordance on medication adherence at 12 months. Participants requested a median of two medications in their psychiatric advance directives (range from zero to six) and refused a median of one medication (range from zero to ten). Between baseline and follow-up there was a 27% increase in the number of medications prescribed that had been requested on the psychiatric advance directive (Wilcoxon matched pairs, $p<.001$). After correction for the number of medications listed in the psychiatric advance directive, a 10% increase in concordance remained significant ($p<.001$). Being prescribed at least one medication requested in the psychiatric advance directive predicted higher medication adherence at 12 months, after the analysis controlled for relevant covariates (odds ratio=7.8, 95% confidence interval=1.8–34.0).

Timing: 12 month follow-up period after intervention. Follow-up interviews were conducted between October 2004 and September 2006.

Setting: Community-based treatment in one of two county-based programs in North Carolina.

Study Design: Randomized, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: The exclusion criteria do not appear to introduce bias, and patients were randomized into the intervention or control group. The sample intentionally over-represented individuals with severe mental illness.

Performance bias: Low Risk: There is no evidence of systematic differences in treatment or co-interventions.

Attrition bias: Moderate Risk: Of the 143 who completed an advanced directive, 123 completed a follow-up interview after one year. Those who completed the interview may have been more likely to be adherent to medication than those who did not, which would introduce bias. No intention-to-treat analysis was done.

Detection bias: High Risk: Patients were interviewed about their adherence, and previous studies have documented that patients tend to overestimate their adherence to medications.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: This study was funded by grants from the National Institutes of Health and by the John D. and Catherine T. MacArthur Foundation. The authors, Dr. Swanson and Dr. Swartz, have received research support from Eli Lilly. Dr. Swartz has also received consulting and educational fees from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, and Pfizer. The other authors report no competing interests.

Applicability: This study is applicable to the clinical question, because it seeks to assess adherence to medications when patients participate in their treatment by completing advanced directives. Also, only individuals in outpatient settings who had psychosis as part of their illness were included, which limits applicability to other diagnoses and settings.

Citation: D. Degmecic et al. Psychoeducation and compliance in the treatment of patients with schizophrenia. Coll Antropol 31 (4):1111-5, 2007

Population: Hospitalized patients with schizophrenia at the University Department of Psychiatry in the University Hospital Osijek, Croatia

Intervention 30 patients were educated about the schizophrenia; while 30 patients were not educated. Psychoeducation groups were held by a psychiatrist once a week for one hour, and patients were educated about the early recognition of schizophrenia symptoms, about the prevention of recurrence of psychotic episodes, about the role of medication in the treatment of schizophrenia, and also about side effects of those medications. Groups consisted of 6-8 patients, and on average patients attended 4 groups. Patients were assessed on the admission to the hospital, at discharge, and 3 months after discharge. Assessments included the Brief Psychiatric Rating Scale (BPRS), Compliance Assessment Inventory, Drug Attitude Inventory, Global Assessment of Functioning (GAF), and a 12-item questionnaire about knowledge of the illness.

Comparators: Patients who underwent the educational program were compared with those who did not

Outcomes: There were statistically significant improvements in schizophrenia symptoms in the intervention group at discharge and 3-months post discharge based on both the BPRS and GAF. There

were also statistically significant improvements in compliance and knowledge of the illness in the intervention group as compared to controls.

Timing: Inpatients attended, on average, 4 one-hour groups and were assessed at admission, discharge, and 3 months post discharge. Average length of stay was about 4 weeks.

Setting: Inpatient psychiatric service in Croatia

Study Design: Non-randomized, non-blinded intervention study

Overall risk of study bias: High Risk

Selection bias: High Risk: The authors do not state that patients were randomized to the two groups, and they also do not discuss inclusion or exclusion criteria. The authors do state that there were no significant differences in the groups at baseline in any of the core measures. Nevertheless, there could be selection bias without randomization and without a more defined inclusion and exclusion process.

Performance bias: High Risk: The intervention involved weekly 1-hour group sessions with a psychiatrist in an inpatient setting. There may be other reasons that patients in the intervention group improved on all the core measures beyond simply receiving education about schizophrenia (e.g. spending more time with the psychiatrist, socializing with other patients). Patients were not blinded in this study, and so those who had been part of the weekly psychoeducational groups may have been more motivated to report that they were compliant or had fewer symptoms by virtue of being in the study.

Attrition bias: Low Risk: Attrition was not discussed in the study, implying that all 60 patients initially chosen to be a part of the study also participated in the follow up.

Detection bias: High Risk: All measurements were based on patient self-report, which tends to overestimate adherence. Patient recall of symptoms may also be inaccurate.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Unknown Risk. There are not statements of conflict of interest

Applicability: This study does measure adherence after educating patients, and so it is applicable to the clinical question. However, due to possible unintended interventions discussed in “performance bias” above, it is difficult to conclude that study effects resulted from the intended intervention (i.e., psychoeducation). Also, the patients were diagnosed with schizophrenia and treated in an inpatient unit in Croatia, which limits applicability to patients in the United States with other diagnoses and in other treatment settings.

Citation: G. Pitschel-Walz et al. Psychoeducation and compliance in the treatment of schizophrenia: Results of the munich psychosis information project study. J Clin Psychiatry 67 (3):443-52, 2006

Population: 236 inpatients who met DSM-III-R criteria for schizophrenia or schizoaffective disorder and who had regular contact with at least 1 relative or other key person. Inclusion criteria included a diagnosis of schizophrenia or schizoaffective disorder (according to DSM-III-R/ICD-9 criteria), age 18-65 years, willingness to receive at least one year of outpatient treatment, indication for at least a 12-month antipsychotic relapse prevention, and willingness to involve one key person. Exclusion criteria included a distance between the patient’s home and the hospital of more than 150km, no regular contact with relatives, regular substance use within the 6 months prior to admission, pregnancy, an IQ of less than 80, lack of competence in German, and no remission in the past 2 years.

Intervention: Patients were randomly assigned to 1 of 2 treatment conditions. In the intervention condition, patients and their relatives were encouraged to attend psychoeducational groups over a period of 4 to 5 months. The patients' and relatives' psychoeducational programs were separate, and each consisted of 8 sessions. Patients in the other treatment condition received routine care.

Comparators: Patients and families in the intervention group were compared to controls who received routine care.

Outcomes: Rates of rehospitalization and medication adherence were assessed at 12 and 24 months. At 12 and 24 months, adherence was better and the rehospitalization rate was significantly reduced ($p<.05$)in patients who attended psychoeducational groups compared with those receiving routine care.

Timing: Outcomes were compared over 12-month and 24-month follow-up periods. The study was conducted from 1990 to 1994.

Setting: Psychiatric State Hospital, Haar, Germany

Study Design: Randomized, intervention study

Overall risk of study bias: Moderate Risk

Selection bias: High Risk: Randomization was based on “blocks” of 8-12 patients. There is no information on how the patients were divided into the blocks. Inclusion and exclusion criteria included contact with a key person; it is possible that subjects with regular contact with a key person are different from those without such contact (e.g., may have less severe symptoms, stronger social support). Exclusion of subjects with substance use in the previous 6 months means exclusion of a significant subpopulation of patients diagnosed with schizophrenia or schizoaffective disorder, especially if cigarette use was included in the definition of substance use.

Performance bias: Moderate Risk: Treating psychiatrists were blind to the randomization. However, the intervention included attendance at group sessions over an extended period of time, which introduces the possibility for unintended interventions (e.g., increased family involvement and interaction with other patients, and increased attention from clinicians).

Attrition bias: Moderate risk. After beginning the study, 26 patients were excluded due to a change in the status of inclusion or exclusion criteria (i.e., change of diagnosis, no indication for antipsychotic relapse prevention, no remission during inpatient stay, and relocation that changed distance between patient’s house and hospital). After acceptance into the study but before outpatient treatment began, 16 patients withdrew consent. Thirty-one patients dropped out of the study before the 12-month follow-up. An additional 10 dropped out before the 24-month follow-up. The 41 patients who dropped out may have systematic differences from those who remained in the study; there were no differences in dropout rate between the intervention and control groups.

Detection bias: Moderate Risk: Adherence was measured by clinician report and confirmed by plasma drug level measurements. Other outcomes were measured by clinician and patient report.

Reporting bias: Low risk. There is no evidence for selective outcome reporting.

Sponsor-related bias: Low risk. The study was funded by the German Ministry of Research and Technology. The authors reported no conflicts of interest.

Applicability: Patients in this study who were part of the psychoeducational intervention groups, and who had family members participate, did have increased adherence, which is specifically germane to the clinical question. However, this result could be confounded by other benefits of attending groups and

having increased family involvement, as discussed in "performance bias" above. Also, the patients were diagnosed with schizophrenia or schizoaffective disorder and treated in inpatient units in Germany, which limits applicability to patients in the United States with other diagnoses and in other treatment settings.

Citation: Gray R. Does patient education enhance compliance with clozapine? A preliminary investigation. Journal of Psychiatric and Mental Health Nursing (3): 285-6, 2000

Population: 44 patients who had been taking clozapine for at least 3 months. 10 patients dropped out of the study, 4 in the intervention group, and 6 in the control group.

Intervention: Patients were randomized to receive 3 sessions, one per week, of patient education (n=22), or routine care (n=22). The emphasis in the sessions was on discussion about issues and concerns about all therapies the patient was receiving, both pharmacological and psychological, although the focus of much of the discussion was about clozapine. Patients were encouraged to explore the positive and negative aspects of their current and prior treatments.

Comparators: Patients who underwent the educational intervention were compared to those who received routine care.

Outcomes: Patients were assessed at baseline, and again after 5 weeks, using two self-report instruments: the Drug Attitude Inventory and a 10-item insight scale. At the 5-week follow up, there were no significant differences between groups in scores on the drug attitude inventory or the insight scale.

Timing: Patients were assessed at baseline and again at 5 weeks. The sessions lasted three weeks.

Setting: The sessions occurred in a room on a hospital ward. The research was done in the UK. The article does not specify whether the patients themselves were inpatients, or whether the study sessions were simply performed in the hospital ward.

Study Design: Randomized, single-blind intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: There is no description of inclusion or exclusion criteria, other than patients had to have been taking clozapine for at least 3 months. There was mention in the study that the two groups were not different on the core measures at baseline.

Performance bias: Low Risk: There were no differences reported in the two treatment groups.

Attrition bias: Moderate Risk: 10 patients out of 44 recruited dropped out of the study, and there was no intention-to-treat analysis. Patients who dropped out may have had different responses to the drug attitude inventory and insight scale.

Detection bias: Moderate Risk: Patients were assessed using self-reports. This introduces bias, since patients may not accurately report their own attitudes in an effort to give "correct" answers.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Unknown Risk. There is no discussion of conflicts of interest or sponsorship.

Applicability: This study focuses on a narrow population of patients who have been taking clozapine for the past 3 months. A brief educational intervention did not improve attitudes or insight, but there was no mention of adherence, alliance, or satisfaction with treatment, which were the foci of the clinical question.

Citation: Hamann J et al. Shared decision making for in-patients with schizophrenia. Acta Psychiatrica Scandinavica 114 (4): 265-273, 2006

Population: Inpatients aged 18–65 years who had an ICD-10 diagnosis of schizophrenia or schizophreniform disorder were included who were fluent in German and willing to give informed consent Exclusion criteria were severe mental retardation, severe psychosis, or short hospital stays that precluded participation. Of the 301 patients with a diagnosis of schizophrenia who were screened during the enrollment period, 107 patients completed the in-patient phase of the trial with 49 patients receiving the intervention and 58 in the control group.

Intervention: Patients in the intervention group received a 16-page booklet covering the pros and cons of oral vs. depot formulation of antipsychotic, first vs. second generation antipsychotics, psychoeducation, and types of socio-therapeutic intervention. Nurses were instructed in the use of the decision aid and assisted all patients in working through the booklet. Patients met their physicians within 24 hours after having worked through the shared decision making aid with their nurse.

Comparators: Inpatients who received the shared decision-making intervention were compared to controls who received routine care

Outcomes: Patients filled out 5 different questionnaires, and physicians and nurses also provided information on their perceptions of the patients' performance in using the decision aid and planning care. Patients in the intervention group had a better knowledge about their disease (P = 0.01) and a higher perceived involvement in medical decisions (P = 0.03) before hospital discharge. The intervention increased the uptake of psychoeducation (P = 0.003). Overall satisfaction with treatment did not differ between patients in the intervention group and the control group. Therapeutic alliance, measured from the clinician’s perspective, did not differ between the intervention and control groups. Clinician-rated patient compliance also did not differ between the groups. However, clinicians in the intervention group were more satisfied with treatment achievements than those in the control group. The authors also state that the intervention was feasible for most of the patients and did not require additional time spent by physicians.

Timing: The intervention took place while patients were in the hospital. Patients were followed for 18 months post discharge although the data reported in this paper describe the comparisons made at the time of hospital discharge. Patients were recruited between February 2003 and January 2004.

Setting: 12 acute psychiatric wards of two German state hospitals (Bezirkskrankenhaus Haar, Klinikum Agatharied) in the greater Munich area.

Study Design: Cluster-Randomized, controlled, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: High Risk: Patients in the intervention group were different in several ways from patients in the control group. Patients in the intervention group had been hospitalized about a week longer during their present stay than patients in the control group; and PANSS ratings for positive symptoms were, accordingly, lower in the intervention group. Patients in the intervention group were slightly younger (Mean = 35.5 vs. Mean = 39.6 years) and had better knowledge about their disease. There were more patients in the intervention group who had been hospitalized involuntarily.

Performance bias: Moderate Risk: Patient's self report measures could be influenced by the knowledge that they had been in the intervention group.

Attrition bias: Moderate Risk: Six patients dropped out of the study (all of whom withdrew consent): 5 in

the intervention group and 1 in the control group.

Detection bias: Low Risk: There were much data obtained through the report of multiple individuals (patients, nurses and psychiatrists), so the ratings were likely adequate in detecting the outcome measures.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: The trial was funded by the German Ministry of Health and Social Security. There was no evidence of bias by the sponsors.

Applicability: This study is relevant to the clinical question, though it studies a narrow population of patients (inpatients in a German state hospital with a diagnosis of schizophrenia).

Citation: Hamann J et al. Shared decision making and long-term outcome in schizophrenia treatment. J Clin Psychiatry 2007; 68(7):992-997.

Population: 107 state psychiatric hospital inpatients with a diagnosis of schizophrenia. Additional details on the study population are described in Hamann J et al. Acta Psychiatrica Scandinavica 114 (4): 265-273, 2006.

Intervention: A shared decision-making (SDM) program on antipsychotic drug choice consisting of a decision aid and a planning talk between patient and physician was compared with routine care ().

Comparators: Inpatients who received the shared decision-making intervention were compared to controls who received routine care

Outcomes: On the whole, authors found high rates of noncompliance and rehospitalization. There were no differences in rehospitalization or compliance between intervention and control groups in the univariate analyses at 6-month and 18-month follow-up. However, after controlling for confounding factors in a multivariate analysis, there was a positive trend ($p = .08$) for patients who received the intervention to have fewer rehospitalizations. Additionally, a higher desire of the patient for autonomy and better knowledge at discharge were associated with higher hospitalization rates. Long-term medication compliance was poor for up to 50% of the patients. The SDM intervention had no clear effect on compliance.

Timing: Study proceeded from February 2003 to January 2004. Patients were assessed at 6 and 18 months after the intervention.

Setting: Psychiatric state hospitals in Germany

Study Design: cluster-randomized, controlled, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk. Since randomization was done using a cluster approach in which all patients at a given site were randomized to the same treatment arm, site specific factors may have produced differences in the intervention and control groups.

Performance bias: Moderate risk. Patients in the intervention group were aware of their randomization status and may have been motivated to give answers on the questionnaires or interviews that they thought were desired by the researchers.

Attrition bias: Moderate risk. 16 patients were lost to follow-up at 6 months, and 30 were lost to follow-up at 18 months. Four patients withdrew consent, and 2 patients died within 18 months after discharge. In sum, 6-month follow-up data were available for 80% of the sample, and 18-month follow-up data

were available for 66%. The study reports that there were no significant differences in drop-out rates in the intervention and control groups. Also, there were no differences between patients who continued the trial and those who dropped out, in terms of age, gender, duration of illness, or PANSS score at discharge.

Detection bias: Low Risk: There were much data obtained through the report of multiple individuals (patients, nurses and psychiatrists), so the ratings were likely adequate in detecting the outcome measures.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low risk. The study was funded by the German Ministry of Health and Social Security. Study authors report honoraria and research support from various industry sources.

Applicability: This study is relevant to the clinical question, though it studies a narrow population of patients (inpatients in a German state hospital with diagnosis of schizophrenia).

Citation: Hornung WP et al. Collaboration with drug treatment by schizophrenic patients with and without psychoeducational training: Results of a 1-year follow-up. Acta psychiatrica Scandinavica (3): 213-9, 1998

Population: The patients were recruited for the study from seven psychiatric centers within a rural region of Germany. The inclusion criteria were as follows: diagnosis of schizophrenia according to DSM-III-R; at least two acute schizophrenic episodes within the past 5 years; registration at an outpatient clinic; need for long-term neuroleptic treatment; and psychopathological stabilization throughout the 4 weeks preceding the study. Patients with diagnoses other than an Axis-I diagnosis of schizophrenia were excluded.

Intervention: Patients were randomly assigned to four treatment groups and one control group. The treatment groups contained psychoeducational medication training (PMT) alone (n=32) or in combination with cognitive psychotherapy (CP) (n=34) and (n=33)/or (n=35) key-person counseling (KC). The 10 sessions of PMT aimed to provide detailed information about schizophrenia and its treatment, and to improve medication management by introducing collaboration between the patient and the psychiatrist in determining medication treatment. Subjects were evaluated at baseline, immediately after treatment, and at a 1 year follow-up.

Comparators: The treatment arms were compared to each other and to controls who received routine care. Each treatment arm contained the psychoeducational medication training.

Outcomes: The baseline measure of good medication compliance was 76.2% for regular attenders and 69.4% for control patients; the post-treatment measure of good medication compliance was 85.7% of regular attenders and 76.6% of control patients. While compliance improved in both groups, the difference between the two groups was not significant. At 1-year follow-up, good medication compliance was found in 82.9% of regular attenders and 79.2% of control patients; this difference between the groups was not significant.

Timing: The PMT lasted 10 weeks, and patients were assessed 1 year after treatment.

Setting: seven psychiatric centers within a rural region of Germany

Study Design: Randomized, controlled, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: Patients were randomized to the various treatment arms, and the inclusion and exclusion criteria did not appear to introduce bias.

Performance bias: Low Risk: There is no evidence of systematic differences in the treatment of the study groups.

Attrition bias: High Risk: 8 of the 84 patients in the treatment group and 11 of the 64 patients in the control group were lost to follow-up. It is not clear whether the analysis accounted for the effects of attrition based on this article. Patients who dropped out may have been less likely to be engaged in treatment and may have therefore affected the results of the study if their responses had been included.

Detection bias: Moderate Risk: Many of the items assessed were based on patient self-report, including a questionnaire about previous medication management over the past year (particularly the patients' level of compliance). Patients are not likely to have a detailed and accurate memory of prior medication management.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: The study was funded by the German Ministry of Research and Technology.

Applicability: Patients were chosen from rural clinics in Germany and all had a diagnosis of schizophrenia. This limits the overall applicability of this study to general U.S. populations. However, the study does investigate the relationship between receiving psychoeducation, and subsequent attitudes toward treatment and adherence to treatment.

Citation: Hornung WP et al. Psychoeducational training for schizophrenic patients: Background, procedure and empirical findings. Patient Education and Counseling (3): 257-68, 1996

Population: The study included 191 outpatients with chronic schizophrenia, 134 in the therapy group, and 54 in the control group. They were recruited within seven psychiatric centers in a rural region of Germany. Inclusion criteria were: Diagnosis of schizophrenia according to DSM-III-R, at least two acute schizophrenic episodes within the last 5 years, attending an outpatient-clinic, need for long-term neuroleptic treatment, psychopathological stabilization within 4 weeks prior to the study. Patients with diagnoses other than schizophrenia were excluded.

Intervention: Patients were randomly assigned to four treatment groups and one control group. The treatment groups contained psychoeducational medication training (PMT) alone (n=32) or in combination with cognitive psychotherapy (CP) (n=34) and (n=33)/or (n=35) key-person counseling (KC). The 10 sessions of PMT aimed to provide detailed information about schizophrenia and its treatment, and to improve medication management by introducing collaboration between the patient and the psychiatrist in determining medication treatment

Comparators: The treatment arms were compared to each other and to controls who received routine care. Each treatment arm contained the psychoeducational medication training.

Outcomes: Patients adherence, knowledge of medications and ratings of ability to self-manage medications were assessed at baseline, immediately after treatment, and at a 1 year follow-up. At the end of the training program, patients who had attended regularly showed significantly better medication compliance relative to their baseline level of compliance and were less confident in their medication self-management skills. After 1 year, the positive effects of the intervention had diminished.

Timing: Subjects were assessed at baseline, immediately after the intervention, and at 1 year post intervention.

Setting: Subjects were outpatients with schizophrenia, recruited from seven mental health clinics in rural Germany.

Study Design: randomized, controlled, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: Patients were randomized to the various treatment arms, and the inclusion and exclusion criteria did not appear to introduce bias.

Performance bias: Low Risk: There is no evidence of systematic differences in the treatment of the study groups.

Attrition bias: High Risk: 8 of the 84 patients in the treatment group, and 11 of the 64 patients in the control group, were lost to follow-up. It is not clear whether the analysis accounted for the effects of attrition based on this article. Patients who dropped out may have been less likely to be engaged in treatment and may have therefore affected the results of the study if their responses had been included.

Detection bias: Moderate Risk: Many of the items assessed were based on patient self-report, including a questionnaire about previous medication management over the past year (particularly the patients' level of compliance). Patients are not likely to have a detailed and accurate memory of prior medication management.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: The study was funded by the German Ministry of Research and Technology.

Applicability: Patients were chosen from rural clinics in Germany and all had a diagnosis of schizophrenia. This limits the overall applicability of this study to general U.S. populations. However, the study does investigate the relationship between receiving psychoeducation, and subsequent attitudes toward treatment and adherence to treatment.

Citation: Iacoviello BM et al. Treatment preferences affect the therapeutic alliance: Implications for randomized controlled trials. Journal Of Consulting And Clinical Psychology 75 (1): 194-198, 2007

Population: Data were collected from the first 75 patients enrolled in an ongoing study comparing the efficacy of supportive–expressive (SE) psychotherapy with sertraline or pill placebo in the treatment of major depressive disorder (MDD). Inclusion criteria were a primary diagnosis of MDD as determined with the Structured Clinical Interview for DSM–IV and a score of 14 or above on the 17-item version of the Hamilton Rating Scale for Depression. Patients were excluded from participation if they had a current or past history of psychosis, bipolar disorder, substance dependence in the past 6 months, and/or current suicide risk or nonresponse to an adequate trial of sertraline or SE therapy within the last year.

Intervention: Subjects were asked what treatment they preferred, then randomized to supportive-expressive psychotherapy (PT), sertraline (S), or pill-placebo (P). Treatment preference, alliance and depressive symptoms were assessed at baseline and periodically throughout the study.

Comparators: Alliance for patients who received their preferred treatment was compared to alliance for patients who did not receive their preferred treatment.

Outcomes: In patients who preferred psychotherapy, therapeutic alliance showed positive development over the course of the study if treatment was congruent with their preferences, while patients who received treatment incongruent with their preference showed a decrease in alliance over time. Patients who preferred pharmacotherapy showed no differences regardless of treatment.

Timing: The psychotherapeutic condition consisted of twice-weekly sessions for 4 weeks, followed by weekly sessions for the next 12 weeks. Patients receiving pharmacotherapy treatment were blind to the treatment they were receiving (sertraline or placebo) and were seen in weekly clinical management sessions with a pharmacotherapist for 16 weeks.

Setting: Outpatient setting in Philadelphia, PA

Study Design: randomized, controlled trial.

Overall risk of study bias: Moderate Risk

Selection bias: High Risk: This study measures the effect on alliance when patients do not get the treatment they prefer, and yet the subjects all had agreed to be randomized to treatment. Only patients who agreed to this randomization were included, and this may affect the results of the study. Patients who chose psychotherapy may be systematically different from those who chose pharmacotherapy, which limits the ability to attribute effects on therapeutic alliance purely to congruent/incongruent treatment assignment. Also, the exclusion criteria focused on illness characteristics (e.g., history of psychosis, substance dependence) may introduce bias into the selected sample of patients.

Performance bias: Moderate Risk: Patients receiving pharmacotherapy were blinded to whether they received sertraline or placebo. However, there was no control group (e.g., time and attention control) for the psychotherapy group.

Attrition bias: High Risk: An intention-to-treat analysis was performed to minimize attrition bias. Nevertheless, since the study was measuring treatment alliance, there is likely a difference in treatment alliance between those who remained with the study and those who were lost to follow-up.

Detection bias: Moderate risk. Self-report measures were used for treatment preference and therapeutic alliance. Subjects in the study may not accurately report their attitudes because they may be trying to give the “right” answer. Depression severity was rated by blind outcome assessors.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: This research was supported by a National Institute of Mental Health Grant. There is no evidence of sponsor-related bias.

Applicability: The study shows that, for outpatients with depression, alliance is improved when patients receive their preferred treatment. This answers the clinical question – involving the patient in the treatment plan improves their alliance with the clinician. However, subjects were treated in an outpatient setting in one U.S. city for depression, which limits applicability across treatment settings and diagnoses.

Citation: Merinder et al. Patient and relative education in community psychiatry: A randomized controlled trial regarding its effectiveness. Social psychiatry and psychiatric epidemiology (6): 287-94, 1999

Population: Subjects were identified from a local case registry and included all patients aged 18-49 years of age with a clinical ICD-10 diagnosis of schizophrenia who were in treatment at one of two community psychiatric centers in Denmark. A total of 135 patients fulfilled the inclusion criteria and were invited to participate in the study. Of these, 46 (34%) agreed to participate, 27% refused to participate and 39% did not respond to the invitation.

Intervention: The experimental group received an eight-session intervention conducted weekly, given separately to both patients and their relatives, using a mainly didactic interactive method focused on topics concerning schizophrenia. The control group received the usual treatment provided in community psychiatry, i.e. psychopharmacological treatment, psychosocial rehabilitation efforts and to some extent supportive psychotherapy.

Comparators: Patients undergoing usual outpatient care were compared to those who had received an 8-week psychoeducational intervention, along with their relatives.

Outcomes: A statistically significant increase in knowledge of schizophrenia in both relatives and patients was demonstrated post intervention and a non-significant trend at 1-year follow-up. Statistically significant changes in the Verona Service Satisfaction Scale Scores in the subdimension of satisfaction with relatives' involvement were demonstrated both for patients and relatives post intervention and for patients at 1-year follow-up. There was a tendency that time-to-relapse increased in the intervention group post intervention and that the schizophrenia subscore of the Brief Psychiatric Rating Scale was reduced in the intervention group at 1-year follow-up. No differences were found between the groups regarding compliance, insight into psychosis, psychosocial function (GAF) or in relatives' expressed emotion scores post intervention or at 1-year follow-up.

Timing: The intervention was 8 weeks long conducted in 1-week sessions. Patients were assessed at baseline, after the intervention, and at 1 year post intervention.

Setting: Two community mental health centers in Denmark.

Study Design: randomized, non-blinded intervention study

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: Of the pool of patients identified from the case registry, a large portion of them did not respond to the invitation to participate (39%) or declined to participate (27%). There was a statistically significant difference between the participants in the intervention and the control group: a diagnosis of self-destructive behavior (suicide attempt or self-mutilation) was more common among the participants than those who refused or did not respond. There were non-significant trends that the participants had shorter duration of illness, that fewer had a previous substance abuse diagnosis and that fewer had experienced a previous compulsory admission. These differences may have affected the some of the findings in the study.

Performance bias: Moderate Risk: It is not clear whether the intervention was being delivered by clinicians who were also involved in the treatment of the control patients, which could result in unrecognized modifications in the approach to usual treatment.

Attrition bias: Moderate Risk: Five patients (10.9%) and two relatives (5.7%) took part in fewer than 50% of the educational sessions. In comparison with the completers, these patients were younger and

patient and relative dropouts had a higher initial total satisfaction with services. Eight patients (17.4%; four intervention and four control patients) were partly lost to follow-up of compliance or relapse data, as they were referred to private practitioners for further treatment (n = 5) or moved to another county (n = 2). One patient in the control group committed suicide during the follow-up period.

Detection bias: Moderate Risk: Several scales were used that had varying levels of reliability and validity reported. However, outcome assessors were blind to treatment allocation.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low risk: The study was in part funded by Lundbeck A/S, Denmark. There is no indication of sponsor-related bias.

Applicability: This study was only concerned with a single diagnosis, schizophrenia, and so may not apply to a general psychiatric population. Also, it was conducted at community mental health clinics in Denmark, which may differ from the models of care available in the U.S. These factors limit applicability, but overall the study does address the clinical question, because it assesses patient adherence after an attempt to introduce psychoeducation (for both patients and their relatives).

Citation: Mundt et al. Effectiveness of antidepressant pharmacotherapy: The impact of medication compliance and patient education. Depression And Anxiety 13 (1): 1-10, 2001

Population: 246 depressed patients, diagnosed and treated at one of three outpatient clinics affiliated with the Kaiser-Permanente Northwest Region (KPNW) healthcare system. Inclusion criteria required 1) DSM-IV diagnosis for current major depression, 2) minimum symptom duration of at least 1 month, 3) prescription of an antidepressant medication during the current office visit, and 4) a Hamilton Depression Rating Scale (HDRS) score of 18 or greater. Patients were excluded from participation if they 1) were under 18 years old, 2) were planning to move away from the area or change HMOs within 1 year, 3) had received psychotherapy or pharmacotherapy for depression during the 6 months prior to study referral, or 4) did not have access to a touch-tone telephone at their residence.

Intervention: This study was designed to investigate the impact of a time-phased patient education program (RHYTHMS™, developed by Pfizer) on medication compliance and treatment outcomes of primary care patients diagnosed with major depression and started on antidepressant pharmacotherapy. Subjects were randomly assigned to either receive or not receive (usual care) the educational materials by mail.

Comparators: Subjects who received the educational materials were compared to those who did not.

Outcomes: Depression severity and functional impairment affecting patients' quality of life were assessed at baseline and 4, 12, and 30 weeks later. Self-reported impressions of improvement and patient satisfaction with treatment were also assessed at follow-up. Clinical assessment data were obtained using an interactive voice response (IVR) system. Upon study completion, prescription fill data of the subjects were extracted from the KPNW Pharmacy System for analysis of medication compliance. Most of the study subjects (63.5%) responded to the pharmacotherapy treatment by study end-point. Few statistically significant differences in either treatment outcomes or duration of medication compliance were found between the treatment groups, and significant differences found were of fairly small magnitude. Patients not receiving the educational materials initially exhibited a more positive response to treatment (Week 4), but this difference did not persist at later follow-ups and was associated with significantly higher relapse rates. A strong time-dose relationship was evident between the duration of the initial treatment episode and treatment outcomes at follow-up, but randomized

treatment assignment did not influence the duration of initial medication compliance.

Timing: Patients received educational materials in the mail and were periodically assessed by phone after that, for up to 30 weeks of follow up. The study was conducted from May 1997 to August 1998.

Setting: 3 outpatient clinics affiliated with the Kaiser-Permanente Northwest Region (KPNW) healthcare system, in Portland, Oregon

Study Design: Randomized, non-blinded intervention study

Overall risk of study bias: Moderate to High Risk

Selection bias: Low Risk: 94.8% of the patients asked to be part of the study agreed to take part, and they were randomized into the two groups. There is no indication that selection of patients introduced bias in the results of the study. The exclusion criteria of not having access to a touch tone telephone at home may introduce bias into sample selection by systematically excluding certain patients (e.g., low socioeconomic status, greater symptom severity and lower functional ability).

Performance bias: Low Risk: There is no evidence of systematic differences in treatment of the study groups. Since the intervention group received the educational materials by mail, it is unlikely that either group received systematically different treatment or cointerventions (e.g., different forms of treatment, varying levels of time or attention, etc.).

Attrition bias: Moderate Risk: The overall compliance rate for completing the follow-up assessments was 83.2% (614 completed follow-up calls to the IVR system of 738 possible). The compliance rate of patients receiving the RHYTHMS™ materials was slightly higher (85.2%) than of those receiving usual care (81.2%). Those who completed the study may have been more likely to be medication compliant, and this may have introduced bias into the results.

Detection bias: Low Risk: Compliance data was confirmed by obtaining prescription fill data from the Kaiser Permanente pharmacy system, thus outcome assessment was blind to group assignment. Data was obtained using an interactive voice response system on the phone.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: High Risk: This study was sponsored by Pfizer, which also developed the psychoeducational materials. These materials and sponsorship may have influenced patients' reported compliance with treatment.

Applicability: This study is applicable to the clinical question because patients who received educational materials were compared to those who did not, specifically in the area of compliance with treatment. However, the materials were developed by a pharmaceutical company and may be dissimilar to education provided by a physician or other mental health professional. Also, the study includes only patients with depression in a community outpatient setting, which limits applicability to other diagnoses and settings.

Citation: Myers, et al. Out-patient compliance with antidepressant medication. The British Journal Of Psychiatry: The Journal Of Mental Science 160 83-86, 1992

Population: The sample comprised 89 consecutive patients attending a psychiatric outpatient clinic and fulfilling the following criteria: a diagnosis of primary or secondary depression according to the criteria of Feighner *et al* (1972), a score of at least 11 on the Hamilton Rating Scale for Depression, no clinical evidence of dementia, at least average intelligence as judged by clinical interview, no retardation, and judged to be non-suicidal.

Intervention: Patients were randomly allocated to each of the three groups, the number allocated to group C being double that of A and B. Group A: One dose of amitriptyline 75mg or mianserin 30mg to be taken at night. Group B: Three doses of amitriptyline 25mg or mianserin 10mg to be taken during the day. Group C: Either A or B above as chosen by the patient. Those who chose A were designated Group Cn and those who chose B were designated Group Cd. Mianserin was prescribed rather than amitriptyline if there was considered to be any risk of overdose, albeit without suicidal intent.

Comparators: The groups were compared to one another in terms of compliance

Outcomes: No overall significant difference was found between doctor-prescribed and patient-chosen regimen, or between once-a-day and three-times-a-day dosage. However, compliance was significantly better in those patients who were allowed to choose, when they selected the three-times-a-day regimen. There was a significant decline in compliance for all regimens over the 12 weeks. There was no evidence that better compliance produced a better therapeutic result.

Timing: 12 week duration

Setting: a psychiatric outpatient clinic in the UK

Study Design: randomized clinical trail

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: Patients were selected consecutively, rather than randomly, so it is possible that included patients are not a representative sample. To be included, patients were non-suicidal, so it is possible that more severe patients were systematically excluded. Patients were also selected for the study based on a diagnosis of depression according to Feighner et al (1972) which may introduce a systematic difference from the diagnosis included in the clinical question.

Performance bias: Low Risk: There is no evidence of systematic differences in the treatment of the study groups or of protocol deviation.

Attrition bias: Moderate Risk: An intention-to-treat analysis was used, but patients who dropped out are likely to have been less compliant than those who remained in the study.

Detection bias: Moderate Risk: Compliance was measured by a series of three questions to the patient and also a pill count. However, since patients are likely to overestimate their compliance, and pill count can be altered by the patient, there is a moderate risk of detection bias.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Unknown. There is no information about sponsorship given in the study.

Applicability: This study is applicable to the clinical question because it measures the compliance of subjects who had their choice about dosing frequency vs. those who did not. However, the choice offered to the subjects was just about dosing frequency, and not about their treatment choices in general, such as which medication they would prefer, or if they would prefer medication at all. This limits the applicability overall to the clinical question. Also, the study includes only patients with a diagnosis of depression receiving treatment in an outpatient setting in the UK, which may limit applicability to patients with other diagnoses in other treatment settings in the U.S.

Citation: Robinson GL, et al. The Effects of a Psychiatric Patient Education to Medication Program on Post-Discharge Compliance. The Psychiatric Quarterly 58 (2): 113-118, 1986

Population: The subjects consisted of 150 hospitalized patients housed on four acute-care receiving

wards and ready for discharge. All of the subjects in the study were voluntary participants who were paid a nominal amount (75¢) for completing the questionnaires required for study inclusion.

Intervention: Patients were randomly assigned to one of three groups: (1) usual care, (2) receiving a 1-2 page hand-out about medications, or (3) receiving the handout plus a verbal review of the information. Subjects were assessed at discharge and at 1st follow-up appointment post discharge.

Comparators: The comparators were patients who received usual care, which included a variable amount of medication-related education but did not include receipt of the hand-out or specialized verbal reinforcement.

Outcomes: Subjects who received the hand-out, with or without verbal explanation, showed improvement in understanding of treatment. Subjects who received written information with verbal reinforcement, but not those who only received the handout, were significantly more compliant than the control subjects. There was no significant difference between groups on pre-test scores.

Timing: Subjects were assessed at discharge and at their first follow-up appointment at one of four community mental health centers. The mean duration between discharge and the first appointment was 14 days.

Setting: The study was conducted at Fallsview Psychiatric Hospital in Akron, Ohio. Fallsview is a 131 bed state receiving hospital which services a seven county catchment area. The study was completed in 1986.

Study Design: Randomized, single-blind, interventional study

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: patients were randomized into treatment arms, and it appears from the study that all patients at this large state hospital who were ready for discharge were invited to be part of the study. Also, the authors note that there were no differences between the study groups at pre-test.

Performance bias: Moderate Risk: The authors note a potential contamination of the control group with elements of the intervention (i.e., some psychoeducation). However, only the intervention group received the specialized hand-out and verbal reinforcement.

Attrition bias: Moderate Risk: The authors note that the drop out rate did not appear to differ significantly between groups, but patients who dropped out of the study may have been more likely to be non-compliant with treatment, biasing the results in favor of greater apparent compliance. There was no systematic follow-up with the subjects who dropped out.

Detection bias: High Risk: Compliance was measured by a 5-question Likert scale ranging from “Never” to “Always” to the question of whether subjects had been compliant with their medications from the hospital. There was no mention of assessing inter-rater reliability, and despite some information being provided to the clinicians (such as a patient questionnaire), the compliance ratings are still impressionistic and based on patients’ self-report, which may not be reliable.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Unknown: There is no mention of sponsorship or funding in the article.

Applicability: This study did answer the clinical question by showing that patients who received more education about risks and benefits of treatment, and specific information about medications, had a higher rate of compliance. The study only concerned hospitalized patients and only evaluated

compliance at the first post-discharge visit, and so the range of applicability of the study is somewhat limited. Also, the age of the study (1986) may limit applicability to current treatment.

Citation: Sterling RC, et al. Patient Treatment Choice and Compliance. The American Journal on Addictions, 6: 168-176, 1997

Population: 127 patients seeking treatment for cocaine dependence. All of these individuals were being enrolled in treatment at this facility for the first time and met DSM-III-R criteria for cocaine dependence at the time of admission.

Intervention: Subjects received either 12 weeks of weekly individual therapy (IND), or an intensive 3-hour, 3 times per week treatment program (INT). Half the subjects were given their choice of treatment, and the other half were randomized into one or the other.

Comparators: Patients who had their choice of treatment modality were compared to those who did not have a choice. Because there was no significant pattern of differences between patients receiving IND vs. INT, the authors only compared choice vs. no-choice rather than comparing IND vs. INT.

Outcomes: Patients who chose IND differed from those who chose INT only in 2 of 41 comparisons: number of previous treatment experiences and ASI Alcohol composite score. Allowing patients to choose their course of treatment did not significantly enhance retention, the proportion of appointments kept, or completion of the 12 week intervention.

Timing: 12 weeks of treatment, with a 9-month follow-up. The study was conducted in 1997.

Setting: a university-sponsored, publicly funded, community-based, outpatient cocaine treatment program located in a central-city area

Study Design: Randomized, non-blind, interventional study

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: Subjects who chose IND vs. INT differed on 2 of 41 comparisons: number of previous treatment experiences and ASI Alcohol composite score. Authors note that the two differences may simply represent chance occurrences. Subjects who did not choose their treatment modality were different on 3 comparisons – all likely due to chance. Patients were randomized into choice vs. no-choice arms, and patients in the no-choice arm were randomized to treatment modality. However, some patients refused to be randomized, mostly because they preferred intensive treatment (INT). This may have influenced the results of the study.

Performance bias: High Risk: The no-choice condition group was part of a different clinical trial in which participants were randomized to either IND or INT. The choice condition group was treated immediately after this different clinical trial concluded. It is possible that there were systematic differences in the treatment administered to the groups due to experience, attitudinal changes or other therapist related factors.

Attrition bias: Moderate Risk: The proportion of patients located for the 9-month follow-up interviews did not differ significantly between the choice and no-choice groups (60% and 76%, respectively), but an administrative lapse (per authors) led to follow-up not being sought for the final 11 cases in the randomly assigned (no-choice) condition. This may have affected results, but the effects of this are unclear.

Detection bias: High Risk: Several of the outcome measures were obtained through patient interview, such as addiction severity, AIDS risk-behavior, days of cocaine use, etc. Patient may under (or over)

report this data, leading to detection bias.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Low Risk: This research was supported in part by a grant from the National Institute on Drug Abuse (NIDA) and performed under the auspices of the Commonwealth Office of Drug and Alcohol Programs (ODAP) and the Philadelphia Department of Public Health, Coordinating Office for Drug and Alcohol Abuse Program (CODAAP).

Applicability: The study is applicable to the clinical question in that it assessed the effect of offering treatment choice on retention in treatment, which is a form of adherence. The study only concerns patients seeking substance abuse treatment, so the scope of the study is fairly narrow and does not apply to all psychiatric patients.

Citation: Vandereycken W and Vansteenkiste M. Let Eating Disorder Patients Decide: Providing Choice May Reduce Early Drop-out from Inpatient Treatment. Eur Eat Disord Rev 17 (3):177-83, 2009

Population: Inpatients on a specialized eating disorders unit. There were 87 patients in the intervention arm and 87 controls.

Intervention: 87 patients who underwent a new admission strategy that emphasized patent choice were compared to 87 controls who were admitted prior to the implementation of the new strategy. The old strategy involved patients starting in an observation group for 1-2 weeks. Staff made decisions about treatment and attempted to motivate the patient to accept the treatment provision. The new strategy involved all patients starting with an admission interview, followed by a tour of the unit and an explanation of the program. The patient came for a 5-day introductory week, and then made a decision about whether to continue with treatment. No attempts were made to change the patient's mind if she opted to refuse further care.

Comparators: 87 prior admissions before the new admission strategy was adopted in 2001

Outcomes: The results indicate that the provision of choice at the beginning of treatment significantly reduced drop-out during the first weeks of inpatient treatment. No differences were found between strategies on later drop-out and weight change (in anorexia nervosa patients) during inpatient treatment.

Timing: Data was gathered from 2002-2004. The admission strategy involved a 5-day introductory period prior to entering treatment.

Setting: A 35-bed specialized female-only inpatient treatment unit for eating disorder patients.

Study Design: Quasi-experimental design which compared patients before and after a new treatment strategy was introduced. The study is a retrospective chart review.

Overall risk of study bias: Moderate Risk

Selection bias: Low Risk: There is no discussion of consenting patients to the study as the study was a chart review only. There were no exclusion criteria per se, and it seems as if the authors chose all patients (in the intervention arm) during a particular period, and then matched them with controls.

Performance bias: High Risk: There is no evidence of systematic differences in the treatment of the groups before and after implementation of the new strategy; however, unreported factors, such as staff enthusiasm for the new approach may have been present and the study design would not eliminate such confounding effects.

Attrition bias: Low Risk: This is not applicable because patients were not followed over time, but rather this was a retrospective chart review.

Detection bias: Low Risk: The two outcome variables were drop out rates and weight change. It does not appear that either variable would be subject to detection bias.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Unknown: There was no mention of sponsorship in the article.

Applicability: The study is applicable to the clinical question because it studies drop out rates (adherence) in patients who were given more vs. less choice in their treatment. However, this study is concerned with a narrow range of patients (all female, all with eating disorders, all inpatient, etc.) which limits its applicability to psychiatric patients in general. Also, the study was conducted in Belgium, and so the effects of additional choice on this population may be different for an American patient population.

Citation: Vreeland B, et al. Efficacy of the Team Solutions Program for Educating Patients About Illness Management and Treatment. Psychiatric Services (Washington, D.C.) 57 (6): 822-828, 2006

Population: 71 outpatients with schizophrenia or schizoaffective disorder from day treatment settings

Intervention: Patients were randomized to a 24-week comprehensive, modularized, psychoeducational intervention focused on illness management called Team Solutions, or to standard care. The intervention involved attending a Team Solutions meeting twice a day, two days a week, for 24 weeks. Each meeting lasted one hour.

Comparators: Patients randomized to standard care were the comparators

Outcomes: Attendance at the meetings varied from 20 to 94 percent, with a mean of 73 percent. Significant improvement was observed in knowledge about schizophrenia and client satisfaction in the intervention group. No changes were observed in symptoms, treatment adherence, or global functioning.

Timing: 24-week intervention. Data collected from September 2002 to September 2003

Setting: The University of Medicine and Dentistry of New Jersey-University Behavioral HealthCare (a statewide mental health care delivery system at the university)

Study Design: Single-blind, randomized controlled trial

Overall risk of study bias: Moderate Risk

Selection bias: Moderate Risk: Exclusion criteria included dementia, mental retardation or intellectual impairment, suicidality, and exposure to more than one Team Solutions workbook. All subjects had to have attended the partial hospitalization program for at least 2 days. Since subjects had to provide consent and be willing to participate in a rigorous 24-week intervention, the participants may not have represented all patients with schizophrenia or schizoaffective disorder.

Performance bias: Moderate Risk: This study was not blinded to the subjects, and so responses may have been affected by knowledge of which treatment arm the subject was in (e.g. knowing that a subject participated in the psychoeducational group, that subject may report that they have more knowledge about schizophrenia). The authors note that the day treatment programs from which participants were recruited included some psychoeducational services, which may have introduced bias from contamination of the control group with exposure to the intervention.

Attrition bias: Moderate Risk: Data were analyzed with a linear random coefficient regression model for

repeated measures, which is "in line with an intention-to-treat analysis." However, there was no discussion of number of drop outs from the study, and it would seem that there would be drop outs because of the length of the intervention (24 weeks). Those who dropped out may have been less likely to score well on tests assessing knowledge of schizophrenia.

Detection bias: Low Risk: Authors report that the questionnaires used in the study have good reliability overall.

Reporting bias: Low Risk: There was no evidence of selective outcome reporting.

Sponsor-related bias: Moderate Risk: The project was funded in part by Eli Lily and Company, which could have introduced bias into the study design or results.

Applicability: This study has overall applicability to the clinical question, though it only focused on patients with a particular set of diagnoses.

Grading of Supporting Body of Research Evidence

Risk of bias: Studies varied in risk of bias from Low to High. However, overall, most studies had Moderate risk. The body of research evidence is made up of many RCTs and several observational studies. However, pooling of data for each outcome is difficult due to study heterogeneity.

Consistency: Inconsistent. The interventions in the studies varied widely, as did the outcome measures and the results of the studies. Some studies found that involvement of the patient in treatment decision-making improved adherence to treatment, but others did not. Some found that patient choice improved clinical outcomes, while others did not. Generally, when patients were educated about their illness or treatment, measurements showed that their knowledge increased. Typically, patient satisfaction improved when there was more contact with the treatment teams but this was not necessarily the case when information was conveyed by printed materials only.

Directness: Indirect. Many studies directly measured adherence and patient satisfaction after an intervention in which patients were educated or included in a decision-making intervention. However, since the interventions were highly varied, and the populations studied were often very different and covered specific diagnoses, the studies overall are indirect when it comes to answering the clinical question.

Precision: Imprecise. The studies have variable outcomes, and the outcome measures evaluated (treatment adherence, attitudes toward treatment, satisfaction with treatment, therapeutic alliance, etc.) are subjective, qualitative, and difficult to measure.

Dose-response relationship: Not applicable. It did appear overall that interventions which involved the patient in treatment improved adherence and satisfaction, but because the interventions were highly varied, and because none of the studies evaluated various "doses" or quantities of interventions, this could not be evaluated.

Magnitude of effect: Weak. Generally, it appears that there is only a modest effect on adherence and therapeutic alliance when decision-making interventions are implemented. This may be because "standard care," which is the comparator to these interventions, is not at all uniform. "Standard care" generally also involves treatment discussions and involvement of the patient in care decisions.

Confounding factors (including likely direction of effect): Since researchers, study participants, and subjects all knew they were involved in studies assessing patient adherence and alliance based on an intervention of some kind vs. standard care, many sources of bias and confounding factors may have

influenced results. For example, clinicians performing "standard care" in these studies may have been more diligent about involving patients in decision-making because these patients were being monitored. It is not always clear whether the same clinicians were providing the intervention and the standard care conditions, which could also have led to shifts in the actual delivered intervention or the way in which standard care was done.

Publication bias: Not able to be assessed.

Applicability: Some studies were not very applicable to the clinical question either because the outcome measures were not exactly related to the clinical question, or because the patient population and treatment setting being studied were too narrow. However, several studies did appear to answer the question

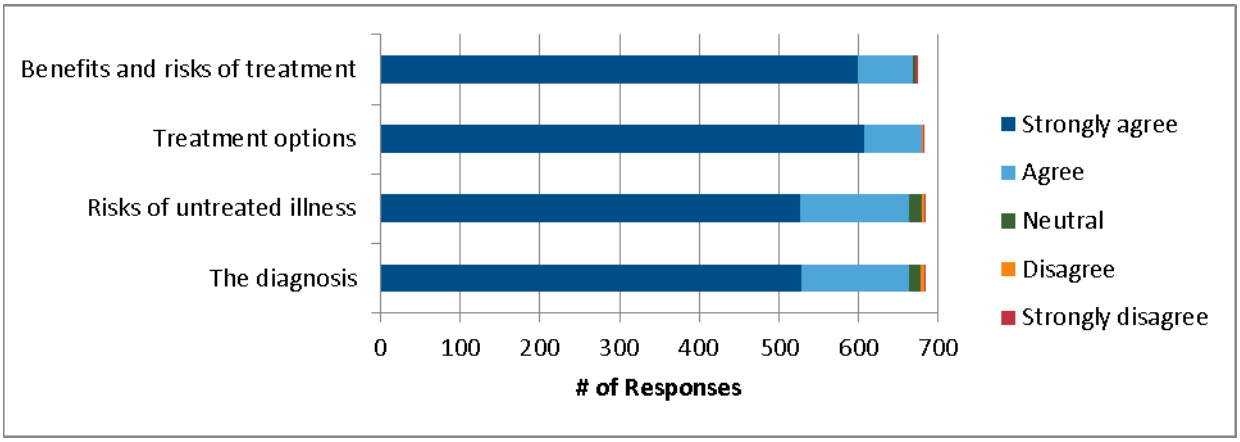
Overall strength of research evidence: Low

Differences of Opinion in Rating the Strength of Recommendations

None

Expert Opinion Survey Results

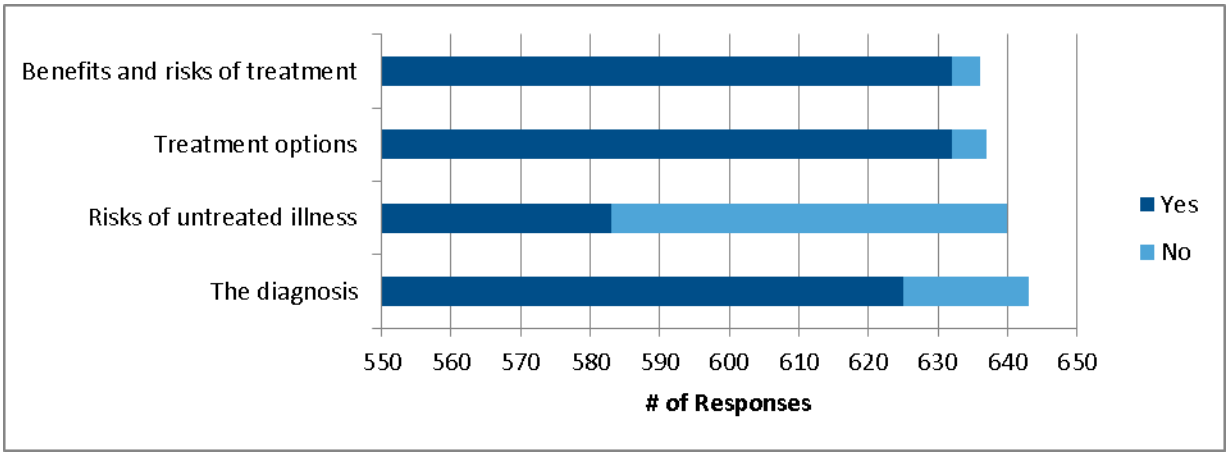
To what extent do you agree that the therapeutic alliance and treatment adherence are improved by explaining the following to patients who have the capacity for decision-making?



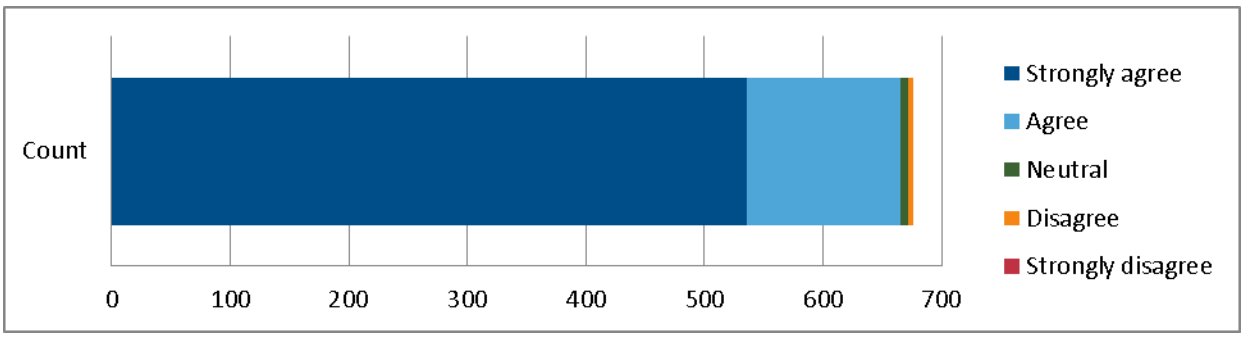
Percentage of experts who "strongly agreed" or "agreed" that therapeutic alliance and treatment adherence are improved by explaining the following to patients who have the capacity for decision-making:

Benefits and risks of treatment	99.3%
Treatment options	99.4%
Risks of untreated illness	97.1%
The diagnosis	96.9%

Do you typically (i.e., almost always) explain these items to your patients who have the capacity for decision-making?



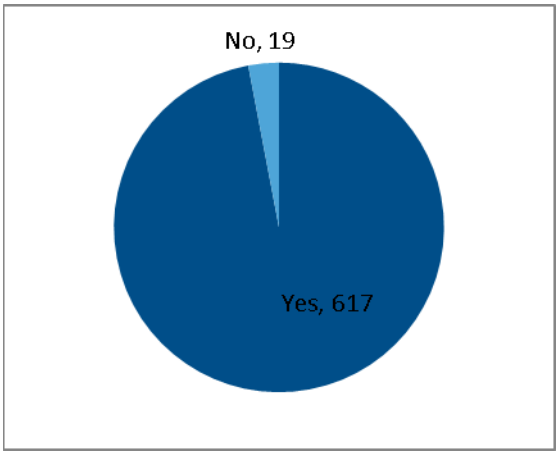
For patients with the capacity for decision-making, to what extent do you agree that the therapeutic alliance and treatment adherence are improved by asking about treatment-related preferences?



Percentage of experts who “strongly agreed” or “agreed” that for patients with the capacity for decision-making, the therapeutic alliance and treatment adherence are improved by asking about treatment-related preferences:

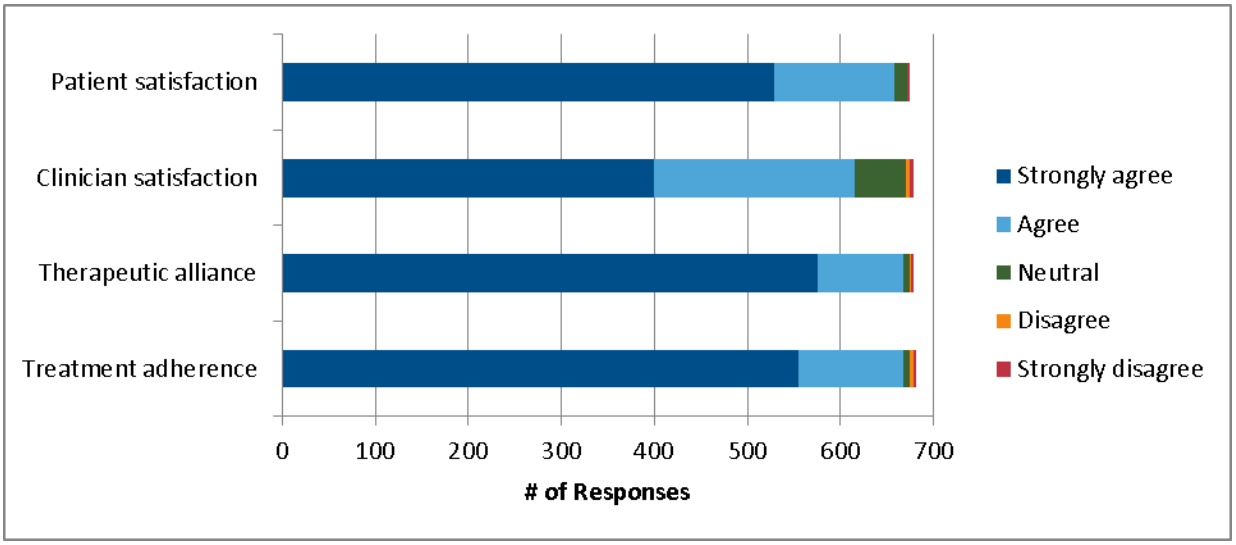
98.4%

Do you typically (i.e., almost always) ask your patients who have the capacity for decision-making about their preferences regarding available treatment options?



To what extent do you agree that the following are improved by "shared decision-making"?

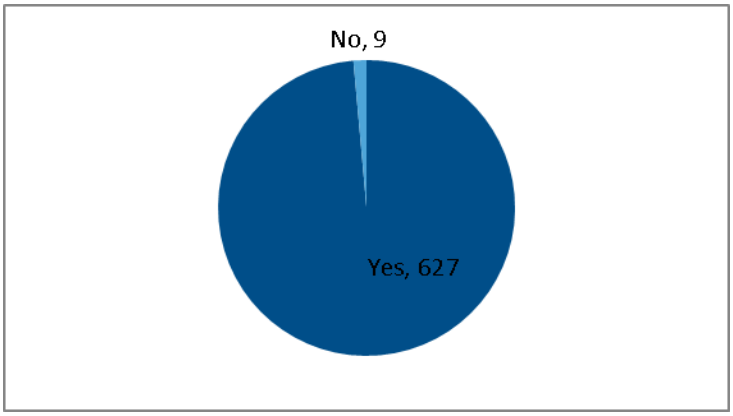
Shared decision-making is defined as collaboration between clinicians and patients about decisions pertinent to treatment, when the patient has capacity for decision-making.



Percentage of experts who “strongly agreed” or “agreed” that the following are improved by "shared decision-making":

Patient satisfaction	97.5%
Clinician satisfaction	90.9%
Therapeutic alliance	98.4%
Treatment adherence	97.9%

Do you typically (i.e., almost always) collaborate with your patients in decision-making regarding treatment?


No, 9
Yes, 627

Guideline 9. Documentation of the Psychiatric Evaluation

Clinical Question

Development of these guidelines was premised on the following clinical question:

For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan improved when the clinician typically (i.e., almost always) documents the following in the patient's medical record? Is coordination of psychiatric treatment with other clinicians improved?

Rationale for clinical tests (e.g., laboratory studies, imaging, ECG, EEG) as part of the initial evaluation

Rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice

Review of Supporting Research Evidence

Overview of Studies

There is no supporting research evidence that specifically addresses the above clinical questions.

Grading of Quality of Individual Studies

Not applicable

Grading of Supporting Body of Research Evidence

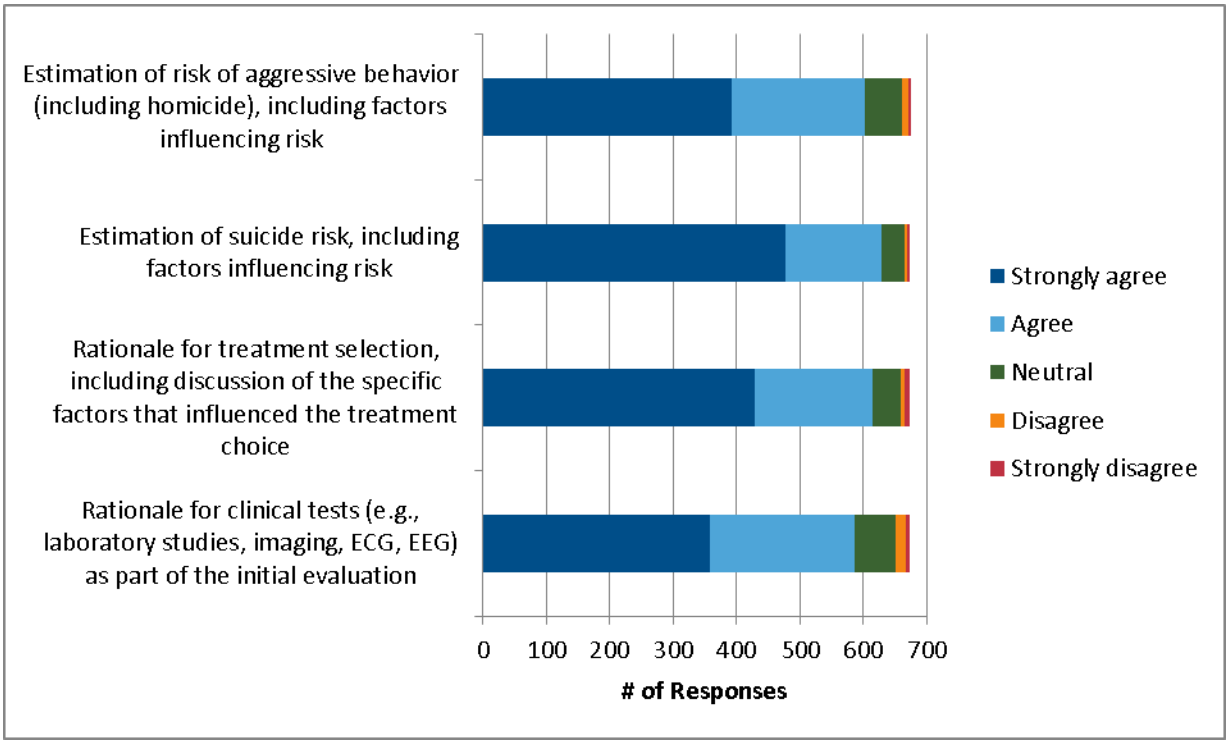
Not applicable

Differences of Opinion in Rating the Strength of Recommendations

One member of the work group was uncertain that potential benefits of documenting the rationale for treatment selection clearly outweigh harms. This difference of opinion is considered minor.

Expert Opinion Survey Results

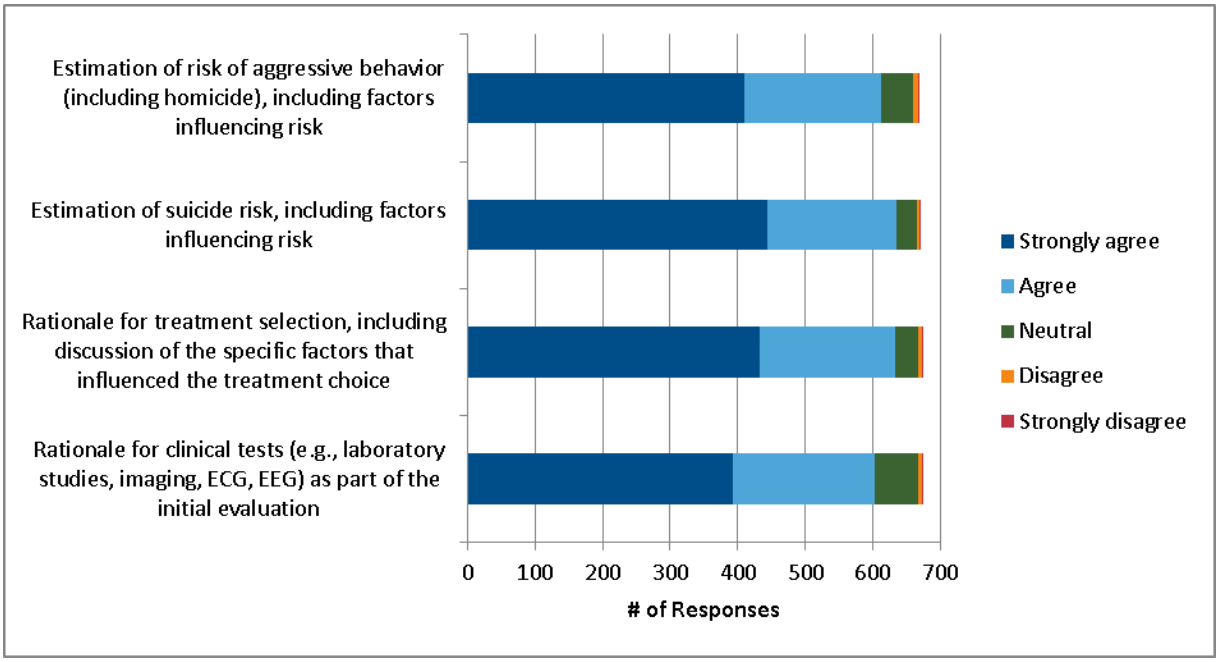
To what extent do you agree that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents the following in the patient's medical record?



Percentage of experts who "strongly agreed" or "agreed" that an individual clinician's decision-making about a patient's psychiatric diagnosis and treatment plan is improved when the clinician typically (i.e., almost always) documents the following in the patient's medical record:

Estimation of risk of aggressive behavior (including homicide), including factors influencing risk	89.3%
Estimation of suicide risk, including factors influencing risk	93.2%
Rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice	91.4%
Rationale for clinical tests (e.g., laboratory studies, imaging, ECG, EEG) as part of the initial evaluation	86.9%

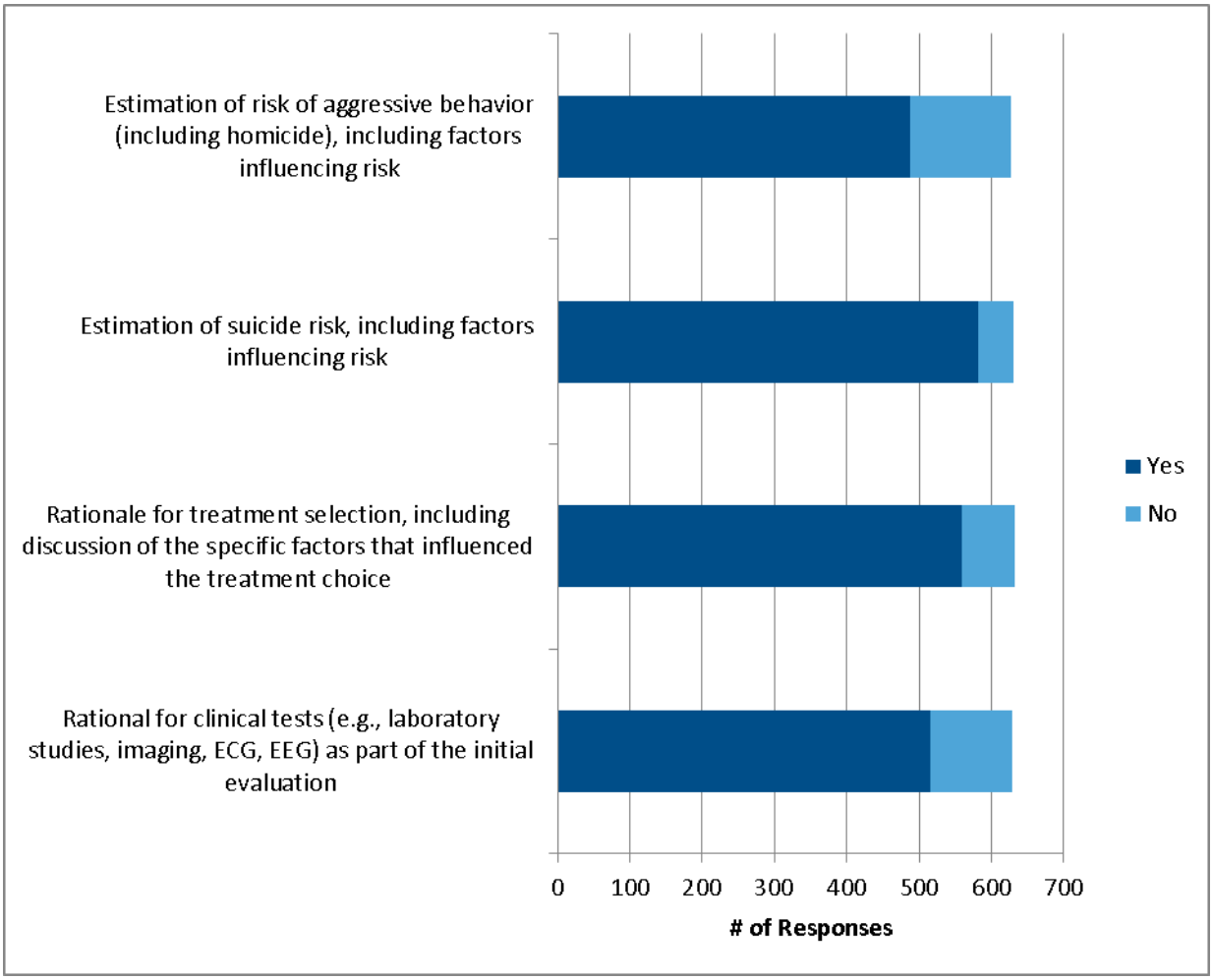
To what extent do you agree that coordination of psychiatric treatment with other clinicians is improved when these same items are typically (i.e., almost always) documented?



Percentage of experts who "strongly agreed" or "agreed" that coordination of psychiatric treatment with other clinicians is improved when these same items are typically (i.e., almost always) documented:

Estimation of risk of aggressive behavior (including homicide), including factors influencing risk	91.3%
Estimation of suicide risk, including factors influencing risk	94.5%
Rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice	93.8%
Rationale for clinical tests (e.g., laboratory studies, imaging, ECG, EEG) as part of the initial evaluation	89.5%

Do you typically (i.e., almost always) document these items in the medical record of your patients?


Estimation of risk of aggressive behavior (including homicide), including factors influencing risk
Estimation of suicide risk, including factors influencing risk
Rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice
Rational for clinical tests (e.g., laboratory studies, imaging, ECG, EEG) as part of the initial evaluation
Yes
No
0
100
200
300
400
500
600
700
# of Responses

III. Quality Measurement Considerations

Guideline 1. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History

These guidelines recommend that the initial psychiatric evaluation include a review of the patient's mood, level of anxiety, thought content and process, and perception and cognition (statement 1); trauma history (statement 2); and psychiatric treatment history (statement 3). As described under "Expert Opinion Survey Results," expert psychiatrists typically practice in very high accordance with these recommendations. The typical practices of other psychiatrists are unknown, but these assessments are understood to be standard components of an initial psychiatric evaluation. As a result, quality improvement activities including performance measures that are derived from these guidelines may not yield substantial improvements in quality of care that would justify increased clinician burden, e.g., documentation burden.

There are important practical barriers to deriving quality measures from statement 3 (assessment of psychiatric treatment history). For example, to assess a clinician's performance of a clinical process, a measure must clearly define the applicable patient group (i.e., the denominator) and the process that is measured (i.e., the numerator). Unlike an outcome measure, a process measure should not depend on the patient's response or report. Furthermore, the clinician's performance of the process must be readily ascertained from chart review or administrative data. For these reasons, it would be impractical to measure the process of assessing a patient's psychiatric treatment history. As described under "Implementation," patients may not know or be able to recall their previous diagnoses or past treatment trials, nor their level of adherence nor response to past treatments. Furthermore, information in medical records may be lacking or incomplete.

Although there may be little to gain in deriving measures from statements 1 and 2, practical barriers are less challenging and relate mainly to a lack of standardization in how findings about psychiatric signs, symptoms, and trauma history are documented. As described under "Implementation," there are many possible clinical approaches and questions that might be used to conduct these assessments, and oversimplification is a possible unintended consequence of measurement. One approach that may minimize this risk could be to measure for the presence or absence of text only in relevant fields of the medical record, e.g., fields for mood, level of anxiety, thought content and process, and perception and cognition. This approach would allow for maximum flexibility in how clinicians document findings of their assessments. Alternatively, a measure could consider the presence or absence of scoring from a relevant measurement tool. As described under "Implementation," the DSM-5 Level 1 Cross-Cutting Symptom Measure (APA 2013) addresses domains that overlap with the assessment items recommended in statement 1. Exceptions to the denominator of performance measures derived from these guidelines might include patients who are unable to participate in the evaluation due to current mental status. Other exceptions may also be appropriate.

Ideally, measures that aim to improve the assessment of specific health conditions should be paired with measures that aim to improve the use of effective treatments whenever the condition is identified. Recommendations about follow-up are out of scope for these guidelines. However, there may be opportunities to pair assessment measures derived from these guidelines with follow-up measures derived from other guidelines.

Guideline 2. Substance Use Assessment

These guidelines recommend that the initial psychiatric evaluation of a patient include assessment of the patient's alcohol use, misuse of prescribed or over-the-counter medications or supplements, and use of other substances (e.g., marijuana, cocaine, heroin, hallucinogens). As described under Expert Opinion Survey Results, expert psychiatrists typically practice in accordance with this recommendation. Among psychiatrists practicing in ambulatory settings, rates of tobacco use screening have been declining and rates of treatment for smoking cessation are low (Rogers and Sherman, 2014). The typical practices of other psychiatrists and mental health professionals are unknown, but they may conduct substance use assessments to varying degrees and through various methods in initial evaluations. This variability could indicate a need to strengthen clinician knowledge, improve training, and increase the time and attention that clinicians give to substance use assessment. Furthermore, there may be opportunities to improve quality in these areas for patients across healthcare settings, not just mental health.

As described under Implementation, the clinical approach and specific questions used to assess substance use may vary. For many patients, substance use may be adequately assessed with a series of straightforward questions or through the use of a standardized questionnaire or self-report scales. For other patients, an individualized approach may be needed. Quality improvement activities derived from these guidelines, including performance measures, should not oversimplify the process of assessing substance use. For example, quality improvement activities may aim to ensure that assessment has occurred and is documented in a patient's record but should avoid specifying use of a specific method of assessment, e.g., a specific scale. This approach is consistent with two existing measures endorsed by the National Quality Forum (NQF): NQF measure #028 assesses the percentage of adult patients who are screened every 2 years for tobacco use and who receive cessation counseling intervention if identified as a tobacco user (http://www.qualityforum.org/QPS/0028). NQF measure #110 assesses the percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use (http://www.qualityforum.org/QPS/0110).

While both of these NQF-endorsed measures are consistent with these guidelines, a more comprehensive measure could also be derived that assesses the percentage of patients seen in an initial psychiatric evaluation who are screened for the use of tobacco, alcohol, or other substances as well as for the misuse of prescribed or over-the-counter medications. Such a measure could be implemented by measuring for the presence or absence of text in fields labeled "tobacco use," "alcohol use," "other substance use," and "misuse of prescribed or over-the-counter medications." This approach would allow for maximum flexibility in how clinicians document findings of their assessments. Alternatively, a measure could consider the presence or absence of scoring from a relevant measurement tool. Exceptions to the denominator of the measure might include individuals who have already been diagnosed with a substance use disorder or patients who are unable to participate in the evaluation due to current mental status. Other exceptions might also be appropriate.

Ideally, measures that aim to improve the assessment of specific health conditions should be paired

with measures that aim to improve the use of effective treatments whenever the condition is identified. Recommendations about follow-up for patients who have a substance use disorder are out of scope for these guidelines. However, there may be opportunities to pair assessment measures derived from these guidelines with follow-up measures derived from other guidelines.

Guideline 3. Assessment of Suicide Risk

These guidelines recommend assessment of key factors associated with increased suicide risk in patients who are receiving an initial psychiatric evaluation. They also recommend documentation of an overall estimation of suicide risk, which is a matter of clinical judgment that is informed by all data collected about an individual patient during the evaluation. As described under "Expert Opinion Survey Results," expert psychiatrists typically practice in accordance with these recommendations. The typical practices of other psychiatrists and mental health professionals are unknown, but they may assess suicide risk to varying degrees and through various methods. Variability also seems common in how suicide risk is documented, e.g., some medical records provide a clear description of the clinician's judgment about a patient's level of risk, while other records only indicate "+SI" or "–SI." This variability could indicate a need to strengthen clinician knowledge about suicide risk factors, improve training about how to conduct a suicide risk assessment, and increase the time and attention that clinicians give to suicide risk assessment, including making an overall estimation of risk.

Quality improvement activities derived from these guidelines, including performance measures, must not oversimplify the process of assessing suicide risk factors and formulating an estimation about overall risk. These guidelines are not intended to represent a comprehensive set of questions relating to suicide risk assessment, nor are they intended to suggest that assessment can or should be reduced to a series of yes or no questions. As described under "Implementation," there are a variety of ways clinicians may obtain recommended information about risk factors. In addition, assessment may be compromised by practical barriers such as a patient's inability to communicate. Many risk factors are difficult to define and may even be impossible to quantify or assess in a standardized way. Clinical judgment must determine which factors merit emphasis in the assessment of an individual patient, and clinical judgment is necessary to synthesize information and observations about the individual patient into an estimation of overall risk.

For these reasons, it would be inappropriate for quality improvement purposes to implement these guidelines as a requirement that all of the recommended risk factors and an overall estimation of risk must be documented for all patients who receive an initial psychiatric evaluation. Furthermore, as described under "Implementation," no standardized scale for assessing risk has been shown to have clinically useful specificity, sensitivity, or predictive value. As a result, many clinicians appropriately use free text prose to describe a patient's suicide risk. Reviewing these free text records for measurement purposes would be impractical.

An approach that considers the above issues could be to measure for the presence or absence of a body of text under a field labeled "suicide risk estimation" in the patient's medical record, without addressing the content of the text. This approach would require that an estimation of suicide risk be formulated into words and documented, but it would not burden the clinician to assess and record risk in a specific, inflexible way. As documentation of suicide risk becomes increasingly standardized and natural language processing becomes increasingly sophisticated, a measure on the specific content of the analysis could be considered.

A liability of this approach is that it would have limited utility to address variability in how clinicians assess and document risk. This approach could also have unintended consequences: As described under "Potential Benefits and Harms," when the amount of time available for an evaluation is constrained, time used to focus on assessment of suicide risk could reduce time available to address other issues of importance to the patient. This possible unintended consequence could be addressed in testing of a fully specified measure.

An alternative approach could be to measure for clinician documentation of risk factors that are typically recorded in an electronic medical record in a standardized way, e.g., presence or absence of current suicidal ideas, prior hospitalization, substance use, and psychosocial stressors. Advantages of this approach include practicality and feasibility and the potential to address specific knowledge deficits, e.g., knowledge that prior hospitalization increases suicide risk. Clinicians might also find a measure that takes this approach to be less burdensome. The main disadvantage of this approach is that it could lead clinicians to focus on the measured factors rather than other, equally important or potentially more important factors that are not measured.

In clinical practice, because of the overlap in risk factors for suicide and aggression, risk is often assessed simultaneously, and an estimation of risk for either suicide or aggression or both is documented in the same paragraph or field in the medical record. As a result, a measure on suicide risk assessment might be paired, combined, or harmonized with a measure on aggression risk assessment.

Ideally, measures that aim to improve the assessment of specific health conditions should be paired with measures that aim to improve the use of effective treatments whenever the condition is identified. Recommendations about follow-up, and derived measures, are out of scope for these guidelines. However, there may be opportunities to pair assessment measures derived from these guidelines with follow-up measures derived from other guidelines.

Guideline 4. Assessment of Risk for Aggressive Behaviors

These guidelines recommend assessment of key factors associated with increased risk for aggressive behaviors in patients who are receiving an initial psychiatric evaluation. They suggest documentation of an overall estimation of risk, which is a matter of clinical judgment that is informed by all data collected about an individual patient during the evaluation.

As described under "Expert Opinion Survey: Results," expert psychiatrists typically practice in accordance with these recommendations. The typical practices of other psychiatrists and mental health professionals are unknown. Anecdotal observations suggest that they may assess risk to varying degrees and through various methods. Variability also seems common in how risk is documented. This variability could indicate a need to strengthen clinician knowledge about risk factors, improve training about how to conduct a risk assessment, and increase the time and attention that clinicians give to assessment, including making an overall estimation of risk.

Quality improvement activities derived from these guidelines, including performance measures, must not oversimplify the process of assessing risk factors for aggressive behaviors and formulating an estimation about overall risk. These guidelines are not intended to represent a comprehensive set of questions relating to risk assessment, nor are they intended to suggest that assessment can or should be reduced to a series of yes or no questions. As described under "Implementation," there are a variety of ways clinicians may obtain recommended information about risk factors. In addition, assessment may be compromised by practical barriers such as a patient's inability to communicate. Many risk factors are difficult to define and may even be impossible to quantify or assess in a standardized way. Clinical judgment must determine which factors merit emphasis in the assessment of an individual patient, and clinical judgment is necessary to synthesize information and observations about the individual patient into an estimation of overall risk.

For these reasons, it would be inappropriate for quality improvement purposes to implement these guidelines as a requirement that all of the recommended risk factors and an overall estimation of risk must be documented for all patients who receive an initial psychiatric evaluation. Furthermore, as described under "Implementation," no standardized instrument for assessing risk has been shown to have predictive validity. As a result, many clinicians appropriately use free text prose to describe a patient's risk. Reviewing these free text records for measurement purposes would be impractical.

An approach that considers the above issues could be to measure for the presence or absence of a body of text under a field labeled "Estimation of Risk for Aggressive Behaviors" in the patient's medical record, without addressing the content of the text. This approach would require that an estimation of risk be formulated into words and documented, but it would not burden the clinician to assess and record risk in a specific, inflexible way. As documentation of risk becomes increasingly standardized and natural language processing becomes increasingly sophisticated, a measure on the specific content of the analysis could be considered.

A liability of this approach is that it would have limited utility to address variability in how clinicians

assess and document risk. This approach could also have unintended consequences: As described under "Potential Benefits and Harms," when the amount of time available for an evaluation is constrained, time used to focus on assessment of risk of aggressive behaviors could reduce time available to address other issues of importance to the patient. This possible unintended consequence could be addressed in testing of a fully specified measure.

An alternative approach could be to measure for clinician documentation of risk factors that are typically recorded in an electronic medical record in a standardized way, e.g., prior emergency visits or psychiatric hospitalization, substance use, and psychosocial stressors. Advantages of this approach include practicality and feasibility and the potential to address specific knowledge deficits, e.g., knowledge that prior hospitalization increases risk. Clinicians might also find a measure that takes this approach to be less burdensome. The main disadvantage of this approach is that it could lead clinicians to focus on the measured factors rather than other, equally important or potentially more important factors that are not measured. In addition, this approach may not encourage clinicians to formulate an overall estimation of risk of aggressive behaviors, as information on these independent risk factors may be collected for other reasons, such as to assess suicide risk or to assess substance use.

In clinical practice, because of the overlap in risk factors for suicide and aggression, risk is often assessed simultaneously, and an estimation of risk for either suicide or aggression or both is documented in the same paragraph or field in the medical record. As a result, a measure on aggression risk assessment might be paired, combined, or harmonized with a measure on suicide risk assessment.

Ideally, measures that aim to improve the assessment of specific health conditions should be paired with measures that aim to improve the use of effective treatments whenever the condition is identified. Recommendations about follow-up, and derived measures, are out of scope for these guidelines. However, there may be opportunities to pair measures derived from these guidelines with follow-up measures derived from other guidelines.

Guideline 5. Assessment of Cultural Factors

These guidelines recommend that an initial psychiatric evaluation include assessment of a patient's language needs (statement 1) and cultural factors related to the patient's social environment (statement 2). Assessment of the patient's personal/cultural beliefs and cultural explanations of psychiatric illness is suggested (statement 3). As described under "Expert Opinion Survey Results," expert psychiatrists typically practice in accordance with these recommendations. The typical practices of other psychiatrists and mental health professionals are unknown. Anecdotal observations suggest that they may conduct language and cultural assessments to varying degrees and through various methods. This variability could indicate a need to strengthen clinician knowledge, improve training, and increase the time and attention that clinicians give to language and cultural assessment. Furthermore, there may be opportunities to improve quality in these areas for patients across healthcare settings, not just mental health.

As described under Implementation, for many patients, language needs can be easily determined. For others, assessment may include establishing both the need for an interpreter and the appropriateness of different interpreter options. Three aspects of language assessment are therefore suggested as the possible focus of quality measures derived from statement 1: assessing the patient's primary language, asking about interpreter preference, and using an interpreter when appropriate. With respect to assessing primary language, a measure endorsed by the National Quality Forum (NQF) is available that assesses the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded (NQF measure #1824, www.qualitymeasures.ahrq.gov/content.aspx?id=27294). A similar measure might assess percent of patient visits and admissions where interpreter preference is screened and recorded. With respect to using an interpreter, an NQF-endorsed measure is available that assesses the percent of limited English-proficient patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency (NQF #1821, http://www.qualitymeasures.ahrq.gov/content.aspx?id=27296).

Unlike language needs, personal and cultural factors, beliefs, and explanations of illness are highly variable and not well defined; there are a variety of appropriate ways clinicians may obtain recommended information; and there are a number of potential barriers to conducting the assessment. It would therefore be difficult to derive meaningful performance measures from either statement 2 or statement 3, and it would be inappropriate to hold clinicians accountable to such measures. However, quality of care might be improved through other activities derived from these statements such as educational activities.

Guideline 6. Assessment of Medical Health

These guidelines recommend that the initial psychiatric evaluation of a patient include assessment of whether or not the patient has an ongoing relationship with a primary health care professional (statement 1). Also recommended is assessment of specific aspects of the patient's medical health (statement 2) as well as all medications the patient is currently or recently taking and the side effects of those medications (statement 3). Although many health care professionals may participate in the evaluation of patients with mental illness, including psychologists, social workers, and nurse practitioners, statements 2 and 3 have greatest applicability to medically trained clinicians. As described under "Expert Opinion Survey Results," expert psychiatrists frequently practice in accordance with the recommendations of these guidelines. The typical practices of other psychiatrists are unknown, but anecdotal observations suggest possible variability. This variability could indicate a need to strengthen knowledge, improve training, and increase the time and attention that psychiatrists give to the assessment of patients' medical status in initial evaluations. Furthermore, there may be opportunities to improve quality in these areas for patients seen by physicians in other fields of medicine.

With respect to statement 1, assessment is straightforward, and the information collected is typically recorded in medical records in a standardized way, i.e., the name of the primary health care professional or primary care clinic. One approach to measurement could be to evaluate the number of patients who receive a psychiatric evaluation for whom the name of the patient's primary care health professional or primary care clinic is documented. Exceptions could include patients who report that they do not see a primary care professional, who cannot recall the name of the clinician or clinic, or who are unable to report this information because of current psychiatric symptoms. Because these exceptions occur frequently in many settings, the approach to implementation might involve measuring for the presence or absence of any text in a field labeled "primary health care professional" rather than for the presence or absence of a specific name. A paired measure could be developed to encourage, whenever "none" or "unknown" is documented, follow-up with such patients to establish a relationship with a primary health care professional. Statement 1 could also inform a more generic measure intended to promote coordination of care across all fields of medicine.

As described under "Implementation," there are many possible clinical approaches and questions that might be used to assess the aspects of medical health described in statement 2. For some patients, particularly those with no serious medical conditions, the recommended items could be assessed through a series of simple questions or through the use of a standardized form. For other patients, especially those with serious medical illnesses co-occurring with a psychiatric condition, a more thorough and individualized approach could be needed. For this reason, quality improvement activities derived from statement 2, including performance measures, should not oversimplify the process of assessment. One approach, for example, might be to measure whether or not the recommended aspects of the patient's medical health are assessed but not how they are assessed or how findings are documented. There are important practical challenges with this approach. For example, implementation would minimally require that a clinician's medical record capture yes or no whether each item was considered during the evaluation. Not all medical records may do this, and even if they do, information

may not captured in an easily retrievable format. Furthermore, findings may not typically be documented unless abnormal, and some abnormalities may not be documented if they are not important for the patient's diagnosis and treatment (e.g., tonsillectomy, nearsightedness). Finally, an important unintended consequence of this approach to measurement, particularly if implemented as a measure of the presence or absence of text within nine separate fields of the medical record, could be that clinicians use time and resources to document findings that are not relevant to a patient's care. Furthermore, such documentation would be distracting to readers of notes and impede clinical thought processes and decision-making.

There are also important practical challenges with respect to statement 3 that could make this recommendation unsuitable for implementation as a performance measure. The presence of a list of medications in the patient's medical record is in itself a poor indicator of how thoroughly a clinician has inquired about all medications including nonprescribed medications and how diligently the clinician has considered side effects and drug interactions of those medications in relation to differential diagnosis and treatment planning. However, it is worth noting that the recommendation is consistent with two measures endorsed by the National Quality Forum (NQF): Measure 0097, "Medication Reconciliation" (http://www.qualityforum.org/QPS/0097), and Measure 0553, "Care for Older Adults—Medication Review" (http://www.qualityforum.org/QPS/0553). NQF Measure 0097 considers the percentage of patients aged 18 years and older discharged from any inpatient facility and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. NQF Measure 0553 considers the percentage of adults 66 years and older who had a medication review in the past year and for whom the medical record includes a list of medications.

Statements 4 and 5 are not appropriate for quality measurement because the balance of benefits and harms of the suggested assessments is uncertain.

Ideally, measures that aim to improve the assessment of specific health conditions should be paired with measures that aim to improve the use of effective treatments whenever the condition is identified. Recommendations about follow-up, and derived measures, are out of scope for these guidelines. However, there may be opportunities to pair assessment measures derived from these guidelines with follow-up measures derived from other guidelines.

Guideline 7. Quantitative Assessment

These guidelines are not appropriate for quality measurement because the balance of benefits and harms of the suggested assessments is uncertain.

Guideline 8. Involvement of the Patient in Treatment Decision-Making

These guidelines recommend that the initial psychiatric evaluation of a patient who has capacity for decision-making and is seen include an explanation of the following: the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment (statement 1). Also recommended are that the evaluation include asking the patient about treatment-related preferences (statement 2) and collaborating with the patient about decisions pertinent to treatment (statement 3).

As described under "Expert Opinion Survey: Results," expert psychiatrists typically practice in very high accordance with these guidelines. The typical practices of other psychiatrists are unknown, but similar high accordance might be expected on the basis that shared decision-making is commonly understood to be a principle of ethical practice, as described under "Rationale." As a result, quality improvement activities including performance measures that are derived from these guidelines may not yield substantial improvements in quality of care that would justify increased clinician burden, e.g., documentation burden.

Measures on the use of shared decision-making have been endorsed by the National Quality Forum (NQF). For example, NQF Measure 0310 (http://www.qualityforum.org/QPS/0310) considers if the medical record of a patient with back pain includes documention that a discussion occurred between the physician and the patient, prior to surgery, of the following: (1) treatment choices, including alternatives to surgery, (2) risks and benefits, and (3) evidence of effectiveness.

Quality measures such as NQF Measure 0310 that aim to promote shared decision-making are consistent with the stated goal of these guidelines but have serious practical limitations. As described under "Implementation," the use of shared decision-making approaches within an initial psychiatric evaluation depends on the individual patient and the clinical context. A priori, the capacity of the patient to collaborate must be evaluated by the clinician. This judgment is by nature a nuanced process and is subject to change over time, e.g., as psychiatric symptoms emerge or subside. Even when a patient is judged to have capacity to collaborate, the level of collaboration that is possible may vary, e.g., depending on the patient's level of insight about his or her psychiatric illness and need for treatment. Collaboration may also vary according to the patient's preferences. For these reasons, shared decision-making is an inherently complex and individualized process, and it would be impractical to document in a standardized way when and to what degree shared decision-making occurs. A checkbox approach, for example, would be undesirable for the purposes of performance measurement because of possible clinician bias and gaming. Patient-reported data might augment clinician-reported data but could also introduce bias, and the process of collecting such data could have the unintended consequence of compromising the doctor-patient therapeutic relationship. A requirement that the medical record include specific text could lead to documentation burden and overuse of standardized language that does not accurately reflect what has occurred in practice. In summary, these approaches to implementing a performance measure could seriously compromise the utility of the measure to influence practice and improve quality of care. The practicality of implementing measures based on these guidelines may be improved, however, with future advancements in electronic medical records

and natural language processing.

Guideline 9. Documentation of the Psychiatric Evaluation

Statement 1 of these guidelines recommends that the initial psychiatric evaluation include documentation of the clinician's rationale for treatment selection, including a discussion of factors that influenced the treatment choice. As described under "Expert Opinion Survey: Results," expert psychiatrists typically practice in accordance with this recommendation. The typical practices of other psychiatrists are unknown, but there may be variability. This variability could indicate a need to strengthen knowledge, improve training, and increase the time and attention that psychiatrists give to this aspect of documentation. Furthermore, there may be opportunities to improve quality in this area for patients seen by physicians in other fields of medicine. However, quality improvement activities that are derived from this recommendation must not oversimplify the process of documentation. As described under "Implementation," the breadth and depth of documentation will depend upon the clinical circumstances and the complexity of decision-making. Clinicians must use judgment to determine what level of documentation is appropriate for an individual patient. A performance measure, for example, that assesses for the presence or absence of specific text in the medical record could lead to documentation burden and overuse of standardized language that does not accurately reflect what has occurred in practice. Because of this practical challenge and potential burden, a performance measure derived from this recommendation is not recommended. The practicality of implementing a measure may be improved, however, with future advancements in electronic medical records and natural language processing.

IV. Guideline Development Process

These guidelines were developed using a process intended to meet standards of the Institute of Medicine (2011). The process is fully described in the following document available on the APA website: http://www.psychiatry.org/File%20Library/Practice/APA-Guideline-Development-Process--updated-2011-.pdf. Key elements of the development process included the following:

V. Management of Potential Conflicts of Interest

Work group members were required to disclose all potential conflicts of interest before appointment, before and during guideline development, and on publication. As described under "Disclosures," no member of the work group reported any conflicts of interest with his or her work on these guidelines. The two members of the Systematic Review Group also reported no conflicts of interest.

VI. Work Group Composition

Because these guidelines addressed aspects of a psychiatric evaluation, the work group was composed of psychiatrists. However, some experts from other disciplines were included in the expert panel that was surveyed, as described under "Expert Opinion Data Collection." The work group was diverse and balanced with respect to their expertise as well as other characteristics such as geographical location and demographic background. Methodological expertise, i.e., with respect to appraisal of strength of research evidence, was provided by the Systematic Review Group. A patient advocate (Fitzpatrick) was involved as an advisor during question formulation and draft review.

VII. Expert Opinion Data Collection

An expert opinion survey was fielded to a panel of 1,738 experts in psychiatric evaluation and management. The response rate for the survey was 45.1% (N = 784); 8.4% of the responses were partial, meaning that at least one of the eight sections of the survey was completed. Members of the panel were peer-nominated in 2011 by current and past APA work group members, chairs of academic departments of psychiatry and directors of psychiatry residency programs in the United States and Canada, and the APA Assembly. Survey questions were adapted from clinical questions developed by an APA expert work group and reviewed by a multidisciplinary group of stakeholders. The survey included questions to address which types of assessments improve identification of patients at risk for suicide and whether the experts typically perform such assessments in practice.

Nominators were asked to identify two types of experts to serve on the panel: researchers and clinicians. Research experts were defined as individuals who are making substantial contributions, via research or scholarly writing, to the area of psychiatric evaluation and management. Clinical experts were defined as individuals who have substantial clinical experience in the psychiatric evaluation of adults or an expert clinician whom the nominator might consult about an adult patient with a complex presentation. The panel was composed of approximately 70% clinical experts, 20% research experts, and 10% experts in both categories. Most of the panel, 76.4%, was nominated once, 14.8% were nominated twice, and the remainder was nominated up to nine times. The majority of the panel was contacted via email to complete the survey online; 1.8% were contacted via mail and 0.6% were not contacted due to lack of email or mailing address or inability to distinguish the intended nominee because of common names.

The composition of the portion of the panel who responded to the survey corresponds closely with that of the entire panel, within 0-4% (i.e., in the number of times panel members were nominated and whether they were identified as clinical or research experts or both).

For each guideline, quantitative data from the survey are shown under Review of Available Evidence. The survey also collected many free text comments, which were reviewed during development of the draft guidelines. Key themes from qualitative data have been incorporated into the implementation section of the guideline.

VIII. Systematic Review Methodology

These guidelines are based upon a systematic search of available research evidence.

Systematic searches were conducted of the MEDLINE (PubMed), PsycINFO (EBSCOHost), and Cochrane (Wiley) databases. The search terms and limits used are available on request from APA.

Search strategies were constructed that included a full range of topics related to psychiatric evaluation given the expected overlap in the retrieved literature for specific guideline questions. An initial search of MEDLINE was conducted in October 2010. This search yielded 250,981 articles. A second set of searches was conducted in October 2011. These searches yielded 32,895 articles in MEDLINE, 7,052 articles in PsycINFO, and 5,986 articles in the Cochrane database. All searches were done for the years from 1900 to the time of the search.

One individual (R.R.) screened 95,166 references from the 2010 search, spanning the years from 2005 to 2010. A second individual (L.F.) screened the 32,895 references from the 2011 search after duplicate articles from the different searches were eliminated. Included articles were a clinical trial (including a controlled or randomized trial), observational study, meta-analysis, or systematic review and were clinically relevant to psychiatric evaluation, i.e., relevant to any possible clinical question that might be addressed by potential APA practice guidelines. Excluded references included articles on nosology of psychiatric disorders, risk factors or associated features of specific disorders, potential etiologies of specific disorders, and course and prognosis of specific disorders.

A total of 5,073 articles met the broad inclusion criteria. These articles were screened by R.R. and L.F. for relevance to the clinical questions formulated for these guidelines and described under "Review of Supporting Research Evidence: Clinical Questions." The total number of studies that were agreed to have relevance to the PICOTS question for each guideline topic is as follows: 0 studies for Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History; 4 studies for Substance Use Assessment; 1 study for Assessment of Suicide Risk; 2 studies for Assessment of Risk for Aggressive Behaviors; 0 studies for Assessment of Cultural Factors; 3 studies for Assessment of Medical Health; 2 studies for Quantitative Assessment; 17 studies for Involvement of the Patient in Treatment Decision-Making; and 0 studies in Documentation of the Psychiatric Evaluation.

An update of the literature search was conducted in September 2014 using the same databases and search strategies used for the October 2011 search. These searches in September 2014 yielded 8521 additional articles in MEDLINE, 1980 additional articles in PsycINFO, and 1310 additional articles in the Cochrane database. After eliminating duplicates, 11644 abstracts were screened for relevance by two individuals (L.F., J.Y.). At total of 65 additional references met the broad inclusion criteria and, of these, 1 study was relevant to Quantitative Assessment.

For supporting sections of these guidelines (e.g., rationale, implementation), additional targeted searches of the literature were conducted to identify relevant references.

IX. Rating the Strength of Supporting Research Evidence

"Strength of supporting research evidence" describes the level of confidence that findings from scientific observation and testing of an effect of an intervention reflect the true effect. Confidence is enhanced by factors such as rigorous study design and minimal potential for study bias. Three ratings are used: high, moderate, or low.

Ratings are determined by the Systematic Review Group, after assessment of available clinical trials across four primary domains: risk of bias, consistency of findings across studies, directness of the effect on a specific health outcome, and precision of the estimate of effect. These domains and the method used to evaluate them are described under "Systematic Review Methodology."

In accordance with the Methods Guide of the Agency for Healthcare Research and Quality (AHRQ 2008), the ratings are defined as follows:

High (denoted by the letter A) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change our confidence in the estimate of effect.

Moderate (denoted by the letter B) = Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate.

Low (denoted by the letter C) = Low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate.

X. Rating the Strength of Recommendations

Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence.'

"Strength of recommendation" describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. As described under Guideline Development Process, the rating is a consensus judgment of the authors of the guideline and is endorsed by the APA Board of Trustees.

There are two possible ratings: recommendation or suggestion. These correspond to ratings of "strong" or "weak" (also termed "conditional") as defined under the GRADE method for rating recommendations in clinical practice guidelines (described in publications such as Guyatt et al. 2008 and others available on the website of the GRADE Working Group at http://gradeworkinggroup.org/index.htm). "Recommendation" (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. "Suggestion" (denoted by the numeral 2 after the guideline statement) indicates uncertainty, i.e., the balance of benefits and harms is difficult to judge, or either the benefits or the harms are unclear.

When a negative statement is made, ratings of strength of recommendation should be understood as meaning the inverse of the above, e.g., "recommendation" indicates confidence that harms clearly outweigh benefits.

When there is insufficient information to support a recommendation or a suggestion, a statement may be made that further research about the intervention is needed.

The work group determined ratings of strength of recommendation by Delphi method, i.e., through blind, iterative voting and discussion. In weighing potential benefits and harms, the group considered the strength of supporting research evidence, the results of the expert opinion survey, and their own clinical experiences and opinions. For recommendations, at least seven of the eight members of the group must have voted to "recommend" the intervention or assessment after three rounds of voting. If this level of consensus was not achieved, the work group could agree to make a "suggestion" rather than a recommendation. No suggestion or statement was made if three or more work group members voted "no statement." Differences of opinion within the group about ratings of strength of recommendation, if any, are described under Review of Available Evidence.

XI. External Review

These guidelines were made available for review in January 2014 by stakeholders including the APA membership, scientific and clinical experts, allied organizations including patient advocacy organizations, and the public. Eighty-seven individuals and ten organizations submitted comments on one or more topics of the psychiatric evaluation guidelines. The work group reviewed and addressed all comments received. Revisions to ratings of strength of recommendation were determined by new Delphi voting.

XII. Approval

These guidelines [will be] submitted to the APA Board of Trustees for approval on [date].

XIII. Glossary of Terms

Anxiety. The apprehensive anticipation of future danger or misfortune accompanied by a feeling of worry, distress, and/or somatic symptoms of tension (APA 2013).

Assessment. The process of obtaining information about a patient through any of a variety of methods, including face-to-face interview, review of medical records, physical examination (by the psychiatrist, another physician, or a medically trained clinician), diagnostic testing, or history-taking from collateral sources.

Capacity for decision making. The ability of an individual, when faced with a specific clinical or treatment-related decision, "to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices" (Applebaum 2007, p. 1835).

Cultural factors related to social environment. The interface of cultural factors with the social environment may include, but is not limited to, an individual's family network, work place, religious group, community, or other psychosocial support network.

Culture. Systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems (APA 2013).

Hopelessness. Feeling of despair about the future out of the belief that there is no possibility of a solution to current problems or a positive outcome

Impulsivity. Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress (APA 2013).

Impulsivity. Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behavior under emotional distress (APA 2013).

Initial psychiatric evaluation. A comprehensive assessment of a patient that has the following aims: identify the reason that the patient is presenting for evaluation; establish rapport with the patient; understand the patient's background, relationships, current life circumstances and strengths and vulnerabilities; establish whether the patient has a psychiatric condition; collect information needed to develop a differential diagnosis and clinical formulation; identify immediate concerns for patient safety; and develop an initial treatment plan or revise an existing plan in collaboration with the patient. Relevant information may be obtained by interviewing the patient, reviewing prior records, or obtaining

collateral information from treating clinicians, family members, or others involved in the patient's life. Physical examination, laboratory studies, imaging, psychological or neuropsychological testing, or other assessments may also be included. The psychiatric evaluation may occur in a variety of settings, including inpatient or outpatient psychiatric settings and other medical settings. The evaluation is usually time intensive. The amount of time spent depends on the complexity of the problem, the clinical setting, and the patient's ability and willingness to cooperate with the assessment. Several meetings with the patient (and family or others) over time may be necessary. 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 here. These guidelines are not intended to address such evaluations.

Panic attacks. Discrete periods of sudden onset of intense fear or terror, often associated with feelings of impending doom. During these attacks there are symptoms such as shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control (APA 2013).

Personal/cultural beliefs. Beliefs related to the patient's personal/cultural characteristics and identity, including but not limited to his or her beliefs about age, ethnicity, gender, race, religion, and sexuality.

Quantitative measures. Clinician- or patient-administered tests or scales that provide a numerical rating of features such as symptom severity, level of functioning, or quality of life and have been shown to be valid and reliable.

Stressor. Any emotional, physical, social, economic, or other factor that disrupts the normal physiological, cognitive, emotional, or behavioral balance of an individual (APA 2013).

Suicidal ideas. Thoughts of serving as the agent of one's own death.

Suicide attempt. A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury (Crosby et al. 2011). It may be aborted by the individual or interrupted by another individual .**Suicide intent.** Subjective expectation and desire for a self-injurious act to end in death.

Suicide means. The instrument or object used to engage in self-inflicted injurious behavior with any intent to die as a result of the behavior.

Suicide method. The mechanism that is used to engage in self-inflicted injurious behavior with any intent to die as a result of the behavior.

Suicide plan. Delineation of the method, means, time, place or other details for engaging in self-inflicted injurious behavior with any intent to die as a result of the behavior.

Suicide. Death caused by self-directed injurious behavior with any intent to die as a result of the behavior Crosby et al. (2011).

Therapeutic alliance. A characteristic of the relationship between the patient and clinician that describes the sense of collaboration in pursuing therapeutic goals as well as the patient's sense of attachment to the clinician and perception of whether the clinician is helpful (Gabbard 2009).

Trauma history. A history of events in the patient's life with the potential to have been emotionally traumatic, including but not limited to exposure to actual or threatened death, serious injury, illness, or sexual violence. Exposure may occur through direct experience or by observing an event in person or through technology (e.g., television, audio/video recording) or by learning of an event that occurred to a close family member or close friend. Trauma could also include early adversity, neglect, maltreatment, emotional abuse, physical abuse, or sexual abuse occurring in childhood; exposure to natural or man-made disasters; exposure to combat situations; being a victim of a violent crime; involvement in a serious motor vehicle accident; or having serious or painful or prolonged medical experiences (e.g., intensive care unit stay).

XIV. References

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XV. Disclosures

<<N.B.: disclosure information is being updated.>>

Dr. Silverman is employed as a professor at Virginia Commonwealth University. He provides expert testimony to courts. He reports no conflicts of interest with his work on these guidelines. (reviewed 7/7/14)

Dr. Galanter is employed as a professor at the New York University Medical School. He reports no conflicts of interest with his work on these guidelines. (reviewed 7/8/14)

Dr. Jackson-Triche is employed as a clinical psychiatrist by the U.S. Department of Veterans Affairs and as a professor at the University of California, Davis. She receives royalties from McGraw-Hill. She reports no conflicts of interest with her work on these guidelines. (reviewed 7/7/14)

Dr. Jacobs is a psychiatrist in private practice, on the faculty of Harvard Medical School, and provides medical-legal consultation including expert testimony on suicidality in psychiatric disorders and suicide causation. He is the president and founder of Screening for Mental Health. He reports no conflicts of interest with his work on these guidelines. (reviewed 7/21/14)

Dr. Lomax is employed as a professor at Baylor College of Medicine. He reports no conflicts of interest with his work on these guidelines. (reviewed 7/8/14)

Dr. Riba is employed as a professor at the University of Michigan. She receives royalties from American Psychiatric Publishing Inc., Saunders, Wiley, and Guilford. She reports no conflicts of interest with her work on these guidelines. (reviewed 7/9/14)

Dr. Tong is employed as a professor at the University of California, San Francisco. He receives royalty payments from Elsevier Publishing. He receives honoraria and travel funds from the National Board of Medical Examiners for test development. He reports no conflicts of interest with his work on these guidelines. (reviewed 7/9/14)

Dr. Watkins is employed as a researcher at the RAND Corporation and is a psychiatrist in private practice. She reports no conflicts of interest with her work on these guidelines. (reviewed 7/7/14)

Dr. Fochtmann is employed as a professor at Stony Brook University. She consults for the American Psychiatric Association on the development of practice guidelines. She has served as a member of Technical Expert Panels for AHRQ and PCORI reviews related to psychiatric topics. She reports no conflicts of interest with her work on these guidelines. (reviewed 7/7/14)

Dr. Rhoads is employed an assistant professor at the University of Arizona and as a medical director for the University of Arizona Medical Center, South Campus, and the Crisis Response Center. He consults for the American Psychiatric Association on the development of practice guidelines. He reports no conflicts of interest with his work on these guidelines. (reviewed 12/18/13)

<<N.B.: Before publication, we will contact the following individuals and ask how they would like to be listed in our guidelines.>>

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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 retain 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

EXECUTIVE SUMMARY

APA Board of Directors,

We are pleased to present this report on the activities of the American Psychiatric Foundation (APF).

The APF continues to represent a tremendous opportunity to leverage the combined need for public education and research into a single robust, effective, and efficient entity. We look forward to continuing the development of the vision, mission, and branding of the APF into 2015.

As we look to 2015, the APF will be facing important decisions on the diversification of our funding sources, composition of the Board, and strategic planning for the APF public education and research programs. Some key issues of the Foundation are highlighted below, with a more comprehensive programmatic update on the following pages.

APF Building Work Group

The APF Building Work Group was established with a charge to work with the APA Ad-Hoc Work Group on Real Estate, Administration, and an outside team of experts to make a recommendation to the APF Board of Directors with respect to the expiration of the facilities lease. At the October 29-30 APF Board of Directors meeting, the APF Building Work Group reported back on their deliberations and proposed a resolution for the APF Board to consider that stated the terms and conditions of the APF investment in the purchase of a building. This resolution was approved unanimously by the full APF Board of Directors.

Diversification of Funding

As we have seen over several years, it has become more difficult to obtain pharmaceutical industry funding for a range of APA/APF initiatives. Government funding also has become increasing limited for mental health research. More than ever, it is important that we continue to diversify our funding base. With the recent hire of Jane Chittick as the new APF Development Director, the Foundation will reignite its efforts to increase corporate, foundation, government, and individual donor giving. We look forward to the next Corporate Advisory Council meeting on December 4.

APF Board Membership

We welcomed two new Public Board members in 2014, Maureen O'Gara Hackett and Owen Garrick, M.D., who bring outstanding corporate and philanthropic leadership strengths to our Board. Four additional Board positions will be coming open in May 2015. This presents us an excellent opportunity to engage in discussions about the composition of the Board, including how we can diversify the expertise on the Board and shift our focus to resource acquisition. The Board will be proposing candidates for the four vacancies at the February 2015 APF Board meeting.

APF Strategic Planning/Prioritization

APF's hallmark is high-quality public education programs that are rooted in evidence-based research. In the programmatic area, we have seen the demand for the Foundation's public education programs continue to grow. Having the financial and human resources to keep up with the interest in the signature programs will be critical to meet this demand. In addition, the Report of the Research Work Group was completed in 2014. The research team will be working with APA and APF leadership to prioritize this agenda as they move forward in the coming year.

We look forward to discussing the opportunities and challenges facing the Foundation in 2015 and beyond. The following report includes a summary of current APF activities, as of November 15, 2014.

REPORT OF THE EXECUTIVE DIRECTOR

A. APF PUBLIC EDUCATION PROGRAMS

Paul T. Burke, Executive Director

Typical or Troubled?® School Mental Health Education Program

The Foundation will fund 25 school systems with grants, materials, and technical assistance training for 99 schools this school year. This represents training for over 17,500 teachers and other school staff. Two webinars were conducted to train grantees on presenting the in-service program to teachers and school staff. Conference calls with the five innovation grantees are taking place quarterly and continue to guide their program development in peer-to-peer and parent-centered training sessions. Grant submissions for the 2015-2016 school year are ongoing.

Corporate Advisory Council Memberships and Meetings

As the APA industry liaison, the Foundation is the negotiator of sponsorships with corporations at the APA meetings. Follow-up to the Annual Meeting discussions with individual companies and ongoing company discussions on membership and annual meeting benefit sponsorships are taking place. In addition, discussions of support for Foundation programs are currently taking place. Meetings with Sprout Pharmaceutical and Alcobra, two new companies in the neuroscience space, have taken place with APA and Foundation staff.

Judicial Leadership Initiative

A service scan took place on November 5, 2015, for the in-courthouse-clinic at the Superior Courts of Washington D.C., with our partner, the Council of State Governments. This is a result of a grant from Arnold and Louise Sagalyn. A training of judges occured at the Judicial Educators Annual Meeting on August 6, 2015 in Chicago. There were also state-level judicial trainings in New Hampshire on October 3, 2015, and in Texas on October 23, 2015. APF is currently preparing grant proposals for a national conference that will involve groups of community judicial leaders in late fall 2015.

Partnership for Workplace Mental Health

The Partnership received a considerable amount of press coverage in recent weeks, including mentions in the *New York Times, Forbes, Medscape, Employee Benefit News, Washington Business Journal, PsychCentral*, and numerous blogs.

The Partnership published its fourth-quarter issue of *Mental Health Works*, which featured Delta Air Lines and their work to foster mental health among their employees through numerous benefits and programs. The average open rate for *Mental Health Works* is 14.8% - well above the education industry average of 8%.

A new employer guide to the Mental Health Parity and Addiction Equity Act (MHPAEA) will be published shortly. The guide updates a previous version to reflect the law's final regulations. The Partnership worked with APA's Office of Healthcare Systems and Financing and Milliman, Inc. on this project.

Since July, Partnership staff presented at several employer conferences and webinars, including the Disability Management Employer Coalition, the Health Enhancement Research Organization (HERO), US Business Leaders Network, First Coast Business Leadership Network, and the Kennedy Forum Illinois. Staff exhibited at the National Business Coalition on Health's annual

REPORT OF THE EXECUTIVE DIRECTOR

conference. There have been 22 conference and webinar presentations to employer audiences thus far in 2014.

The Partnership actively continues its Right Direction worksite depression awareness program. Business coalitions from around the country have applied for implementation grants through the National Business Coalition on Health (NBCH) to bring Right Direction to their employer communities. Grants to be announced at NBCH's annual conference in November include: St. Louis Area Business Health Coalition, Mid-America Coalition on Health Care, South Carolina Business Coalition on Health, and the Northeast Business Group on Health. New materials were developed, including three additional posters, a business card handout, refreshed web content, a new implementation guide, and planning and evaluation tools for program.

New to the Partnership, the ICU worksite program will soon be released to employers for use in addressing stigma and encouraging help-seeking by employees in distress. The award-winning ICU program was gifted to the Partnership by DuPont. Two large employers with more than 30,000 employees are early adopters of the program and are in the process of rolling it out to their respective organizations.

The Partnership Advisory Council will meet in early November by conference call. The agenda will included a discussion about the results of a survey of Partnership employer contacts. According to the survey, 73% said that the program increased their understanding of the importance of mental health in the workplace and 56% said Partnership materials have helped them take action to address mental health in their organization.

B. APF RESEARCH

William Narrow, M.D., M.P.H., Acting Director

National Study of Psychiatric Practice under Health Care Reform

This study will provide the APA with important information on the status and readiness of psychiatrists as health services move into new models of care and on treatment gaps and access issues facing psychiatrists and their patients. Detailed analytic plans have been developed, and data analyses are under way to examine 1) psychiatrists' readiness and receptivity to changing roles and health care delivery systems; and 2) patient access to mental health treatment and services under health care reform. Data analyses are under way.

Medicaid Psychiatric Treatment Access Study

Although the Affordable Care Act reflects a major milestone in expanding health and mental health benefits and improving treatment access, there are concerns regarding the capacity of the available treatment infrastructure to meet current or increased demand for services. APF research staff fielded this study in a national sample of 1,500 psychiatrists treating Medicaid patients to document patient access to evidence-based psychosocial and pharmacologic treatments, including psychotherapy, alcohol or other substance abuse treatment, assertive community treatment, case management, supported employment, and housing. It will provide an important baseline of empirical data to support advocacy efforts for access to clinically indicated medications and psychosocial treatment for Medicaid psychiatric patients. Data analyses are under way.

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E-mail and Web-Based Physician Education Program on the Dissemination of Off-Label Use of Atypical Antipsychotics

APF research staff are collaborating with the APA Division of Education and Office of Quality Improvement and Psychiatric Services on a novel application of interactive learning modules to help educate physicians on the risks, benefits, and costs of off-label use of atypical antipsychotics. The study is supported by the Agency for Healthcare Research and Quality (AHRQ) through a demonstration research grant, which APF research staff helped develop. APF research staff are leading the evaluation of the program. The CME activity was launched in April with a self-assessment exercise, "Understanding the Evidence: Off-label Use of Atypical Antipsychotics." Five clinical vignettes with questions have been released since June, 2014, covering depression, dementia, eating disorders, anxiety disorders, and personality disorders. A vignette on PTSD is in production; additional vignettes will be released through the end of 2014. All components of the course offer *AMA PRA Category 1 Credits*™ and are available free of charge.

2015 APA Research Colloquium for Junior Investigators

This annual mentoring opportunity will be held May 17, 2015, in conjunction with the APA Annual Meeting in Toronto. A distinguished group of researchers in psychiatry has been recruited as mentors for the 2015 Research Colloquium. Successful applicants will receive a $1,000 travel stipend to present their research in a one-day meeting with distinguished senior leaders in psychiatric research. Junior investigators will receive guidance, mentorship, and information on career development and grantsmanship. The deadline for applications is December 1, 2014.

C. APF Board Approval of Awards: for information only

These award recipients were approved by the APF Board of Directors at their October 29-30, 2014 meeting.

Awards	**Recipient(s)**
Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry	James F. Leckman, MD
Agnes Purcell McGavin Award for Prevention in Child and Adolescent Psychiatry	Charles H. Zeanah, MD
Alexandra Symonds Award	Carol A. Bernstein, MD
Blanche F. Ittleson Award for Research in Child/Adolescent Psychiatry	James T. McCracken, MD
Isaac Ray Award	Marvin Swartz, MD
Kun-Po Soo Award	Russell Lim, MD
Simon Bolivar Award Lecture	Carlos A. Zarate, MD
George Tarjan Award	Marie-Claude Rigaud, MD
Administrative Psychiatry Award	Herbert Pardes, MD
APA/NIMH Vestermark Psychiatry Educator Award	Geraldine Fox, MD, MHPE

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American Psychiatry Geriatric Early Career Award supported by the John A. Hartford Foundation in honor of Dilip V. Jeste, M.D	Michelle Leigh Conroy, MD
Senior Psychiatrist Berson Award	Allan Josephson, MD
Public Psychiatry Residence	Dorothy E. Roberts, JD
Patient Advocacy Award Lecture	Patrick J. Kennedy
Deisseroth K. Adolf Meyer Award	Karl Deisseroth, MD
Alexander Grainick Award for Schizophrenia Research	Philip D. Harvey, PhD
David A Mrazek Memorial Lecture in Psychiatric Pharmacogenomics	James L. Kennedy, MD

D. OFFICE OF HIV PSYCHIATRY
Ian Hedges, Associate Director

Last month, APA received, through its new subcontractor EDC, its sixth contract for HIV mental health training, which significantly decreased the funding that the Office traditionally received, as well as moved away the majority of in-person trainings to web-based modules. The primary goals for the new contract include (1) providing training and education through predominantly virtual methods, including but not limited to web-based and online technologies for the Substance Abuse and Mental Health Services Administration to host on their website; (2) providing four national and regional in-person trainings for psychiatrists and other front-line mental health care providers (3) developing training materials to keep clinicians up to date on evidence-based research and practices; and (4) providing technical assistance to trainers and requestors of training. This opportunity also is allowing the National Association of Social Workers, the American Psychological Association, and the APA to partner with each other in presenting topics of mutual interest to each profession.

Additionally, Ian Hedges assumed the role as Associate Director of the Office of HIV Psychiatry on November 3, 2014, after Carol Svoboda and Diane Pennessi announced their departures. Since the beginning of November, the Office is promoting new, free CME modules around HIV and mental health that are available on APA's Learning Management System, which will assist physicians in states that require HIV-related CME. The Office also is rolling out a World AIDS Day Campaign to highlight current developments in the field around HIV integrated care, the widespread prevalence of HIV-associated neurocognitive disorders, and the effectiveness of pre-exposure prophylaxis (PrEP).

E. APA MINORITY FELLOWSHIP PROGRAM
Marilyn King, Assistant Director, Minority Fellowship Programs

Fellows presented two workshops at the 2014 IPS meeting in October in San Francisco: one on "Addressing Disparities in American Indian Mental Health," and the other on "Training Experiences of Minority Individuals in Psychiatry: Then, Now and How to Create the Best Future." Both of these workshops were also presented at the May Annual Meeting and were well-attended. Fellows also participated in special educational workshops titled "Advice to Young Authors from an Old Editor," facilitated by Dr. Robert Freeman and a workshop on "Medical

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Contract Negotiation," facilitated by Dr. Napoleon Higgins. Fellows and medical students met with experts during the mentor breakfast. Ten minority medical students joined the fellows at the IPS meeting, participated in special activities, and were assigned a fellow as their mentor.

Staff is preparing fellowship announcements and mailings for applications for the 2015-2016 MFP fellowship for residents and students, to be mailed to chairs, departments of psychiatry, and residency training directors as well as Deans of medical schools. We are continuing our efforts to recruit more aggressively to Native Americans and Hispanic/Latinos. Announcements also were sent regarding the research awards and the congressional fellowship.

Fellows continue to work on projects at their home institutions and participate on monthly conference calls.

The fall 2014 edition of SPECTRUM is available on the fellowship webpage and was emailed/mailed to chairs of departments of psychiatry and residency training directors as well as alumni and the District Branch networks.

Staff attended special mentoring sessions for residents and medical students at the American Academy of Child and Adolescent Psychiatry (AACAP) meeting in October.

F. LIBRARY AND ARCHIVES

Gary McMillan, M.A.L.S., M.S., Director, Melvin Sabshin Library & Archives

Public Information

Since the last report, there have been over 4,000 visitors to the Library website and nearly 900 to the Archives webpage. The librarian completed the implementation of the PolicyFinder database project. It is up and running, providing full-text access to the over 200 documents which comprise the Association's official policies. Even with limited publicity during this test phase, the database has been used by over 600 visitors.

Reference and Research Services

The librarian responded to over 150 requests for research and information as well as dozens of quick reference requests: roughly 60% from APA staff (including District Branches); 20% from members; and 20% from nonmembers (e.g., reporters, attorneys, health care providers, academics, etc.). Several in-depth research projects were completed regarding APA history and policies.

Document Delivery

Over 238 requests for documents were filled. Year-to-date, there have been over 400 document requests from members and staff, up from 380 request in 2013. Interlibrary loan lending transactions numbered 67 for this time period. Year-to-date, the Library has filled 93 interlibrary loan request, up from 34 in 2013. The Library benefits from reciprocal borrowing agreements with the Mid-Atlantic members of the National Network of Libraries of Medicine and nation-wide members of the Association of Mental Health Librarians. APA receives free articles from these library partners and, in turn, supplies journal articles free of charge to this group of libraries

REPORT OF THE EXECUTIVE DIRECTOR

which includes academic health sciences libraries, regional medical centers, specialty hospitals (e.g., Alfred I. duPont Hospital for Children and the Children's National Medical Center), psychoanalytic institutes, medical specialty associations' libraries, and government hospitals (e.g., Walter Reed National Military Medical Center and Washington DC VA Medical Center).

Visiting Scholars

Nine visiting researchers used archival collections between April and mid-November. Three more scholars are scheduled to be here before the end of the year, and appointments are being made for early 2015. One collection, the Central Inspection Board reports, was used for the first time. Because the reports were prepared under contract with state hospitals or a state mental health agency, the librarian secured permission from each state client (Maryland, North Carolina, Virginia, and West Virginia). The administrators were fascinated to read these reports from the 1940s and 1950s and noted that some of the same problems pointed out in the studies are still problems today.

This concludes the APF Report to the APA Board of Trustees.

APA Board Ad Hoc Work Group on Education and Training

Progress Report to the Board of Trustees

In August 2014, APA President, Dr. Paul Summergrad, appointed members from various levels of psychiatric education and representatives from stakeholder education associations to a new Ad Hoc Work Group on Education and Training. The **charge** of the Work Group is to make recommendations to the Board of Trustees for changes in psychiatric education and training by reviewing current pressures on residency education and training including the following areas: Graduate Medical Education (GME) funding and other funding sources, curricula changes (related to areas such as neuroscience), changed models of training for residents that are aligned with changes in health care delivery (i.e., integrated care and payment models), and research pipeline. Other issues to consider when reviewing the above areas include opportunities and challenges in residency and also reviewing medical student education; proposals for shortening the length of training (e.g., fast-tracking) and also considering the needs of subspecialties; and core changes as appropriate to psychiatric education and training fields, and as a professional society given the APA's size and within its resource and capacity.

Members of the Work Group include:

Richard Summers, MD, Chairperson
Sheldon Benjamin, MD, Member
Tami Benton, MD, Member
Carol Bernstein, MD, Member
Lara Cox, MD, Member
Jed Magen, DO, MS, Member
Michele Pato, MD, Member
Laura Roberts, MD, Member
John Sargent, MD, Member
Christopher Thomas, MD, Member
Glenda Wrenn, MD, Member
Greg Briscoe, MD, ADMSEP Representative
Carlyle Chan, MD, AAP Representative
Jeffrey Lyness, MD, ABPN Representative
Mark Rapaport, MD, AACDP Representative
Christopher Varley, MD, AADPRT Representative
Annelle Primm, MD, MPH, APA Administration
Kristin Kroeger, APA Administration
Nancy Delanoche, MS, APA Administration

Through a group survey, several conference calls and one meeting, the Work Group identified four focus areas where the APA can make the most impact:

1. **Pipeline:** Discussions within this group include: critical review of new GME funding models and advocacy around GME; ideas for engagement of medical students to increase workforce and advocacy around increasing subspecialty workforce; and APA

as convener of joint meetings with all education groups to coordinate activities in this area.

2. **Training Program Structure**: Discussions within this group include: the need for generalist training to meet public health needs; issues of fast tracking into non-child fellowships; training in integrated care; ensuring neuroscience as a core aspect of general psychiatry training; and educational outcomes.

3. **Faculty Development:** Discussions within this group include: advocacy for psychiatry as a primary care specialty; development of a teaching academy and visiting scholars programs; model curriculum for neuroscience training and research skills relevant to clinical care; development of modules for faculty development in quality improvement; review of and involvement in clinical guideline development because of their educational importance.

4. **Collaboration**: Discussions about collaboration include: support for and dissemination of the Council on Medical Education white paper on educating psychiatrists for integrated care practice; enhancement of inter-specialty education through development of initiatives with a small group of representatives from AAFP, ACP, ACOG, AAP and APA; and enhancement of inter-professional work.

The work group will present a progress report to the Board in March 2015.

REPORT OF THE DISTINGUISHED SERVICE AWARD WORK GROUP

Chairperson: Paul Summergrad, M.D. (APA President, 2014-2015)
Members: Carol C. Nadelson, M.D. (APA Past President), Allan Tasman, M.D. (APA Past President), Saul Levin, M.D., M.P.A. (Chief Executive Officer and Medical Director)
APA Administration: Margaret Dewar (Director, Association Governance), Chiharu Tobita (Sr. Projects Manager, Association Governance)

The Distinguished Service Award (DSA) Work Group met via conference call to review and discuss submitted nominees to receive the 2015 Distinguished Service Award. The DSA Work Group is pleased to recommend the following recipients of the 2015 Distinguished Service Award selected unanimously by the Work Group.

2015 Distinguished Service Award (individuals)
- Jack W. Bonner, M.D. - Joseph T. English, M.D. - Dilip V. Jeste, M.D. - Wayne J. Katon, M.D. - Helen Mayberg, M.D.
2015 Distinguished Service Award (organization)
- Academy of Psychosomatic Medicine

Distinguished Service Awards (Individuals)

Jack W. Bonner III, M.D., the Emeritus Clinical Professor of Clinical Neuropsychiatry and Behavioral Science at the University of South Carolina School of Medicine, is being recognized for his many contributions to the profession of psychiatry and its growth and development. At the APA, Dr. Bonner is known for his longtime work with APA finances as Chair of the Finance and Budget Committee and for his numerous leadership roles over the past 30 years. He has been a leader both in administrative psychiatry and in the private sector. Dr. Bonner is the recipient of the 2002 Warren Williams Assembly Speakers Award, 2005 Nancy C. A. Roeske Certificate of Recognition of Excellence in Medical Student Education Award, and received the 2011 Presidential Commendation.

Joseph T. English, M.D., the Sidney E. Frank Professor at the Department of Psychiatry and Behavioral Sciences, and the Director of the Sidney Frank and Haresh Donor Programs at New York Medical College, is being recognized for his many contributions to APA and psychiatry at the American Medical Association (AMA). Dr. English served as Chair of the AMA Section Council on Psychiatry from 1996-2001 and as a delegate from APA to AMA for 19 years. When Dr. English began his work with the AMA, , the profession of psychiatry was not well-recognized. Dr. English initiated a strategic plan to improve and expand APA's relationship with AMA. , Through his leadership, the APA and the Section Council focused on strategic priorities. Consequently, in the following 15 years, two dozen psychiatrists were elected to leadership positions at AMA, and Dr. English was appointed an AMA Commissioner of

JCAHO. AMA attitudes towards psychiatry became both respectful and admiring. His outstanding efforts ensured psychiatry's successful involvement in decision making at all levels of the House of Medicine.

Dilip V. Jeste, M.D., the Associate Dean for Health Aging and Senior Care, Estelle and Edgar Levi Chair in Aging, Distinguished Professor of Psychiatry and Neurosciences, Director of Sam and Rose Stein Institute for Research on Aging, at the University of California San Diego (UCSD), is being recognized for his contributions to geriatric psychiatry and neuropsychiatry. Before joining the UCSD, Dr. Jeste was the Chief of the Units on Movement Disorders and Dementias at NIMG and a Principal Investigator on a number of research and training grants. Dr. Jeste is a Past President of the APA, the American Association for Geriatric Psychiatry (AAGP) and the West Coast College of Biological Psychiatry, and Founding President of the International College of Geriatric Psychoneuropharmacology. Dr. Jeste has received many awards including the George Tarjan Award, and two Distinguished Lecturer Awards from the APA*; Exemplary Psychiatrist Award* from the National Alliance on Mental Illness; and the *MERIT Award* from the NIMH.

Wayne J. Katon, M.D., a Professor and Chief of Psychiatric Services and the Director of Division of Health Services & Psychiatric Epidemiology at the University of Washington School of Medicine, is being recognized for his contributions to the field of psychiatry. Dr. Katon is the Editor-in-Chief of General Hospital Psychiatry and the Past President of the Academy of Psychosomatic Medicine (2012-2013). He is known for his work on the Collaborative Care Model and his contributions as one of the leading psychosomatic researchers in the world.

Helen Mayberg, M.D., a Neurologist and a Professor of Psychiatry, Neurology, and Radiology, and Dorothy C. Fuqua Chair of Psychiatric Neuroimaging and Therapeutics, at Emory University School of Medicine, is being recognized for her leadership in a multidisciplinary depression research program dedicated to the study of brain circuits in depression and the effects of various antidepressant treatments. Dr. Mayberg was recognized by Emory University for pioneering deep brain stimulation research (DBS) which has been named as one of the first hypothesis-driving treatment strategies for a major mental illness.

Distinguished Service Award (Organization)

The Academy of Psychosomatic Medicine is being recognized for its leadership in integrated care and the education of psychiatrists in medical psychiatry. Its mission and vision states that the organization "represents psychiatrists dedicated to the advancement of medical science, education, and healthcare for persons with comorbid psychiatric and general medical conditions and provides national and international leadership in the furtherance of those goals. The Academy of Psychosomatic Medicine vigorously promotes a global agenda of excellence in clinical care for patients with comorbid psychiatric and general medical conditions by actively influencing the direction and process of research and public policy and promoting interdisciplinary education."

The Distinguished Service Awards will be presented at the Convocation Ceremony held during the 2015 APA Annual Meeting in Toronto, Canada.

Action 1:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Jack W. Bonner, M.D.?

Action 2:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Joseph T. English, M.D.?

Action 3:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Dilip V. Jeste, M.D.?

Action 4:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to, Wayne J. Katon, M.D.?

Action 5:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Distinguished Service Award to Helen Mayberg, M.D.?

Action 6:
Will the Board of Trustees approve the recommendation of the Distinguished Service Award Work Group to award the 2015 Organization Distinguished Service Award to Academy of Psychosomatic Medicine?

Board Ad Hoc Work Group on APA Referendum Voting Procedures

Members: Renée Binder, MD; Jenny Boyer, MD, JD, PHD; Glenn Martin, MD and Melinda Young, MD

Administration: CEO and Medical Director, Saul Levin, MD, MPA; APA Counsel Colleen Coyle; Director of Association Governance Margaret Dewar; Senior Projects Manager, Chiharu Tobita

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

July 2014 – The Board discussed the issue at its summer meeting and voted to appoint a WG which could consider both the APA referendum process and weigh options available for change or improvement in the current process. The WG is chaired by Dr. Renee Binder with Drs. Jenny Boyer, Glenn Martin and Melinda Young serving as members.

The work group met by conference call on October 1st, with the involvement of Dr. Levin, Ms. Coyle, Ms. Dewar and Ms. Tobita. The work group agreed on the importance of the Board giving thoughtful consideration to concerns raised by large numbers of members on important issues, and considered the best ways to address these concerns.

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

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

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

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

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